MONITOR'S BASELINE COMPLIANCE ASSESSMENT REPORT
GOLDEN GROVE ADULT CORRECTIONS AND DETENTION FACILITY
St. Croix, Virgin Islands

In Re:
UNITED STATES OF AMERICA v. THE TERRITORY OF THE VIRGIN ISLANDS
(Case No. 86/26)

Settlement Agreement of December 3, 2013

Completed by:

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Independent Monitor
December 3, 2013

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TABLE OF CONTENTS

PURPOSE

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

EXECUTIVE SUMMARY & ASSESSMENT OVERVIEW

Pursuant to Section X subsection D paragraph 1 of the Settlement Agreement, a first site visit (Baseline Assessment) was conducted September 9-13, 2013. The Monitor and Parties mutually agreed to delay the visit beyond the 30 days stated in the Agreement due to scheduling conflicts and to allow adequate time to prepare.

The monitoring team consisted of Mr. Kenneth A. Ray, Monitor and operations expert; Ronald Shansky, MD, correctional medicine expert; and Roberta Stellman, MD, correctional mental health and suicide prevention expert. The selection of Dr. Shansky and Dr. Stellman involved input and concurrence by the Parties as required in Section X subsection C paragraph 3 of the Agreement.

Prior to the site visit, the Monitor coordinated communication between the Parties and monitoring team in preparation for the onsite visit. Additionally, the Monitor provided to the Territory documents and information to assist them regarding implementation planning, policy and procedure development, as well as proposed itinerary and proposed outcomes for this visit.

The site visit included a startup meeting on the first day involving representatives from both Parties, onsite tours, staff interviews, various inspections, document reviews, meetings, and a culmination meeting during the morning of the last day. Participation and involvement by the Parties was cooperative and active. Additionally, the Monitor and the Parties reviewed a draft of the Monitor's contract proposed by the Territory and worked toward mutually amicable contract provisions. Although we were unable to finalize the contract during this time, subsequent revisions have been provided and we continue to work toward resolution on matters of conflict. Furthermore, the Monitor provided the Parties with a first-year Monitoring Budget; the budget has been approved.

Assessment Overview

This Settlement Agreement contains six (6) Sections. Each section contains a number of specific and measureable compliance requirements (Provisions). Combined, these six sections contain 129 provisions; 119 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 formulation, and 2) implementation. The Monitor and the monitoring experts provided non-binding recommendations for each provision found not in compliance with the Agreement. A draft assessment report was provided to the Parties for review and comment as required, and reasonable consideration was given to those comments in completing the final report.

The baseline assessment found 108 of the 119 provision in Noncompliance, seven (7) in Partial compliance, none in Substantial Compliance, and two (2) remain in a Pending status for review during the December 2013 site visit. Implementation provisions were not measured using these standards but a narrative description of compliance is provided at this time; the required evaluation standards may be applied in evaluating these provisions in future reports once the Monitor has more clarity about doing so from the Parties. Overall, 91% of the provisions remain in Noncompliance, 6% in Partial Compliance, 0% in Substantial Compliance, and two (2) in a Pending Status. The figure below illustrates these assessment evaluation ratings.

Each provision in this report is in bold print and shadowed for clarification purposes.

GGACF Sept 2013 Baseline Compliance Assessment Ratings

Compliance Sections	Provisions	Non Compliance	Partial Compliance	Substantial Compliance	Pending
IV. Safety and Supervision	58	52	4	0	0
V. Medical and Mental Health Care	36	34	0	0	2
VI. Life and Fire Safety	10	10	0	0	0
VII. Environmental Health and Safety	11	8	3	0	0
VIII. Training	4	4	0	0	0
Totals	119	108	7	0	2
Compliance Percentages		91%	6%	0%	2%
IX. Implementation (Narrative)	10	0	0	0	0

It is the opinion of the Monitor and monitoring experts that very little has improved at GGACF since the issuance of Findings of Fact Report (filed on 02/08/13). GGACF remains a dangerous and violent environment and is inadequately staffed, equipped, funded, maintained, and operated to provide and consistently sustain environmental and operational conditions of inmate care and confinement that meet constitutional requirements. This will be further demonstrated in the assessment findings of this report.

Policies and procedures, in general, remain underdeveloped, incomplete, and/or nonexistent, much as described in the Findings of Fact report. The lack of adequate policies and procedures contributes, in part, to inconsistent and dangerous security practices and habits. This was evidenced by cells doors and housing unit access points being padlocked and chained, internal housing unit gates being left open, housing unit control room doors being left unlocked, nonfunctional security lighting throughout external and internal security perimeters, ill-maintained security fencing, an inadequate number of and broken portable radios, nonfunctional security door control panels, nonfunctional camera system and control panels in the two operational towers, ill-maintained and broken cell door components and observation windows, and various other practices that allowed inmates to move about the campus without being searched. Exacerbating these conditions is a serious lack of adequately trained and supervised correctional staff, and an overarching common frustration among staff regarding leadership support and commitment to improve security and poor environmental conditions.

Access to and possession of dangerous contraband by inmates appears to be a pervasive and persistent problem at GGACF based on interviews, housing unit inspections, and examinations of incident reports and activity logs. The presence of knives, machetes, cell phones, and large amounts of illegal drugs, for example, continues within the facility. GGACF officials report that there has not been a facility-wide shakedown (comprehensive cell inspection and facility search) in more than two years. This is very troubling if only based on the facilities' known history of contraband and violence. However, contraband report documents provided to the Monitor show that incidents of contraband and the volume of contraband confiscated has increased significantly since the approval of the Agreement.

There appears to be no adequate complaint system in place for inmates. Although forms exist that inmates can use to present complaints and grievances, access to and submission of forms is unpredictable. Many of the boxes located in the cells used for inmates to submit complaints

and/or sick requests are broken and/or filled with garbage. It seems obvious that no systematic process exists for this requirement.

Environmental conditions remain unsanitary and unhealthy throughout the facility. Housing unit temperatures are too high despite efforts using portable coolers. Cells emit the odor of mold and mildew and many flood during heavy rains. High housing unit temperatures create risks for dehydration and dangerous side effects from psychotropic medications. Mold and mildew remains a serious problem through the housing units, cells, recreation areas, ceilings, and shower areas. Lighting is broken and/or nonfunctional in some areas. Kitchen and food service areas are in serious ill repair and dirty. Cooking equipment is broken, some are dangerously located, broken floor tiles create serious trip hazards. Insects were found on food and in kitchen areas. Inmates have limited access to drinkable water; there are broken cell sinks, toilets, and showers that must be repaired. Environmental conditions, overall, remain poor and unhealthy.

Fire and life safety conditions remain inadequate to predictably protect inmates and staff from fire and/or smoke. Fire sprinkler systems are nonfunctional and inmates use the sprinkler heads in their cells as make-shift clothesline brackets. Cell doors are padlocked, a padlocked chain provides access into one entire housing unit. Many occupied cells had exposed and/or frayed electrical wires, some near water leaks, some electrical boxes showed evidence of burn marks where electrical shorting has occurred. Fire drills are not regularly conducted nor are staff adequately trained, equipped, or prepared to effectively respond to fire emergencies. There is no fire or master key control program whereby officers are routinely assessed to demonstrate competency with basic fire safety response measures. Inmate cells are cluttered with combustible items, i.e., empty commissary packaging and paper. Inmates interviewed reported having those items for more than a month. Staff do not have access to breathing equipment needed to respond safely to a fire incident. They would not be able to safely search for or rescue others from a smoke filled structure. It does appear, however, that GGACF possesses an experienced and competent fire safety coordinator who can provide expert guidance toward compliance in these areas.

Administrative investigation policies and practices are inadequate to ensure timely review, consistent tracking, or consistent resolution of facility mishaps and staff misconduct. There is no systematic process for initiating, investigating, or managing this administrative component of quality management and assurance. Supervisors do not regularly review housing unit logs or incident reports to proactively initiate administrative inquiry into real and/or potential problems. Administrative investigations are primarily reactive and there is little evidence of follow-up.

Medical, mental health, and suicide policies, procedures, and practices are inadequate to ensure timely delivery of these health care requirements. Policies and procedures, in general, are underdeveloped or nonexistent. Existing staffing levels cannot provide adequate level of required care and administrative staff are not sufficiently engaged in program management to ensure program or care continuity. Mentally ill inmates are not properly assessed and treated in many instances. There are no formal treatment plans, no basic counseling services, few treatment encounters with qualified providers or even enough qualified providers to deliver minimum levels of care if treatment programs were possible. There is little to no follow-up or monitoring of mentally ill inmates placed in segregation by qualified mental health providers. There is no formal or systematic medication management program in place to monitor medication assisted treatment regimes. The lack of an organized, systematic, and regularly reviewed health records

system makes it very difficult to track patients or even develop any measurable health care quality assurance program.

We were provided no evidence to assess compliance with use of force or restraints provisions in the Agreement.

The training program is in a state of significant change according to GGACF officials. It is their intention to rebuild the entire training program and to bring it onsite under direct control of the Warden, which is a positive sign. However, there was no evidence provided to determine the effectiveness of the existing training program. We were provided an outline of training topics but the current training curriculum was not available for examination to determine its efficacy relative to pre- and in-service training, or whether any training topics were changed or added to accommodate implementation of the Agreement.

Agreement implementation has not appeared to have yet gained much traction. We were provided no evidence of an implementation plan beyond a very basic policy and procedure implementation schedule. A planned and systematic process for Agreement implementation does not exist and current levels of information and data tracking are insufficient to support such a process.

Despite a lack of progress and noncompliance with virtually all of the provisions in this Agreement, Territory officials voiced a serious commitment to comply with the Agreement.

BASELINE ASSESSMENT METHODOLOGY

The Baseline Assessment involved activities before, during, and following the onsite visit by the monitoring team and the Parties. The team consists of Mr. Kenneth A. Ray, M.Ed., Monitor; Roberta Stellman, MD, Psychiatrist; and, Ronald Shansky, MD, Correctional Medicine.

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

Pursuant to Section X.D.1 of the 2013 Settlement Agreement, the Monitor provided the following information to the Territory and 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 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
    - 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 will assist the Monitor to determine compliance and the degree to which each of the compliance ratings (non-compliance, 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. A monthly compliance report is proposed until the reporting system and compliance progress evolves to justify less frequent routine reporting.

Non-exclusive information required for the baseline visit and monitoring includes the following: many of these documents were not provided as requested. Territory officials stated following the baseline visit that some of this information did not exist. We, therefore, again request all documents as required under Sections X.B paragraph 2 and IX paragraph 8 of the Agreement. The Monitor offered technical assistance to the Territory to develop necessary documents that currently do not exist.

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 county 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) <u>Medical and Mental Health Information:</u>

27. A mock or blank chart containing all forms used, filed in appropriate order.
28. <u>The infection control policies.</u>
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. 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.
49. Documentation reflecting any training that facility staff have received on suicide prevention, including certificates and training materials.
50. All documents related to the any suicide occurring within the past year.
51. List of all persons on warfarin, Plavix, digoxin.

C) Suicide Prevention Information:

52. All policies and directives relevant to suicide prevention.
53. All intake screening, health evaluation, mental health assessment, and any other forms utilized for the identification of suicide risk and mental illness.
54. Any suicide prevention training curriculum regarding pre-service and in-service staff training, as well as any handouts.
55. 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.
56. The entire case files (institutional, medical and mental health), autopsy reports, and investigative reports of all inmate suicide victims within the past three years.
57. List of all serious suicide attempts (incidents resulting in medical treatment and/or hospitalization) within the past year.
58. List of names of all inmates on suicide precautions (watch) within the past year.
59. The suicide watch logs for the past year.
60. Clinical Seclusion logs for the past year.
61. Use of clinical restraint logs for the past three years.
62. Any descriptions of special mental health programs offered.

63. A list of all uses of emergency and forced psychotropic medications in the past year
64. A list of any use of force associated with the administration of psychiatric medications for the past year.
65. A description of medical and mental health's involvement/input into the disciplinary process and clearance for placement in segregation.
66. 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.

The Territory did not provide all of the documents prior to the baseline visit as requested (specifically requested items number 3, 17, 19, 22, 23, and 25-66), and as required in the Settlement Agreement (Section IX paragraph 8). This somewhat hampered preparation by the monitoring team; many, but not all, of those documents were provided during and following the visit. The Monitor was advised by Territory officials that other documents requested but were requested did not exist. We will discuss this and the matter of documents needed for periodic review during the December visit.

Documents and information provided did afford the monitoring team a reasonably basic understanding about GGACF operations and conditions from which to perform an adequate baseline assessment. However, the absence of requested documents and information did impair the monitoring teams' pre-visit, onsite, and post assessment work somewhat. Going forward, it is important to reiterate that the effectiveness of the monitoring process and the Territory's ultimate success in fulfilling its obligations with the Agreement are, in large part, products of the Monitor having timely access to requested documents. The Monitor will remain considerate of the Territory's technological and resource limitation affecting the timely access to requested documents with the understanding that the information is ultimately needed to ensure accurate, complete, comprehensive, and objective monitoring of the Agreement.

It is important to note that the onsite baseline visit was very productive despite a lack of requested information. Territory officials and participants were exceptionally cooperative, involved, and supportive throughout this aspect of the monitoring process. The Territory's repeated desire to fully comply with the Agreement was evidenced by its active cooperation and involvement in the onsite visit. Similarly, United States Department of Justice representatives participating in the onsite assessment were equally cooperative and involved, which helped to maximize visit efficiency and productively. The presence of both Parties during the onsite visit assisted assessment focus and allowed for collaborative and timely resolution of important matters of mutual interest. Therefore, the Monitor and monitoring team respectfully requests that these representatives from both Parties participate at all future assessment visits.

The monitoring team used three primary reference points from which to assess compliance and progress with Agreement. These included: 1) the agreed 2012 Findings of Fact document, 2) documents, information, and data provided prior to, during, and following the onsite assessment, and 3) the onsite visit, which included meetings, discussions, interviews, campus tours and inspections. Site inspections were conducted during daytime and nighttime hours to better understand operational functioning, strengths, and deficiencies.

During this assessment, the monitoring team toured the campus, inmate housing units and cells, dayrooms and program spaces, food service/kitchen areas, maintenance and workshops, the armory, intake/booking area, control rooms and officer posts, outer perimeter and fencing, medical and mental health areas, both active tower, and the animal pens. We talked with BOC representatives and staff, and spoke with inmates.

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: While it is recognized that the requirement to develop and implement effective policies and procedures is clearly described and defined in this Agreement, doing so does not alone either fully meet its substance or intent. Well-researched, evidence-based, comprehensively implemented and regularly evaluated and updated policies are only one tool for providing constitutionally reliable protection and care of inmates at GGACF. The substantial intent of this Agreement is to ensure that GGACF provide consistent and deliberate safety, security, and care of all inmates at all times. This requirement extends to all substantive areas i.e. security, health care, suicide prevention, sanitation, the use of force, training of staff, inmate and staff supervision, etc. It is important, therefore, to remind the Parties that completion and implementation of effective policies does not, alone, provide sufficient evidence of compliance with provisions involving policy and procedure development. Partial and Substantial Compliance requires valid and reliable proof that conditions of confinement at GGACF meet minimum constitutional requirements and are likely to continue to do so beyond the life of this agreement.

Effective correctional security policies and procedures provide staff with clearly written and systematic work methods to ensure adequate protection and care of inmates. These documents explain all the "who, what's, when's, where's, why's, and how's" while helping to ensure compliance and accountability in their implementation and efficacy.

An examination of incident reports, jail logs, and practices evidence a clear lack of adequate policies and procedures. Here are a few examples:

One September 4, 2013 an inmate was slashed in a housing unit. The records suggest that no officer was on I Unit when the attack began. One inmate pursued the inmate-victim from one housing unit to another without staff intervention and with the assistance of unlocked housing

unit doors. Once the officer arrives to stop the assault, the reports indicate that the victim-inmate spat at the officer. This officer then retreated to the office/control room. The inmate was able to gain access into this office area and a fist fight ensured before backup officers could arrive to stop the violence. The reports also indicate that during this event, many other inmates were trying to get out of the housing unit gate. The existence of, and compliance with, adequate policies and procedures could have easily prevented or mitigated this violence and serious breach in facility security.

In another incident reported to occur on July 11, 2013, an inmate-on-inmate homicide was the direct result of failures in security policy, training, and the lack of adequate security policy and practices. In this case an inmate was able to obtain a large knife and fatally stab another inmate near the kitchen area. The knife was not "home-made" but appeared to be a professionally manufactured weapon that was brought into the facility and accessible to the offending-inmate. The suspect-inmate seems to have been inadequately supervised before this event, was able to enter the G housing unit and give the knife to another inmate. This and other serious threats to inmates and staff seem virtually unstoppable based on unlocked housing and control room doors observed during the baseline assessment.

Neither or the incident reports discussed above alluded to any remedial, preventive steps to be taken or what policies or procedures were violated and/or should be reviewed to prevent future violence. The absence of any administrative reports provided to the Monitor leads to a conclusion that no administrative investigation occurred and/or no action was taken to retrain or discipline staff whose noncompliance with policies and procedure may have contributed to these events.

Most policies are in need of significant reform. Policies and procedures provided are outdated, unsigned, and most not referenced to professional regulations or standards, inconsistent, and appear to not be followed by staff in many instances based on observations of campus, housing areas, and security control areas. There are no policies or procedures that specifically stratify the defendant and offender populations (jail or prison) according to risk and needs. The two operations (jail and prison) are essentially stratified by gender and conviction status. Although the Settlement Agreement does not specifically state a condition to meet any professional standards or regulations pertaining to the operations of a correctional facility, it is highly recommended that Defendant's base policy development and implementation on professional corrections standards as they are well researched, evidence-based, and very useful in establishing and maintaining a constitutionally-sound correctional operation.

RECOMMENDATIONS:

1. Revise/develop housing classification policies based on a current validated intake and review classification instrument. Submit document drafts as indicated in the Agreement before implementation.
2. Timely complete and submit a policy development plan that includes, at a minimum, the following elements:
   A. Policy title with related procedure titles
   B. Primary policy references
   C. Person(s) responsible for document development

D. Expected dates to be forwarded to the Monitor and USDOJ for review and approval, date(s) of staff training, implementation date

3. Review current population to verify accurate risk/need classification levels and housing, reclassify and appropriately house as indicated by review process findings.
4. Refer to IV.F. regarding specific classification and housing policy recommendations.

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

ASSESSMENT: Noncompliance

FINDINGS: Post orders for all posts are vital to effective and consistent correctional operations. Post orders should be well-researched and written, easy to interpret and apply, easily accessible by staff at their duty posts, and regularly evaluated and revised as needed to ensure consistent continuity of post and facility operations.

Documents titled "Specific" and "General" post orders were provided following the baseline visit. Specific Post Orders comprise 10 pages of specific post directives, General Post Orders comprise in excess of 200 pages of general directives ranging from specific post duties to operational functions. Specific Post Order pages are not numbered, General Post Order pages are numbered but it is difficult to determine between Post Order and regulations, as they appear to be blended. The two sets of documents are formatted quite differently, none are signed by approving authority, none are dated, and none have document review, revision, and/or dates established or issued, nor do any of these documents include professional or regulatory references as previously discussed A general examination of both sets of documents suggest that many of these directives are not followed by staff based on observations of practices, housing and cell conditions. The Orders are not numbered, making it impossible to accurately reference any Order, section or subsection. Some of these directives would be virtually impossible to apply and/or comply with simply due to inadequate security staffing levels, mal- and non-functioning security equipment, and poor cell lighting. I was unable to locate any Post Order (Specific or General) that established minimum staffing levels for any security post. I also found no specific Post Orders specifying supervisor-to-officer ratios.

A partial examination of officer logs for Units L, K, X, I, and 9A dated June to September 2013 clearly evidence Post Order deficiencies, inadequate staffing levels, and/or lack of supervision as discussed:

Month	Unit	Staffing Deficiencies Reported By Officers
June	L	No relief officer at shift change
July	K	Only one (1) officer to two (2) office post
August	9A	No relief officer for break, unit officer leaves unit unattended for break
	X	Security check finds 13 female inmates unsupervised, unit rear doors not locked
	I	No officers in I/J unit at shift change
Sept	I	No supervisor on duty, no unit relief officer
	I	No supervisor unit checks during 4-12 shift

It seems more likely than not that these seven log entries reflect a larger, undocumented, problem. All of these reports evidence serious, and likely persistent and pervasive, problems

with inadequate staffing levels – though it takes no less than six to seven months to fully train a corrections officer for service – supervision, and inmate and staff safety and security.

These are only a few of many very troubling log entries written by officers. Many other entries report real and significant health risks to the inmates as demonstrated by a few log entry examples below:

June 18, 2013 (L Unit)
Basic health needs are at risk because inmates do not have access to water after nighttime lock down as stated in the log, "Last call for water at this time; slots are closed. IM DR complaining about urine bag being clogged up.

June 19, 2013 (L Unit)
- An inmate complains of head pain and "passes out in his room"
- "No staffing relief available…24-hr shift ensues". In this entry, an inmate shows an officer a blood-filled toilet after urinating.

July 18, 2013 (K Unit)
There was only one officer present when normally two are assigned to the unit. The reporting officer reports "this practice is hazardous to both officer and inmate safety due to the status of the unit." Additionally, it was reported that the backup generator did not come on during a power outage.

August 4, 2013(K unit)
The officer reports, "Major repairs are needed within the unit from lighting fixtures, missing ceiling tiles, faulty locks, cells, cracks, mold and mildew…Administration is fully aware of these safety and health hazard conditions in this facility, also discrepancies in security but blatantly refuses to rectify them!!!"

These few log entries represent only a small number of reports for only a few housing units and only over an approximate three-month period (June-early Sept) but clearly evidence serious security, safety, and health problem that appear persistent and pervasive. Additionally, it is very difficult to garner consistent compliance with policies and procedures by staff when they feel that their concerns are ignored by administrators.

RECOMMENDATIONS:

1. Subsequent to policy and procedure development and revisions, conduct a complete review of existing Specific and General Post Order to ensure they are:
   A. post specific;
   B. accurately represent post staffing needs and post resources needed to operate the post safely and consistently;
   C. are numbered, cross-referenced with policies/procedures, and formatted in a manner that makes them easy to interpret and apply;
   D. maintained at each post, kept current, and easily accessible;
   E. regularly reviewed, revised, updated;
   F. consistently enforced;
   G. known to staff through pre-service, in-service, and ongoing training.

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

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

ASSESSMENT: Noncompliance

FINDINGS: Each housing unit inspected was issued two radios and charges. However, radios were observed to be left in unit control rooms when officers were in the housing units or outside the control room with control room doors left unlocked. This practice presents an extreme staff and inmate safety and security risk without legitimate justification. Additionally, some officers interviewed complained about nonfunctioning radios and having to share one radio at times.

RECOMMENDATIONS:

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

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

FINDINGS: Based on onsite observations, interviews with staff and inmates, a review of unit and incident report logs, inmate supervision is inconsistent, unreliable, and ill-performed. Post order limitations discussed previously contribute to this problem. For example, the many of the screen mesh on the cell doors are damaged to point that they prevent clear viewing into the cell by officers and inmates were allowed to cover viewing ports to prevent the officers from performing scheduled or random security checks. This single deficiency can easily create conditions for inmates to prepare or cause serious harm to other inmates, to themselves,

conceal and/or use contraband, or experience an undetected medical or mental health emergency.

RECOMMENDATIONS:

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

B. Contraband

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

a. Clear definitions of what items constitute contraband;

ASSESSMENT: Partial Compliance

FINDINGS: Although current policies and regulations list what constitutes contraband, these policies are outdated, some are underdeveloped, and some are incomplete.

During the first day onsite, the Warden advised the monitoring team that a "shakedown" of the entire facility had not occurred in two years. This is clearly an unacceptable policy and/or practice as it creates an incarceration culture that promotes and encourages the introduction, use, and easy movement of contraband throughout the entire facility.

Additionally, at no time did I observe any inmates being searched as they entered or exited a housing unit, kitchen or shop areas, but did observe inmates entering and leaving those areas. This further encourages contraband movement throughout the campus.

RECOMMENDATIONS:

1. Review, revise, and develop contraband policies to include all forms of contraband, consequences for its introduction and possession, and actions staff are to take in its collection and disposition.

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: A review of housing unit logs (June-Sept, 2013) and Incident Log (October 2012 – September 2013) reflect a serious, dangerous, chronic, and pervasive contraband problem exists throughout the facility.

There were approximately 407 incidents reported on the Incident Log for the period examined. Almost one-third (125 /407) involved discovery of contraband and/or the likely presence of contraband (e.g., "intoxicated inmate"). The risks presented to staff, other inmates, and facility security, based on descriptions of seized contraband, ranged from minor to serious physical security breaches, to potentially deadly as shown in the table below listing items reported.

Incidents Logged

Incident Reported	2012 (3mos)	2013 (8mos)	Combined (11mos)
All Incidents	99	308	407
Contraband	42	83	125 (est.).

Contraband Found

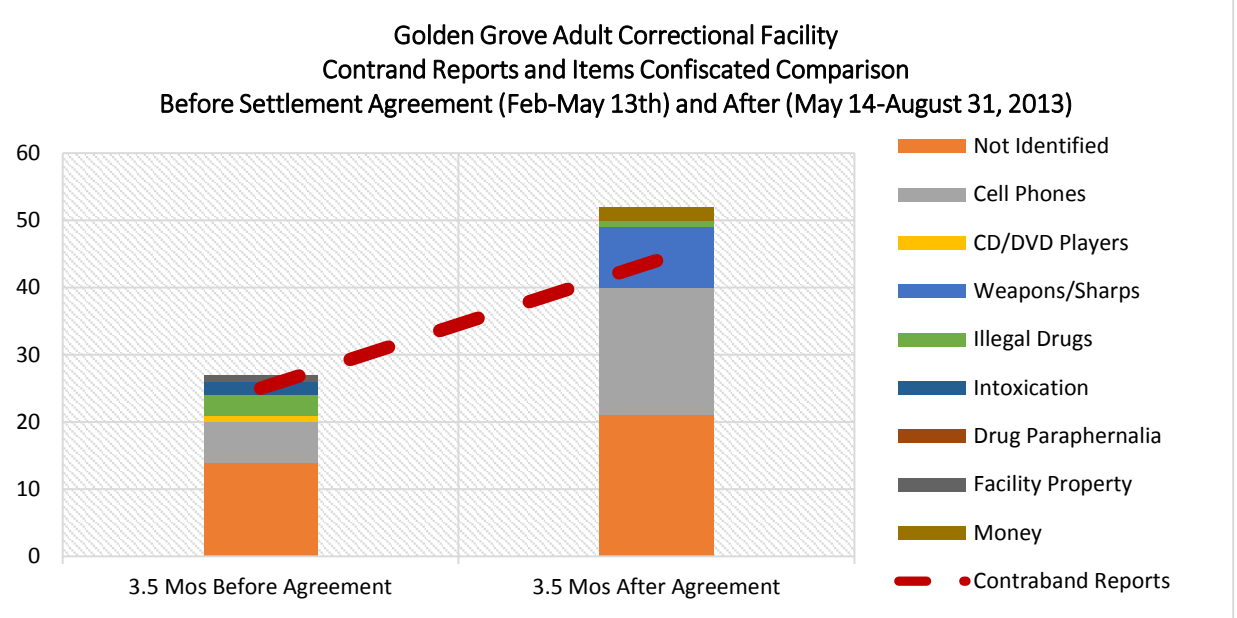
Contraband Found	2012	2013	Total (11mos)
Not Identified	16	38	54
Cell Phones	18	28	46
CD/DVD Players	0	2	2
Weapons/Sharps	2	7	9
Illegal Drugs	4	6	10
Intoxication	0	2	2
Drug Paraphernalia	1	2	3
Money	2	2	4

Contraband reporting data should be viewed as 1) positive efforts being made by GGACF officials and many staff to improve facility safety and security, and 2) as clear and convincing evidence that the facility is a dangerous environment for inmates and staff. These data also seem to support implications resulting from staffing level deficiencies, inadequate inmate and housing unit supervision, staff supervision, and the ease to which inmates can obtain contraband as evidenced by a 2013 inmate assault involving serious physical injury caused by manufactured machete, a reported removal of 73 bags of marijuana from Unit 9A in May 2013, and an inmate-on-inmate homicide occurring earlier this summer. Further analysis of contraband reports and the number of items confiscated following approval of the Order on May 14, 2013 demonstrates significant increases in these incidents and volume of most contraband-types.

A cursory analysis of contraband incident reports for 3.5 months (approximate) before and following approval of the Settlement Agreement found the following changes in reported incidents and items confiscated:

- Reported contraband incidence increased 76 percent (25/44);
- Number of unidentified items increased 50 percent (14/21);
- Number of cell phones increased 215 percent (6/19);
- Number of CD/DVD/Players decreased 100% (1/0);
- Number of Weapons/Sharps/ increased from 0 to 9 in comparison;
- Illegal drugs decreased from 3 to 1 seizures.

GGACF Contraband Reports & Confiscations Before and After Approved Settlement Agreement	Before SA Feb	Mar	Apr	May 13th	After SA May 14th	Jun	Jul	Aug	3.5 Mos Before Agreement	3.5 Mos After Agreement
Contraband Reports	3	12	10	2	2	16	9	15	25	44
Not Identified	1	5	8		0	8	6	7	14	21
Cell Phones	1	5	0	1	4	6	2	6	6	19
CD/DVD Players	1	0	0	0	0	0	0	0	1	0
Weapons/Sharps	0	0	0	0	3	3	1	2	0	9
Illegal Drugs	1	0	2	0	1	0	0	0	3	1
Intoxication	0	2	0	0	0	0	0	0	2	0
Drug Paraphernalia	0	0	0	0	0	0	0	0	0	0
Facility Property	0	0	1	0	0	0	0	0	1	0
Money	0	0	0	0	0	0	0	2	0	2
Totals	4	12	11	1	8	17	9	17	27	52



The reports do not clarify whether these increases resulted from increased attention to this issue, increased volume of contraband, or both. These findings clearly demonstrate the presence of pervasive and persistent dangers to staff and inmate safety, security, and welfare of staff and inmates that can be mitigated and better controlled via effective policies, and staff and inmate supervision.

Additionally, an inspection of the medical unit found open cabinets containing scalpels and other dangerous medical devices. Leaving exam rooms cabinets and exam rooms unlocked and unattended provides no help in preventing access to contraband and exposes inmates and staff to very serious personal safety risks.

RECOMMENDATIONS:

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

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

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

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

5. The Monitor requests electronic submission of the current Incident Log each month for review and analysis purposes, and to provide technical assistance as indicated.

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

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

ASSESSMENT: Noncompliance

FINDINGS: Refer to 1B above.

RECOMMENDATIONS: Refer to 1B above, expand application of recommendations to provision c (i-iii) above.

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

ASSESSMENT: Partial Compliance

FINDINGS: Examination of contraband incident data, current policies and procedures, and staff interviews suggest the presence of a basic confiscation and preservation practices.

RECOMMENDATIONS:

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

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

ASSESSMENT: Partial Compliance

FINDINGS: Similar to above.

RECOMMENDATIONS: Similar to above specific to admissions policies and procedures, internal and external escorts for visitors to the facility.

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: Many inmates were observed wearing personal "street clothes" and not standard-issue correctional uniforms. This practice creates substantial risk of escape and potential conflict among inmates.

RECOMMENDATIONS:

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

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

ASSESSMENT: Noncompliance

FINDINGS: None of the inmates were observed wearing correctional identification. However, the Warden has developed an inmate identification card that he showed the Monitor during this assessment and intends to implement it soon. Not all non-uniformed staff wore official identification but should. The monitoring team was provided official identification upon entry into the facility each day; the identification cards were numbered, recorded by the officer, and collected each day before our departure.

RECOMMENDATIONS:

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

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

ASSESSMENT: Noncompliance

FINDINGS: Perimeter security gates were locked during this assessment except for a few instances when entering the facility at the beginning of the assessment. Some internal campus gates stood open providing access between buildings and recreation areas. Although this can be considered efficient for certain inmate movement purposes, the practice is more likely a convenience resulting from inadequate staffing levels. Internal gates leading into housing units were unlocked as were the doors into and between unit control rooms. Unit pipe chase/electrical doors were unlocked, which provided easy access to these areas by inmates. Many cell door locks were broken, many lockable cell doors had inmate-made devices attached to them to prevent them from locking. Most of the cell doors require manual locking and unlocking due to control panel designs and some inoperability issues. Inmates have been known to exit their cells and units, allegedly undetected, access the yard or other housing and assault other inmates. It is imperative that all cell doors remain locked when locked, that inmates are prohibited from, and sanctioned for, manipulating cell or other locking devices, and staff are required to adhere at all times to basic security locking protocols.

The inmate slashing and homicide events previously discussed are two very real examples of why it is important to enforce security locking-control policies and the dangerous and deadly consequences of those policies not being consistently practiced.

RECOMMENDATIONS:

1. Review, revise, develop, train, implement, evaluation policies and procedures related to facility security pertaining to locking and unlocking access points, units and cell doors, and other locations requiring consistent access controls.
2. Repair/replace all broken locks and keys.
3. Develop, revise, implement, audit lock/key inventory.
4. Regularly inspect keys, locks, and electronic locking systems to ensure reliable functionality, detection of tampering, and timely repair/replacement.
5. Ensure staff are adequately trained in the proper use of mechanical and/or electronic locking systems according to their post assignments.
6. Consistently sanction inmates for attempting or manipulating any security locking system or device.
7. Secure access to keys and electronic locking control panels.
8. Keep security doors locked!
9. Consider replacing or upgrading existing unit control panels to provide for remote electronic locking and unlocking of unit and cell doors.
10. Increase video surveillance of internal and external access points to ensure rapid detection of attempts to disable or damage locking devices/systems.
11. Increase perimeter and internal lighting to improve detection of sabotage to locking devices and mechanisms.
12. Supervisor should inspect all locking systems during each shift and report for investigation and/or repair any signs of lock disrepair, malfunctioning, or manipulations.
13. Consistently enforce security locking policies and procedures with staff and inmates.

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

ASSESSMENT: Noncompliance

FINDINGS: The facility is currently understaffed with maintenance personnel to keep up with lock repairs and/or replacement. Unit logs examined show that staff do report unit and cell door lock problems. Otherwise refer to previous provision.

RECOMMENDATIONS:

1. Develop an "all-locks" maintenance plan for review with the Monitor during the December 2013 assessment. 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 off line.

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: According to the training assistant interview, a background and criminal history check is performed on all uniformed and civilian applicants. However, a review of a few staff personnel folders did not find documents to verify this practice, nor did the folders contain supervisory review documents. Territory officials state that these documents are on file at the BOC central office and are available for review during the next visit. It is, however, important to state that the personnel/training program is currently under redevelopment and the records filing process has not been completed.

RECOMMENDATIONS:

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

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: A comprehensive staffing analysis has not yet been initiated**,** though the parties and monitor discussed and agreed to delaying the analysis until potential operational efficiencies could be evaluated. Observations during this assessment, staff interviews, and examinations of unit and incident log strongly suggest the facility is significantly understaffed. Only two of three security towers are operational due to staffing limitations and there seems to be a chronic shortage of relief staff. Inadequate staffing levels, combined with inadequate physical security controls (e.g. functional locks, control panels, cameras, lighting, etc.), and inconsistent security practices significantly increase safety and security risks to staff, inmates, and visitors.

RECOMMENDATIONS:

1. Complete a comprehensive staffing study using the Staffing Analysis process of the National Institute of Corrections.
2. Appropriate funding to hire sufficient numbers of staff to establish and maintain adequate levels of facility safety and security in accordance with staffing analysis results.

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

ASSESSMENT: Noncompliance.

FINDINGS: The Monitor was not provided with an existing staffing plan. Security staffing schedules provided during this assessment did not provide adequate information to accurately determine authorized and actual staffing levels, or whether current security staff deployment practices met operational needs considering facility/campus design and layout, scheduled and unscheduled activities and events, population factors, etc. In the absence of those documents, I can only conclude that no standard staffing plan exists and that a policy of staffing deployment does not exist and/or is not followed, and/or is not routinely managed.

GGAF cannot effectively protect inmates and staff from harm, provide constitutional conditions of confinement, or provide adequate health care services in the absence of adequate staffing levels and plans. Staffing plans help correctional managers and supervisors devise effective staff deployment strategies, maximize and prioritize use of staffing resources, and help to ensure that staff are where they need to be, when they need to be there, doing what they need to do.

RECOMMENDATIONS:

1. Update existing security staffing plans for review with the Monitor during the December site visit.
2. Identify current and anticipated security staffing deficiencies.
3. Be prepared to discuss the staffing and analysis issues in more depth, and Plan provisions during the December visit.

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

ASSESSMENT: Noncompliance

FINDINGS: Refer to above findings.

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

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

ASSESSMENT: Noncompliance

FINDINGS: Refer to previous findings.

RECOMMENDATIONS: Refer to previous recommendations.

E. Sexual Abuse of Prisoners.

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

ASSESSMENT: Noncompliance

FINDINGS: Documents provided to the Monitor by GGACF include a general PREA policy. This policy is not dated, signed, or numbered. It is unknown if staff are aware of the policy or have completed training on PREA or this policy. The policy does not explain PREA and does not include all PREA definitions. The current policy also does not include all PREA requirements according to PREA standards. Additionally, inmate handbooks do not include PREA topics, their rights within PREA and methods for reporting violations, nor are PREA information documents provided to inmates upon admission.

RECOMMENDATIONS:

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. Complete the PREA Self-Audit.
5. Review, revise, develop, train, evaluate policies and procedures that include, at a minimum, the following PREA topics:

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

F. Classification and Housing of Prisoners

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

a. The development and implementation of an objective and annually validated system that classifies detainees and sentenced prisoners as quickly after intake

as security-needs and available information permit, and no later than 24-48 hours after intake, considering the prisoner's charge, prior commitments, age, suicide risk, history of escape, history of violence, gang affiliations, history of victimization, and special needs such as mental, physical, or developmental disability;

ASSESSMENT: Noncompliance

FINDINGS: Current classification policies and procedures are found in Section 3 of GGACF Policy and Procedure for Inmate Records, Booking and Inmate Processing, and Inmate Classification (pp.47-55, dated July 1, 1993). According to Territory Officials, the classification process was developed with the assistance of Dr. Jim Austin, classification expert, and the National Institute of Corrections. However, it is unknown whether facility-specific classification protocol was put into place. No additional or new classification policies or procedures consistent with the elements of F.1.a above were provided to the Monitor. Additionally, current policy Table of Contents shows classification procedures on pp. 47-55; Section 3 is paged 49-50 and appears to be missing several pages.

The current admission and review classification instruments are outdated and cannot, therefore, reliably reflect actual classification levels and housing decisions. The current classification is inadequate because: 1) classification decision making is not based on a current and empirically-validated classification tool, and 2) the high levels of institutional violence and contraband reporting in incident logs strongly are indicative of the absence of a valid and reliable classification system.

RECOMMENDATIONS:

1. Complete an empirical validation of the current classification instrument(s).
2. Review, revise, develop, train, implement, and evaluate policies and procedures that provide more accurate and complete guidance for a valid and reliable classification system for non-convicted and convicted inmate populations.
3. Consider requesting assistance from the National Institute of Corrections for assistance in this process and the development of an objective classification system.

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

ASSESSMENT: Noncompliance

FINDINGS: Detainees and convicted offenders are generally held in separate buildings except for female inmates who cohabitate in the same building. Inmates are generally housed according to their security level based on behavioral history and whether their background includes violent criminal acts. According to Territory Officials, inmates are also housed and/or separated for administrative, disciplinary, special needs, and/or work assignments. This is a very basic and unreliable practice for managing inmates and is not based on a reliable classification system. Such a practice is known to facilitate violence against inmates and staff,

the introduction of contraband, and can create substantial barriers to inmate health and wellbeing.

RECOMMENDATIONS:

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 to target population cohorts for housing and separation that is more consistent with behavioral risks, and needs.

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

ASSESSMENT: Noncompliance

FINDINGS: This practice is as much a classification issue as it is a security management issue. As previously discussed, security locking and unit supervision issues are inadequate and deficient based on an examination of the Incident Report and Unit logs. It is imperative that previously discussed security control deficiencies are addressed and corrected without delay. However, even the best classification tool and system is defeated when security and inmate supervisions policies and procedures are not followed consistently as observed during this assessment and evidenced in incident logs, reports, and housing unit logs.

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: Partial Compliance

FINDINGS: There is a current practice and general policy for reclassifying inmates following incidents involving violence and disciplinary events. However, this process, as previously stated, should be empirically validated.

RECOMMENDATIONS:

1. Refer to previous classification findings and recommendations.

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

ASSESSMENT: Partial Compliance

FINDINGS: The newly implemented Incident Log Report is a good step in this direction as is the activation of the GGACF Gang Intelligence Unit. Additional improvements to information and data collection and analysis are warranted.

RECOMMENDATIONS:

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

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

FINDINGS: There is currently no formal mechanism or process for regularly reviewing status and conditions of inmates housed in segregation. Several inmates housed in segregation presented with very poor hygiene and appeared to be seriously mentally ill. Some inmates interviewed indicated that they did not know how long they were to remain in segregation and several of those with apparent mental illness stated they had not seen a health care professional in weeks. There is clearly no formal monitoring process in place.

RECOMMENDATIONS:

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

G. Incidents and Referrals

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

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

ASSESSMENT: Noncompliance

FINDINGS: No such policy has been issued as of yet; this indicates that such reporting does not occur. This seems further evidenced by previous discussion involving Unit Logs wherein officers report serious security and facility deficiencies that seem to go unresolved. This lack of policy, procedure, systematic resolution and quality management appears to not only be discouraging and frustrating to correctional staff, but can promote noncompliance to policies and procedures in general, and provides management no reliable tools for effective staff deployment or security/safety hazard mitigation.

RECOMMENDATIONS:

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

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: Gang/incident intelligence team meetings are regularly held but do not include, as a rule, senior management (team leaders) as discussed above.

RECOMMENDATIONS:

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

c. Requirements for preservation of evidence; and.

ASSESSMENT: Noncompliance

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

RECOMMENDATIONS:

1. Refer to similar recommendations regarding contraband.

d. Central tracking of the above incidents.

ASSESSMENT: Noncompliance

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

RECOMMENDATIONS:

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

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

ASSESSMENT: Noncompliance

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

RECOMMENDATIONS:

1. Include this element in the required policy and procedure.
2. Establish reasonable time frames as indicated.

H. Use of Force by Staff on Prisoners

1. **Defendants will develop and submit to USDOJ and the Monitor for review and approval 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: Documents provided show that GGACF rules and regulations pertaining to staff use of force are scattered throughout these documents and not located in a unified Use for Force Policy and Procedure document, which is considered a standard method for maintaining policies. As such, it was very difficult to locate, accurately interpret, and/or reconcile similarities and conflicts between these regulations. In some cases, the regulations conflicted making it impossible to determine what and when force is authorized and used. I was unable to identify a standard Force Continuum document although Use of Force, Firearms, and Use of Chemical Agents is listed in the Pre-Service Training outline provided. I not did find use of impact weapons (batons) listed in the training outline but did observe them present in control rooms and possessed by the segregation housing officer.

RECOMMENDATIONS:

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

2. No incident report involving use of force were provided to the Monitor to determine the existence of unnecessary or excessive force. The Monitor again specifically

requests to be provided ALL documents involving incidents where force is used by staff against inmates.

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

ASSESSMENT: Noncompliance

FINDINGS: Refer to findings in H.a. above

RECOMMENDATIONS:

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

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

ASSESSMENT: Noncompliance

FINDINGS: Refer to findings in H.a. above

RECOMMENDATIONS:

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

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

ASSESSMENT: Noncompliance

FINDINGS: Refer to findings in H.a. above

RECOMMENDATIONS:

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

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

ASSESSMENT: Noncompliance

FINDINGS: Refer to findings in H.a. above

RECOMMENDATIONS:

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

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

ASSESSMENT: Noncompliance

FINDINGS: Refer to findings in H.a. above

RECOMMENDATIONS:

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

g. Supervision and videotaping of planned uses of force;

ASSESSMENT: Noncompliance

FINDINGS: Refer to findings in H.a. above

RECOMMENDATIONS:

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

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

ASSESSMENT: Noncompliance

FINDINGS: Refer to findings in H.a. above. Additionally, an interview with one tower officer revealed that they are not trained or qualified in the use of a firearm from a tower location. It is extremely important that firearms training and regular re-qualification policies mandate training and demonstration of proficiency in the use of a firearm under all conditions and circumstances in which it is authorized for use. No officer should ever be authorized to carry a firearm unless and until fully training, tested, and qualified to do so and then only under the conditions and circumstance for which they were trained to do so.

RECOMMENDATIONS:

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

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

ASSESSMENT: Noncompliance

FINDINGS: Refer to findings in H.a. above

RECOMMENDATIONS:

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

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

ASSESSMENT: Noncompliance

FINDINGS: Refer to findings in H.a. above

RECOMMENDATIONS:

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

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: Refer to findings in H.a. above

RECOMMENDATIONS:

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

1. Administrative investigation of uses of force;

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: Refer to findings in H.a. above. Also refer to findings regarding incident reporting, tracking, and quality assurance.

RECOMMENDATIONS:

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

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

ASSESSMENT: Noncompliance

FINDINGS: Refer to findings in H.a. above

RECOMMENDATIONS:

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

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

I. Use of Physical Restraints on Prisoners

1. Defendants will develop and submit to USD0J 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: Refer to findings in H.a. above. Additionally, and as previously stated, no reports involving the use of restraints were provide to the monitoring team. The absence of such reports makes it impossible to determine whether the use of restraints was reasonable, necessary, and/or permissible.

RECOMMENDATIONS:

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

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

ASSESSMENT: Noncompliance

FINDINGS: Refer to findings in H.a. above

RECOMMENDATIONS:

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

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

ASSESSMENT: Noncompliance

FINDINGS: Refer to findings in H.a. above

RECOMMENDATIONS:

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

d. Required observation of prisoners placed in restraints;

ASSESSMENT: Noncompliance

FINDINGS: Refer to findings in H.a. above

RECOMMENDATIONS:

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

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

ASSESSMENT: Noncompliance

FINDINGS: No specific policy or procedure currently exists regarding use of physical restraints on inmates with suspected or known mental illness, or that involve appropriate consultation with either medical or mental health staff.

Well researched, clear, and comprehensive policies and procedures for this aspect of force/restraints/restraint chair is critical for ensuring appropriate use of restraints involving inmates with mental illness and/or who suffer from medical conditions that could be exacerbated from restraint use. Medical and mental health staff must be involved in decisions to use and terminate use of restraints on this population.

Therefore, decision making in the use of restraints on this population must include a multidisciplinary process involving custody, medical, and mental health staff and professionals to ensure the utmost care and monitoring is taken to protect this population from psycho-emotional and/or physical harm.

It is important that all restraint devices function properly according to manufacturer specifications, are routinely inspected for functional reliability and, are applied properly and in a manner that reduces harm risks. Inmates should only be restrained if and when less restrictive alternatives have failed to ensure inmate and staff safety and/or when those alternatives are determined by the multidisciplinary process as likely ineffective.

Inmates under restraint should be regularly monitored for circulation and potential physical harm by qualified medical staff, and for psycho-emotional harm by qualified mental health staff. Restraints use should not exceed four (4) hours in duration without authorization by licensed qualified medical and mental health professionals in consultation with custody management.

RECOMMENDATIONS:

1. Develop, train, implement, and evaluate well-researched, well-written, clear, and complete policies and procedures to managing the use of restraints process.
2. Involve a multidisciplinary process in decision making to use, monitor, and terminate restraint use.
3. Train all staff in this process and the proper use of restraints and less restrictive alternatives.
4. Develop training lesson plans for this process that ensure staff competency in both knowledge and application of the restrain policies and procedures. Always train using the actual restraint devices authorized.
5. Develop and implement a reporting and tracking system for restraint use. Leadership should review all restraint use on a monthly basis to ensure policy compliance and take remedial/corrective actions, whether to policy, procedure, or staff noncompliance, in a timely manner. All remedial/corrective actions should be documented and maintained.

f. Required termination of the use of restraints.

ASSESSMENT: Noncompliance

FINDINGS: Same as above

RECOMMENDATIONS:

1. Same as above.
2. Ensure the policy includes restrictions on restraint use duration and termination requirements.

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: There are no clearly written policies and procedures for ensuring confidential access for reporting complaints or that includes assistance to inmates with cognitive and/or communication (verbal/written/auditory) impairments. Although the incident log notes "confidential" in certain cases, this practice is informal and discretionarily determined according to specific circumstances. Discussions with the Warden about this issue revealed that both confidentiality and communication impairment issues are dealt with on a case-by-case basis, but no formal policies and procedures exists. Those discussions also suggest that management is aware of these needs, takes appropriate steps to meet those needs, but does so in the absence of written guidelines.

It is also important that policies and procedures direct under what conditions housing unit officers are authorized to resolve complaints. This issue must be studied carefully with specific written controls when promulgating policies and procedures. It is important for the protection of staff and inmates that inmates have timely access to a complaint/grievance process that is unfettered by unauthorized resolution by correctional staff. Such controls and guidelines will also facilitate inmate access to their rights, care and alert facility officials (administration, security, medical, mental health) to ongoing risks to inmates and staff.

There is no formal inmate complaint/grievance tracking system currently in place. Although complaint forms are available to inmates, there is no system established to ensure that complaints are resolved, followed-up, and/or monitored. Current practices also differ among unit officers, according to inmate and staff interviews. Some officers allow free access to complaint forms, others state they attempt to resolve matters informally before issuing a form, still others require all completed complaint forms to be submitted by the inmate to the officers for further processing. Inconsistencies in the complaint process exposes staff and inmates to erroneous allegations of misconduct, increases risks of inmate abuse by staff, places inmate health care and rehabilitation at risk, and thwarts development of a valid and reliable complaint reporting and tracking system. However, even the best inmate complaint system is rendered ineffective if inmates do not have the means to ensure complaints are reliably collected and reviewed. Many of the boxes used to collect complaints and sick requests at the housing units were found unlocked and/or broken. Some of these boxes were filled with trash, which clearly evidences ineffective management oversight by housing unit officers, supervisors, and management.

RECOMMENDATIONS:

1. Review, revise, develop, train, and implement inmate complaint policies and procedures.
2. Develop and implement a valid a reliable complaint reporting and tracking system.
3. 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.

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

ASSESSMENT: Noncompliance

FINDINGS: Same as above

RECOMMENDATIONS:

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

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

ASSESSMENT: Noncompliance

FINDINGS: Again, there is no formal policy on this subject matter.

RECOMMENDATIONS:

1. Complete required policies and procedures.
2. Include specific policy and procedural provisions requiring corrective action for staff noncompliance, and that ensures timely, consistent, and appropriate disciplinary action against staff who violate the policy.

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

ASSESSMENT: Noncompliance.

FINDINGS: Same as above, and with previous discussions about records and tracking systems.

RECOMMENDATIONS:

1. Develop and implement a formal centralized tracking system of inmate complaints and grievances that includes necessary complaint information and facts and complaint disposition.

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

ASSESSMENT: Noncompliance

FINDINGS: Currently, there is no formal process or policy for periodic management review of inmate complaints. Reviews are performed on a case-by-case basis.

RECOMMENDATIONS:

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

K. Administrative Investigations

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

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

ASSESSMENT: Noncompliance

FINDINGS: These policies and procedures have not been submitted as stated above, have not been submitted to the Monitor for review and comment.

RECOMMENDATIONS:

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

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 finding 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: Same findings as above.

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: Same findings as above

RECOMMENDATIONS:

1. There is no formal pre- or in-service training program to train staff who are involved in initial and/or administrative investigation.
2. Provide adequate training of staff on topics in areas of incident scene investigation and appropriate administrative investigation methods, processes, techniques, legal and ethical issues, etc.
3. Provide training for administrative/leadership in the areas of administrative investigation oversight, coordination, and management.
4. Develop and implement, as an adjunct to these policies and procedures, an "Investigators Manual" that provides guidance to staff responsible for oversight and investigative activities.

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

ASSESSMENT: Partial Compliance

FINDINGS: Although the policies and procedures required under this provision have not been submitted as discussed, current GGACF regulations establish written penalties for staff misconduct. Discussions with the Warden indicate that corrective action against staff involved

in any misconduct does and will occur when supported by evidence. It is also important, however, to use a similar investigative/corrective action process for maintaining compliance with policies and procedures in general, e.g., following security policies, etc.

RECOMMENDATIONS:

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

V. MEDICAL AND MENTAL HEALTH CARE

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

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

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

ASSESSMENT: Noncompliance.

MEDICAL FINDINGS: At the time of our visit, we were informed that medical staff coverage was 8:00 a.m. to 8:00 p.m. seven days per week, which meant that non-qualified medical and mental health staffs, i.e., correctional officer staff, were in fact conducting the intake screens during this period. In addition, the process itself, including the policies, does not require that the qualified health care staff develop a disposition in order to facilitate continuity of care at the completion of the intake screen. As an example, a patient entered with diabetes, receiving insulin twice per day. During the intake screen, the health care person did not ascertain when the patient had received her last insulin dose and, in fact, there were no orders written to facilitate insulin dose continuity until 48 hours after intake. Clearly, this creates liability for the patient, which, with a well-designed process, would be avoidable. In addition, the intake screen lacks details with regard to a number of items related to chronic diseases, infection control matters, such as TB symptom questions, substance use details that facilitate the development of an understanding of the liability for withdrawal problems, and other items. We look forward to working with the Golden Grove staff to develop an improved process, including an improved screening tool. We were notified that in the budget to be implemented 10/1/2013, are resources to insure health care staff presence for expanded hours between 8:00 a.m. and midnight seven days per week. This would be an improvement. We also looked at the volume of detainees received between the hours of midnight and 8:00 a.m. during the three-month period of June, July, and August 2013. What we found was, of 151 intakes totally within the three-month period, 24 were admitted between midnight and 8:00 a.m. However, of those 24, 14 arrived after midnight but were released the same day. Therefore, during a three-month period, only 10 inmates arrived after midnight and stayed more than a day. We discussed with the health care leadership strategies to insure that even after midnight, if there is no health care staff person on site, the intake screen could in fact be performed by an on-call health care staff member who could do the screen via video technology from home while the patient was in the intake area. The initial screen would not include vital signs unless an officer could utilize automated equipment to collect that information. Either way, health care staff will be on site in less than eight hours and at that point, vital signs certainly could be completed. Although the current process is fraught with problems that interfere with the ability of the program to substantially comply with the Agreement, we did discuss an approach that would clearly meet the intent of the Agreement. The Golden Grove staff seemed extremely receptive to

the approach. What follows is an outline for this approach, which should ultimately be promulgated into a policy and procedure.

1. All intake health care screens are performed by qualified health care staff, mostly onsite, but during off hours, potentially via video technology while the health care staff member is at home.
2. The use of an expanded screening tool that captures significantly more relevant health care data that enables the health care staff screener to develop a plan for disposition to facilitate care continuity.
3. Training of the health care staff on the use of the new tool.
4. The development of acuity indicators that direct the health care staff screener on the urgency of scheduling the health assessment (1-3 days), a sick call visit, or a chronic care clinic visit as well as mental health follow-up, including suicide precautions.
5. The daily review of the screens and the dispositions to provide feedback to the screening staff so that their performance continually improves.
6. Included in the acuity measures are indications of when the physician must be contacted immediately based on the need for medical orders or input from the physician with regard to the appropriate steps for a given patient.
7. A tracking system for all intakes so that every intake that has been identified with some medical problems or mental health problems and who receives a plan with a specific disposition in fact has that plan carried out. This would be in the form of an intake-tracking log that includes the date that the follow-up is to occur.

RECOMMENDATIONS:

1. Out of the seven elements listed in the findings, develop a draft policy and procedure along with a new intake screening form for submission to the Monitor.
2. Feel free to solicit input and/or consultation through the Monitor for the development of this policy and procedure.

MENTAL HEALTH FINDINGS:

The intake process is flawed, and even when incoming inmates are identified through the screening tool or the officer's observations as having mental health problems referrals often do not occur, resulting in misidentification and lack of services for those individuals. The facility currently has underdeveloped, non-implemented, and non-practiced medical policies. As a result, there is not a standardized system of mental health intake assessments within the facility. Staffing is inadequate in quantity and composition to meet the needs of the seriously mentally ill housed at GGACF.

Many of the policies are well written and comprehensive but not applicable to this facility. Policies may describe an ideal vision but the procedures should always reflect the actual practice including whatever constraints exist within the facility.

RECOMMENDATIONS:

1. The nurse intake screen needs to contain all relevant data elements for both mental health history and symptoms as well as suicide screening.

2. Policies and procedures should be revised and/or developed that are consistent with number one above.

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: The policy reviewed by us requires the health assessment to be completed within three days and in fact, several records we reviewed did not have a health assessment completed within the obligatory three days. In addition, the health assessments did not always conclude with an initial problem list and plan as is appropriate in order to initiate ongoing care. Additionally, the intake screen data did not seem to impact the urgency of the completion of the health assessment. It is obvious that based on patients' acute or chronic problems, the initial health assessment is more or less urgent. A type 1 diabetic must have their health assessment performed the same day that they enter; on the other hand, a patient with good blood pressure control may have their health assessment delayed until the third day so that in the meantime the blood pressure is monitored and the clinician performing the health assessment has multiple data elements to utilize for the plan of treatment for the hypertension. It is important for the clinicians performing the health assessments to appreciate that these assessments are being completed in order to develop an initial problem list and plan for each problem, as opposed to exclusively being performed in order to document a history and physical exam. The following elements should become part of the health assessment policy.

1. Based on criteria provided to the health screener, the health assessment must be performed by an advanced level provider (MD, DO, ARNP, PA, etc.) based on medical need, on either day 1, day 2 or day 3.
2. The health assessment, when conducted for a patient with a chronic disease, should include chronic disease specific history elements in order to determine, at the time of the health assessment, an appropriate plan.
3. The health assessment for patients at risk of withdrawal problems must include relevant history and physical assessment in order to determine whether a withdrawal monitoring protocol and treatment plan needs to be implemented. Where the screening history suggests the possibility of withdrawal problems, the physician should be contacted to determine the need for withdrawal monitoring.
4. The health assessment plan for patients with chronic diseases must include referral for chronic disease follow-up.
5. Plans must include diagnostic monitoring as well as indicated therapeutic interventions.
6. An intake log should be used to track the occurrence of health assessments to determine the timeliness of necessary services.
7. The Medical Director should review each health assessment for feedback to the clinicians regarding the quality of the professional performance.

RECOMMENDATIONS:

1. Utilize the elements listed under "Findings" to promulgate a new policy and procedure for the performance of health assessments.

2. Utilize the Monitor and his team for any consultation or technical assistance.

MENTAL HEALTH FINDINGS:

The mental health assessment requirements is for an appropriately credentialed Mental Health Professional to perform a comprehensive mental health assessment for those inmates whose intake screens contain positive response for either mental health history questions and/or suicide screening. Currently the only staff person having those requirements is the psychiatrist but this person is rarely onsite and does not conduct most of these assessments.

Medical and mental health assessments are currently performed by a licensed practical nurse and licensed master in social work intern, respectively. In addition, the licensed practical nurse informed me that she has had no training specific to mental health, which is a requirement for the NCCHC intake assessment standard. Appropriately credentialed clinicians who may perform a comprehensive mental health assessment include Qualified Mental Health Professionals as defined but his agreement. These include independently licensed medical and mental health professionals with appropriate training and experience.

I spoke with the licensed practical nurse that completes all of the initial health assessments. The team was initially informed that inmates are escorted to medical as soon as they are processed at intake during the day and the next morning if the inmate comes in overnight. However, in actual practice the nurse informed me that the intake can take days to complete and sometimes even a week.

Medical staff has to obtain an escort in order to go across the compound to the intake or detainee area. However, once someone is identified by the intake nurse as having a mental health issue, the mental health counselor sees them, usually within a day. She documents a comprehensive biopsychosocial assessment in a traditional format. Unfortunately, the mental health counselor is not independently licensed as required by this standard. She currently has a license as a Master Level Social Worker Intern in Florida and an Addictions and Substance Abuse Certification. While these qualifications enable her to work effectively in providing counseling services, comprehensive psychological evaluation and treatment plans should be developed by an independently licensed mental health professional.

We also requested copies of the health services clinical staff credentials while onsite. We were told that licenses and credentials are maintained in the Bureau office and copies were not available on site for our inspection. Mrs. Jennifer Charles, the mental health coordinator, did provide me with copies of her credentials, which indicate that she is a licensed Master Social Work Intern in the State of Florida as well as a Certified Addictions Counselor.

Copies of the officers' screening are not filed in the medical record.

RECOMMENDATIONS:

1. Comprehensive mental health assessments should be performed by practitioners who are licensed to practice independently and reach diagnostic conclusions on all intakes with positive response to mental health and/or suicide question on the intake screen. It is recommended that GGACF hire an independently licensed mental health professional to

complete all initial assessments and provide services for complicated cases as well as suicide prevention monitoring.

2. Suggest the following template for comprehensive mental health assessment:

THE INITIAL MENTAL HEALTH ASSESSMENTS

SUBJECTIVE/ OBJECTIVE

- The subjective portion of the entry shall contain critical elements required by the DSM (current version) to support the differential diagnosis and global assessment of function.
- Past history will note pertinent findings such as prior hospitalizations, commitments, periods of outpatient psychiatric treatment and substance abuse treatment, any episodes a self-injury, suicidal ideation are intent and/or significant aggression. In addition, a history of victimization or perpetration of abuse should be noted. Significant medical illnesses and history of traumatic brain injury should be listed.
- Inquiry into previous work history, military history, prior incarceration, and other significant psychosocial information should be provided.
- Family history should include any history of psychiatric or substance abuse disorders as well as suicidal behavior in close family members.
- Substance abuse history including current use and previous symptoms when withdrawing should be entered in the chart.
- Current medications as well as response to prior treatment regimens should be listed.
- The mental status examination will contain appropriate corroboration in a narrative form to the symptom checklist. Thus, should the clinician check a box indicating hallucinations, it is appropriate to describe the content and nature of the reported symptom(s).

ASSESSMENT

- All assessments completed by psychiatrists, independently licensed mental health professionals, or qualified psychiatric/mental health nurse practitioners shall contain a full five axis diagnosis based on the American Psychiatric Association's DSM (current version) unless a template form does not require this information.

PLAN

- The plan will include medications (or referral for a medication evaluation) if indicated.
- Referrals for appropriate psychosocial interventions, comments on discharge planning, and a follow-up for general health needs will also be indicated in the plan.
- In addition, a risk assessment, if indicated, as well as the clinician's professional opinion as to the degree of risk will be entered.
- All records will indicate the date (or approximate date (e.g., return in 3 weeks) of the next clinically appropriate follow-up visit.

- Primary Axis I and Axis II diagnoses should be entered on the master problem list by a Qualified Medical or Mental Health Professional as defined by the Agreement.
- Other disciplines may initially list the symptom deficits such as cognitive deficits and thereafter defer to the diagnosis provided by the above specified disciplines.

3. Suggest the following template for progress note monitoring/follow-up documentation:

THE PSYCHIATRIC PROGRESS NOTE

SUBJECTIVE/OBJECTIVE

- Comments should be entered concerning any reports of side effects or relevant clinical symptoms presented by the patient.
- Describe patient's report of changing in symptom control and overall functioning.
- The clinician should comment on any recent PAC admissions, or transfers to segregation and the impact of those status changes as reported by the inmate.
- The clinician should indicate the clinical response by the patient to the current treatment plan and the presence of medication side effects.
- Significant additions and deletions in diagnostic categories should be substantiated by DSM (current version) criteria recorded in the subjective portion of the note.
- The reasons prompting significant changes in medications or the patient's treatment plan should be explained by history or findings

ASSESSMENT

- Provide an assessment pertinent to the data documented.

PLAN

- The appointment designated as the return to clinic time should be clinically appropriate.
- Laboratory studies should be ordered as clinically appropriate.
- Any planned interventions are documented

4. As part of the required Staffing analysis, GGACF should complete a detailed staffing analysis to determine the number of qualified mental health professionals required to deliver adequate services to detainees and prisoners.

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; (this report will focus on sick call under this section)

ASSESSMENT: Noncompliance.

MEDICAL FINDINGS: Although the draft policy with regard to both acute and chronic medical conditions has some useful elements within, there are not only many things missing, but also the

practice as evidenced in the records does not conform to the draft policy. We also have not seen any policy that deals with prenatal care for pregnant prisoners. With regard to acute conditions, the policy must articulate the goal that access must be provided through processes that insure confidentiality of request as well as actual clinical service. In addition, access for acute conditions must be both timely and predictable; thus, if an inmate requests service for an acute problem, they must have a reasonable expectation that they will receive that service within two days. In reviewing the housing units, we identified damaged or inoperable sick call slip collection boxes, thus resulting in requests probably going through custody staff. In addition, in reviewing medical records from a recent few days in the past month, we identified several records in which the nurse never performed an assessment, presumably because they were going to refer to the physician, but several days after the request, the patient had been seen neither by a nurse nor by a physician. This is a process that is neither timely nor predictable. With regard to the sick call process, the following elements should be integrated into the draft policy.

1. General population inmates place their requests in a locked box in their housing unit to which only health care staff has access to retrieve the slips. Slips are retrieved daily.
2. Patients in lockdown have their requests retrieved directly by health care staff on a daily basis as opposed to collection on a daily basis from a box. Slips are retrieved daily.
3. On the same day the slip is collected, it is triaged by a nurse for acuity and urgency. Those determined to be urgent or emergent must be seen that same day. Most will be seen as routine and should be seen by nursing staff within one day.
4. When a nurse determines from the paper triage that the patient will need to be seen by a clinician, they must still perform an assessment within one day.
5. Referrals to clinicians after nurse face-to face-assessment can be made on the basis of the assessed severity of the presenting symptoms, but all must be seen by a clinician within five days.
6. A sick call log must be utilized which begins with the triaging nurse entering patient identification data along with presenting complaint and the date the patient is seen for a nursing assessment. After the nursing assessment is completed, if the patient is referred on to a clinician, the date of that visit should also be tracked.
7. On a weekly basis, the head nurse should review the nursing progress notes with the respective nurses who performed the service with an eye toward identifying opportunities for improvement.
8. On a monthly basis, the Medical Director should review clinician notes with an eye toward identifying opportunities for improvement.

RECOMMENDATIONS:

1. The elements in the above findings should be used to promulgate a policy and procedure related to access to care and sick call.
2. The Monitor's team should be utilized for consultation and/or technical assistance.

MENTAL HEALTH FINDINGS:

The limited and unpredictable hours of psychiatric service are not conducive to the scheduling needs of the service. The mental health coordinator is currently performing biopsychosocial assessments independently and without review by the psychiatrist. Her credentials allow her to adequately provide counseling services, implement components of a treatment plan, conduct

group therapy, and discharge planning; however, a fully licensed master's level mental health professional should be added to the service to perform these assessment functions. In addition monitoring of individuals on suicide watch, making determinations whether to change the level of watch, following people removed from suicide watch, and development of treatment plans should be performed by a fully licensed independent master's level mental health professional. Despite several requests, we were never provided with a staffing schedule or matrix. GGACF currently has a full-time master level social worker and a part-time psychiatrist for a few hours per week. In the past, the facility contracted with a counseling service to provide group and individual counseling (The Village) but that contract ended due to nonpayment and subsequent failure to reach an agreement with this care provider. There has been no staffing increase to compensate for the loss of that service. As a result, the two staff members are providing only the minimum service consisting of assessments of referrals, counseling follow-ups for some of those people assigned to the caseload, and infrequent psychiatric visits. The counselor will expedite visits to the psychiatrist for inmates with acute problems, but the common result is a delay in the management of those inmates on the chronic care caseload because there are insufficient hours of psychiatric time to allow for scheduling of urgent and routine visits in the clinic.

The psychiatrist is currently partially retired but continues to be available to the facility. In general, it appears that he will be on site for part of Tuesday and may return on Thursdays if notified in advance by the mental health professional. Due to the sparse number of psychiatric hours currently available, some patients may be rescheduled to return to clinic in six months to a year.

In the course of our visit, we discovered one of the few female detainees who were identified as having thoughts of self-harm on intake but never received any referral to mental health. This woman identified herself to us during our tour of the facility and was obviously identifiable as a person with mental illness. Yet, she was never scheduled with mental health even though medical had filed an order from the court for a competency evaluation in her medical record. The mental health caseload represents a lower than expected percentage of inmates in treatment. The question as to whether there is under-identification of mental illness during the intake process and difficulties with that process needs to be explored through a quality improvement process.

RECOMMENDATIONS:

1. Sick requests containing mental health complaints, needs, and/or symptoms should be referred by the medical department to qualified mental health staff for review and resolution.

2. The facility needs to define by policy the qualifications required for each clinical process as well as time frames to complete these processes and provide the clinically necessary follow-up.

3. Again, a staffing analysis needs to be completed to determine the required minimum number of psychiatric hours and counseling hours needed.

4. The Bureau may wish to consider implementing tele-psychiatry to enhance the availability of psychiatry hours on an island that currently only has one psychiatrist.

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

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 medications upon discharge for prisoners with serious medical and mental health needs;

ASSESSMENT: Noncompliance.

MEDICAL FINDINGS: We have not been provided with any policy or procedures regarding medication management. The findings section, therefore, will contain elements that can be used to promulgate a policy and procedure. Medication management seems to involve a haphazard process that includes unlocked, open, and unattended pharmacy room, open medication bottles, and an overall unsecure process. This must be corrected immediately.

1. Medication management must be conducted in a manner that is consistent with professional guidelines as well as territory nursing and pharmacy practice statutes.
2. Only appropriately credentialed clinician staff may write orders for medication.
3. The goal for timeliness of patient receipt of routine medications is within 24 hours of receipt of clinician order.
4. For critical medications, defined as insulin, anticoagulants, seizure medications and other specific medications such as Plavix, along with HIV medications, an effort should be made to prevent dose discontinuity. That is, based on the community order, patients should not be allowed to miss a single dose if at all possible.
5. With few exceptions, clinicians should strive to order medications on a frequency of no more than twice per day.
6. For patients on a twice a day regimen, medication administration should occur roughly 12 hours apart.
7. A limited set of stock medication should be available onsite to be administered in order to facilitate medication continuity.
8. The stock medications onsite should ordinarily include at least one medication in every common chronic disease class.
9. Medications must be stored under lock and key with controlled substances under double lock and key.
10. Only designated staff should have access to the keys.
11. All controlled substances must be administered on a dose-by-dose basis with a record of dosages utilized, including the name of the patient who received the dosage.
12. At the end of each shift, two staff people should be present for counting the available controlled substances.
13. When medications are administered, nurses should conduct the administration according to the five rights.

14. Patients for whom medication is administered should appear with an ID card and a container of water so that they can ingest the medication with water.
15. Post-ingestion, the officers should be responsible for a mouth check to insure there is no contraband.
16. As soon after administration as possible, nurses should document on a medication administration record the receipt or the refusal of the medication.
17. On a monthly basis, the Medical Director must review the appropriateness of clinical prescribing.
18. A policy should be drafted that insures that patients about to be released to the community are provided with at least a two-week supply of any chronic medications. The policy must build in required health care reentry planning by the health care program.

RECOMMENDATIONS:

1. The above elements should be included in a draft policy and procedure dealing with medication management.
2. The Monitor staff should be sought for consultation or technical assistance in the drafting of this policy and procedure.

MENTAL HEALTH FINDINGS:

Medications are currently provided by a local Diamond pharmacy. Psychotropic medications are purchased in bulk bottles and dispensed by a licensed practical nurse on the units. An inspection of the environment revealed current stock bottles of Haldol, Stelazine, Risperdal, Zyprexa, Haldol Decanoate and Abilify. Antidepressant stock consisted of Celexa, sertraline, and Wellbutrin. Ziprisidone and benztropine are also available. No expired medications were identified. The registered nurse informed me that medications are packaged in labeled envelopes and carried to the units. However, the envelopes are simply labeled with the inmate's name. There are no other identifiers including the name of neither the medication nor the Sig. Without being knowledgeable of the US Virgin Islands Board of Pharmacy requirements I cannot comment as to whether this practice is below the local standard. Medications are administered BID.

The door to the clinic pharmacy was never observed to be locked throughout our entire period of inspection. The controlled substance key ring was noted to either be placed on the lockbox or on the desk near the door of the room even when there was no medical staff present. On the afternoon of September 10, 2013 a nonmedical staff member was observed leaning against the controlled substance cabinet in the pharmacy while speaking with a nurse. We were told that the narcotics/controlled substance count is only performed weekly. The staff has just begun a log list for sharps control but the registered nurse did not know the frequency with which these items are logged at this moment in time. This list must be properly managed and inspected into help reduce contraband within the facility and to reduce risk of serious harm to inmates and staff.

Oftentimes documentation demonstrates transcribed orders but it is unclear what time the order was written and then what time the order was actually taken off.

Almost all records reviewed on site showed no routine monitoring for psychotropic side effects including a baseline and follow-up AIMS examination on those persons receiving neuroleptic medications. This further demonstrates deficiencies involving a lack of monitoring of mentally

ill inmates housed in segregation and dangers of serious physical illness or death due to excessive exposure to heat by inmates on certain psychotropic medications.

Medication administration records do not indicate a start date, stop date, name of prescribing clinician. Some lacked frequency of administration as well.
The medical records do not consistently demonstrate monitoring for side effects from medication or consent by the inmate to accept a particular medication and their awareness of the potential side effects and risks.

There are no formal systems in place for the notification of health services by classification of upcoming releases and by health services to provide discharge medications. Staff informed us that the current time there is no discharge planning process to ensure aftercare follow-up and medication continuity.

RECOMMENDATIONS: GGACF officials must take timely action to correct the deficiencies identified in this findings section above.

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: We received a policy approved in May 2010 titled "Confidentiality of Medical, Mental Health, Dental and Recovery Services Information." This policy describes procedures for maintenance of medical, mental health, dental and recovery service files. However, the policy requires that every inmate entering a BOC facility will have a mental health file that is separate from the medical file. This particular provision is wrong. It is important that all clinical care is integrated into a single file. There may be a dental section within the medical file and a mental health section within the medical file, but the file itself must be a unitary file. The procedure indicates that the medical file must contain all medical information and that this should be maintained separate from the inmate's master file. This is appropriate. However, there are a variety of staff including a CNA or nursing staff that ultimately has a hand in medical file maintenance as an added part of their other duties. The end result is medical files that are not well maintained and therefore there is information that should be accessible timely which in fact is not. The following are some basic principles and guidelines for an effective adequate health records management system:

1. The health administrator is responsible for overseeing medical records management.
2. Medical records will be managed in a way that insures and protects patient confidentiality.
3. The record will contain a problem list that allows access to it immediately upon opening the medical record file.
4. Clinicians and only clinicians are responsible for updating the problem list with any new or additional problems.
5. Documents obtained from the provision of offsite services, such as consultations or procedures or emergency room visits or discharge summaries, must be filed only after reviewed by a clinician, who documents their name and the date of the review on the document.

6. Dental and mental health records are filed in reverse chronology, generally within their own sections.
7. The medical record program should maintain data on the percentage of records available at the time of appointments as well as the timeliness within which offsite service documents are filed within the record after receipt and review by clinicians from the offsite service.
8. This service needs a policy on medical records documentation that would include required elements in each different type of documentation. For example, a standardized progress note for psychiatry that routinely assessed for medication side effects would ensure better compliance in monitoring for these common problems and allow for quality assurance chart review.

9. GUIDELINES APPLICABLE TO ALL MEDICAL RECORD ENTRIES:
   - All entries shall be legible
   - Each entry shall list the inmate's name and MDC number
   - Each entry shall be signed by the clinician and indicate their professional degree
   - All entries shall be dated and timed
   - Current housing location, such as special housing or isolation, should be apparent by reading the chart
   - Every assessment and clinical visit notation shall follow the SOAP format (unless the documentation is on a required template that is structured differently) and make every effort to provide the narrative information necessary for another clinician to understand the writer's assessment.

RECOMMENDATIONS:

1. The above elements should be utilized to draft a more detailed medical record policy.
2. The Monitor's staff should be utilized as resources to facilitate development of the policy and procedure.

MENTAL HEALTH FINDINGS:

Medical records are stored in a separate room. They are alphabetized and do not have a Bureau of Corrections number. Name alerts are utilized when necessary.

There are no medical records personnel to organize and maintain the medical files. As a result, the records are disorganized. The mental health professional reported she was told not to file records in the charts until they were reorganized.

Medication administration records show orders transcribed but lack essential components such as a start date, stop date, and the name of the ordering clinician. The administration records may demonstrate significant medication noncompliance, yet there is no system of written notification to the clinician and no evidence in the records reviewed that medication compliance is taken into consideration at the time of the visit. More often than not, MARs are missing from the medical record.

The medical records are not in chronological order and records are not always filed in the correct section of the chart. Chart sections are not labeled. Some charts are combined medical and

mental health records while others are separated and the facility should consistently do one or the other.

There is no policy that drives the organization and quality of the medical record. Medication administration records were frequently absent for months at a time. Entries are not routinely timed and often the signature is illegible and lacks credentials. The quality of the documentation is poor and often insufficient to support a diagnosis and treatment plan.

The only documents that contain a current and past history consistently are the biopsychosocial assessments completed by the mental health coordinator. However, many of the charts reviewed did not contain this document and therefore, more often than not, lack of a past and present history.

RECOMMENDATIONS:

1. One chart per inmate, combining medical and mental health documentation for an integrated record.
2. I have recommended that the mental health professional immediately file her notes in the medical record so they are available for the psychiatrist to review.
3. A policy needs to be developed with documentation guidelines and instructions for organizing and maintaining the medical record.
4. Quality improvement effort should be undertaken to track compliance with policy once implemented.

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

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

ASSESSMENT: Noncompliance.

MEDICAL FINDINGS: This items was dealt with under letter (c), including recommendations for the policies. Although logging was occurring, it was not performed conscientiously and there were inconsistencies between the logging and what was found in the medical records.

RECOMMENDATIONS: See letter (c) findings and recommendations.

MENTAL HEALTH FINDINGS: The current sick call process is not confidential because inmates must hand their requests to an officer. Sick call request boxes on the units were served be either broken, used to store other equipment, or unlocked and therefore useless. At the current time, the facility has not implemented a sick call log that would enable demonstrating compliance with all of the above requirements.

RECOMMENDATIONS:

1. A confidential process needs to be established that enables:

- monitoring of the timeliness of retrieval of sick call requests
- appropriate triaging by a registered nurse or mental health professional (in the case of mental health requests)
- timeliness of response by the appropriate qualified health professional
- appropriateness and effectiveness of the treatment plan generated.

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

ASSESSMENT: Noncompliance

MEDICAL FINDINGS: Tracking of care and monitoring of these services was found to be either non-existent, incomplete, inconsistent, and/or not routinely reviewed and utilized as indicated. We have described in each required service area how tracking of care and monitoring should be performed.

MENTAL HEALTH FINDINGS: Same as above.

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

ASSESSMENT: Noncompliance.

MEDICAL FINDINGS: Some work has been completed, starting with the creation of a chronic care policy as well as chronic disease guidelines based on material prepared by the National Commission on Correctional Health Care. In addition, an internist who is a cardiologist has been hired to see chronic care patients onsite weekly. All of this is very encouraging. However, what needs to be done is the completion of the chronic care policy and the training of the onsite consultant so that he is familiar with both the chronic disease guidelines and the policy. At this point, that familiarity does not exist. In addition, clarity needs to be developed with regard to how to insure continuity of care from the moment patients with chronic diseases enter the facility. Under (a) we described an example of a recently entering detainee with type 2 diabetes maintained on insulin for whom orders were not written, including for the insulin, until about 48 hours after she entered. The chronic disease policy must describe a method for approaching these diseases from the point of identification on entry and be designed in a way that is consistent with the urgency of the medical need. This begins with the screen, is succeeded by the health assessment and then the initial chronic disease visit. The following elements are critical to a well-run chronic disease program.

1. The model that is utilized must be based on the concept of disease control with (for common diseases) standard definitions of good, fair and poor control. The NCCHC chronic disease guidelines utilize this format.
2. The clinical practice must be consistent with the chronic disease guidelines.
3. The policy must address patients who enter with critical needs, such as insulin. An example would be for patients with type 1 diabetes or whose disease is poorly controlled, such as a patient with extremely elevated blood pressure. Patients whose disease is poorly controlled should be seen as soon as possible, with at minimum a call to the on-call physician. Based

on the patient's medication and other needs and degree of control, the health assessment may take place in a range of from 1-3 days, based on clinical need.

4. The program must require an initial chronic disease visit during which substantial disease specific history is obtained, identifying symptoms and organ damage and current disease control. The NCCHC website has both initial chronic disease visit forms and a form for follow-up visits. These were discussed with the internist consultant, who appeared quite interested in utilizing them for documentation. These forms require specific questions based on each specific common disease be asked during the history.
5. The guidelines should describe what the baseline diagnostic assessment must include and these should be followed by the clinician.
6. Patients should be followed at a frequency dictated by disease control. In general, patients in good control may only need to be seen every three months; those in poor control must be seen in no more than four weeks.
7. At the visits, the medication regimen should be reviewed and orders written that insure that the patient does not run out of medication prior to the next visit.
8. At the first clinician visit, the chronic disease problem must be entered on the problem list and the patient referred to the internist and enrolled in the chronic care program. The program must maintain a chronic disease registry, which indicates which patients have one or more specific chronic diseases. This registry is dynamic, as people are entering weekly and being released weekly. A nurse may be assigned to maintain the chronic disease registry.
9. The Medical Director should review the chronic disease records on a regular basis for both compliance with the chronic disease guidelines as well as determining whether the clinician took appropriate action when the degree of control was either fair or poor.

RECOMMENDATIONS:

1. Utilize the above nine elements to expand your chronic disease policy and the guidelines as well as the forms.
2. Contact the Monitor and his staff for consultation and/or technical assistance.

MENTAL HEALTH FINDINGS:

Currently, the mental health professional maintains the case list that identifies those inmates followed both on the detainee and the sentence side of the facility by the psychiatrist. The psychiatrist informed me that inmates prescribed medications for a temporary problem will not be included in the caseload. The list contains the inmates name, diagnosis, medication regimen, BOC number, and date of birth. The list is lacking the date for the next psychiatric and counseling visit. In reviewing the medical records it is clear that people are not scheduled for follow-up as medically necessary or in a timely manner.

RECOMMENDATIONS:

1. A minor modification to the current case list log as recommended above would improve the tracking capabilities of the facility.

2. The list should contain both the BOC number and the inmates' date of birth.

3. Any inmate followed by mental health should be captured on a log, perhaps one for psychiatry and one for counseling.

ASSESSMENT: Noncompliance

MEDICAL FINDINGS:

RECOMMENDATIONS:

MENTAL HEALTH FINDINGS:

Patients are scheduled in chronic care mental health clinic in unpredictable and inconsistent fashions. Frequently people appear to be lost to follow-up and may be seen every 5 to 12 months despite a diagnosis of a serious mental illness.

Chart review uncovered examples of inmates decompensating during a long hiatus between visits, which may have been prevented had they been followed more frequently.
Inmates who presented with acute symptomatology were not scheduled for an earlier follow-up, but again may have been seen months later, which may result in prolonged housing in isolation, or deterioration in the person's condition.

RECOMMENDATIONS:

1. As mentioned previously, a policy that would dictate required time frames for follow-up of people in the chronic care mental health clinic may improve the timeliness of return visits and allow for tracking when looking for quality outcomes.
2. All prison inmates on a mental health caseload should have at a minimum a monthly well-being check by a mental health professional. Minimum frequency of psychiatric visits should be outlined by policy.

See related findings by Dr. Shansky for items v, vi, g. and h.

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

ASSESSMENT: Noncompliance.

MEDICAL FINDINGS: We have been provided neither complete training materials nor documentation of staff who have completed the required training. We are also aware that there have been difficulties communicating with the on-call physician. The line staff expressed frustration about being able to access a clinician timely during an urgent or emergent problem. This issue must be resolved. We understand that there is a plan to have a full-time Medical Director responsible for both St. Croix and St. Thomas. That person needs to own the clinical outcomes of the patient population. One will not be able to expect that type of ownership and accessibility unless the territory makes a

commitment both financially and otherwise to the proposed Medical Director. The prognosis for the medical program hinges in our opinion on the territory's ability to make a satisfactory commitment to their Medical Director, who must then make a commitment to the patients and staff. The Medical Director must not only be accessible by phone but also be involved in training staff and seeing patients onsite. This will be discussed in greater detail under letter (j) that addresses staffing. The emergency care urgent/emergent policy must address the following items:

1. Urgency is based exclusively on patient perception.
2. When a patient notifies a custody officer that they have an urgent problem, the custody officer is required to contact medical without exception and medical is obligated to perform an assessment, preferably in the clinic but possibly in the housing unit, also without exception.
3. Based on that assessment, the patient's problem can be addressed definitively or an advanced level clinician must be contacted for further direction. An advanced level clinician may need to come in or the nurse may place the patient on the phone with the advanced level clinician who can perform part of the assessment telephonically.
4. All urgent care calls must be logged into an urgent care log that contains patient identifiers, date, time, presenting complaint and disposition. Where the disposition requires sending the patient offsite to an emergency room, when the patient returns the patient must be returned through the medical unit, a nurse must review the offsite service paperwork and where indicated, contact the advanced level clinician. If the offsite service paperwork is not available, the nurse should contact the emergency room and have that documentation faxed or scanned and sent by e-mail.
5. Based on the patient's condition on return, the patient may be held for observation or returned to his housing unit. In any event, there must be a primary care clinician follow-up visit with the patient as soon as possible but in no more than three days. At that visit, the primary care clinician must document a discussion with the patient regarding the offsite service findings and any plans.
6. The emergency response policy should include requirements for training and certification in basic like support and first aid, documentation of such training as well as requirements for emergency drills.

RECOMMENDATIONS:

1. The above elements should be utilized in drafting the urgent/emergent care policy and in constructing the urgent/emergent care log.
2. The Monitor and his team should be contacted for any consultation or technical assistance.

MENTAL HEALTH FINDINGS: The island hospital has closed their psychiatric unit. When patients have acute situations that cannot be managed within the facility they can be sent to the emergency room. That department can maintain the individual for up to 48 hours while attempting to medicate them for stabilization. Once the patient is compliant with medications they are returned to GGACF. If needed they are placed in isolation until they are able to take their medications, eat, and follow commands. If necessary, the facility will have to locate an off-island psychiatric hospital.

There were no current cases to review that required such placement. The facility currently does not have a log of inmates sent to the emergency departments and therefore retrospective review for quality purposes cannot be done.

The facility is currently not staffed adequately and designed physically to accept and monitor acutely ill persons with a mental illness once the emergency room releases them after 48 hours if they remain acutely ill.

There are communication issues between security and medical at the facility. When someone is sent on an emergency basis to the hospital after hours that information is not relayed in a timely fashion to the medical department. In addition, the list of who was sent out from the facility is not accurate according to the medical director. The medical service must depend on the log from transportation, which currently is being provided at the end of each month by security.

Currently, emergency requests are completed within 24 hours and routine within 48 hours. Access is dependent on the availability of patrol rovers. When there is an urgent need the staff can call the warden to obtain a rover.

RECOMMENDATIONS:

1. Suggest a policy that is highly detailed and provides a well delineated list of staff responsibilities to emergency response.
2. Facilitate an emergency transportation system.
3. Train staff in CPR and schedule CPR-certified staff during hours when medical staff is unavailable.
4. Stock the following essential equipment in a secure location and train staff on use: respiratory barriers, Ambu bags, and defibrillators.
5. Schedule accordingly so there is Correctional staff available to provide non-ambulance transportation to an off-site healthcare facility.

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

ASSESSMENT: Noncompliance

MEDICAL FINDINGS: With regard to the timely referral for specialty care and procedures, the following elements should be utilized to promulgate the policy and procedure.

1. Prior to an order for a specialty consultation or procedure, there should be a progress note in the record indicating the basis for the need for such services.
2. Once the order is written, it should be received by a scheduler who schedules the appointment within 30 days or less.
3. The day before the appointment is to occur, custody must be informed so that they can prepare the escort resources necessary for the service to be obtained.
4. If the service is cancelled by the offsite service, or because of lack of custody, it must be rescheduled as soon as possible.
5. At the time of the progress note, the clinician should be describing the service to the patient in order to avoid ordering something that would later be refused.

6. When the patient returns from the offsite, custody must bring the patient to the medical staff, who can determine whether the offsite service report is available. If it is not, they must contact the offsite service and have it faxed or scanned and sent.
7. When the nurse reviews the report, they must determine whether there may be any urgent orders, in which case the physician must be contacted for such orders.
8. Once the report is available, the patient should be scheduled to be seen by the Medical Director or designee so that there can be documentation of a discussion with the patient regarding the findings and plan. All of these elements must be part of the policy and procedure.

RECOMMENDATIONS:

1. Use the above elements to construct an offsite service policy and procedure.
2. Contact the Monitor or his team if any technical assistance or consultation is needed.

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

ASSESSMENT: Noncompliance

MEDICAL FINDINGS: Overall, follow-up care was found inconsistent or non-existent. Follow-up requirements are described in each service area.

RECOMMENDATIONS: See above

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

ASSESSMENT: Noncompliance.

MEDICAL FINDINGS: We have not been provided documents regarding the intoxication and detoxification policies and procedures and/or guidelines. The intake screen is the place where the program makes its initial determination about the liability related to whether either intoxication or detoxification are relevant issues. This requires that a more detailed substance history is obtained. We will work with the staff to enhance the intake medical screen so that critical information is obtained at the time of the intake screen. Critical information includes the duration and volume of substance use, the most recent use, any history of withdrawal symptoms or hospitalizations, all of which can be utilized to determine the risk. In addition, the Medical Director must develop protocols at a minimum for alcohol, benzodiazepines and opiates that include both monitoring, usually performed by nurse staffing, as well as treatment. The monitoring by the nurses should include a scoring methodology, above which requires contact with the physician. We will work with the Medical Director and nursing staff to insure these elements are created.

RECOMMENDATIONS:

1. Develop policy and procedure and guidelines beginning with intake screening and leading to protocols for monitoring and treating each of the major common substances.
2. Contact the Monitor or his staff for consultation and/or technical assistance.

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

ASSESSMENT: Noncompliance.

MEDICAL FINDINGS: We reviewed two documents, one labeled "Infection Control Activities," and the other labeled "Infectious Disease Management." The first document, Infection Control Activities, begins with a description of universal precautions. However, it does not provide the basis for the universal precautions. The basis of universal precautions is the assumption that all bodily fluids are potentially infected and therefore precautions have to be utilized when dealing with them. The infection control activities policy should begin with that statement, and then the application of the policy flows logically. The infection control activities policy also describes training of inmates to perform cleanup activities when bodily fluids soil items, and yet we have not seen any training materials that would suggest the inmates are adequately trained. There is a section that deals with post-exposure prophylaxis that appears to be consistent with Centers for Disease Control recommendations. There is also a section on surveillance activities, which should be reported on a quarterly basis to the quality improvement committee. Such a report should include not only the incidence of sexually transmitted diseases, HIV infections, hepatitis and MRSA and food poisoning but also sanitation and sterilization activities in the dental program along with post-op infection rates in the dental program. The infectious disease management program and policy need some adjustment, particularly with regard to tuberculosis testing and treatment. As an example, under tuberculosis testing and treatment, number 3 states, "Inmates with signs and symptoms of potential infections will be placed on respiratory isolation until his or her PPD is read." If patients have signs and symptoms of active tuberculosis, they must have a chest x-ray as soon as possible to rule out active disease. This is independent of the skin test result. In addition, it indicates that patients with a history of prior positive skin test will obtain a chest x-ray and will remain in respiratory isolation and protective mask until the x-ray results are available. This is not necessary. Patients with a prior history of positive PPD should be queried regarding TB symptoms. If in fact the query is completely negative, there is no need for isolation until the chest x-ray is completed. Therefore, the infectious disease management policy does require some additional modifications.

RECOMMENDATIONS:

1. Work through the Monitor and his staff for consultation and/or technical assistance.

i. Adequate suicide prevention, including:

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

ASSESSMENT: Noncompliance

MENTAL HEALTH FINDINGS: The facility practice regarding suicide watch does not comply with the policy presented for review. The mental health staff is unaware of any suicide watch in the facility since March 2013. Yet, in reviewing the officers' log for L unit, an individual was

identified as being on suicide watch on June 24, 2013. This person was never referred to mental health by a behavioral checklist. No suicide risk assessment tool has been implemented.

RECOMMENDATIONS:

GGACF needs to develop a communication system that is timely and reliable for notification regarding inmates placed on suicide watch, behavioral referral requests, and intake referrals.

(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: As mentioned elsewhere in the body of this report, despite a policy outlining how suicide watch should be documented and at what frequency, the officer logs in no way reflect that practice The facility currently is thinking of retrofitting a smaller group holding cell into a suicide prevention cell because there are no cells within the housing units that would meet qualifications as a suicide resistant cell. We were told that when somebody is on suicide watch they are kept in their cell under constant observation. However, review of security logs did not support that information.

RECOMMENDATIONS:

While the current policy does define the frequency of watch, it has not been approved and implemented. The policy needs to be put into effect.

(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: There is no suicide risk assessment instrument available. Mental health is not always notified of the suicide watch and therefore a 24-hour time frame cannot be met.

RECOMMENDATIONS:

1. A practical policy and procedure needs to be implemented and monitored for compliance.
2. It is suggested that the service considered developing a standardized progress note that would include a suicide risk assessment and a suicide watch treatment plan.

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

ASSESSMENT: **Pending next inspection**

MENTAL HEALTH FINDINGS: We were told that cut down tools are located in the officers control center. The monitoring team did not inspect for cut down tools, however.

(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: See the report of findings by Mr. Ray.

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

ASSESSMENT: Noncompliance

MENTAL HEALTH FINDINGS: See the report of findings by Mr. Ray.

(vii) availability of suicide resistant cells;

ASSESSMENT: Noncompliance

MENTAL HEALTH FINDINGS: Currently there are no suicide-resistant cells within the facility. The warden is considering converting a holding cell in the intake area into a suicide resistant cell.

RECOMMENDATIONS:

1. Given the difficulty expressed by medical staff in obtaining the patrol officer to escort them to the intake area, it is unlikely this location would facilitate compliance with the proposed policy that requires daily assessment by mental health.

2. In addition, most policies will require nursing rounds each shift as well as administration of medication as ordered.

3. Retrofit cells designated for suicidal inmates to be suicide proof. Consult with Mr. Ray about retrofit options and specifications as needed.

(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: We were informed that the facility places all inmates on suicide watch on constant observation due to the absence of the suicide resistant cell. However, the one log entry indicating an inmate was placed on suicide watch by security not only failed to document the watch every 15 min., but the only entries in the log for the entire unit's activities was recorded by the unit officer. In addition, the log is maintained in the officers' bubble, which

would mean that constant observation would have to be broken for the second officer to enter the bubble and make an entry every 15 min.

Inmates are currently housed on L-unit for monitoring. Our observation of the cells on that unit indicated very impaired visibility through a small window screen in the door that would make it unlikely an officer could conduct an adequate constant observation of a person in that cell. The height of the window and the food port are such that to carry out constant observation would require a person to either stand constantly or sit in a very crouched position in order to attempt the observation. Neither is desirable and nor likely to occur as required by the current policy draft.

RECOMMENDATIONS:

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

(ix) procedures to assure implementation of directives from a mental health professional regarding:
(1) the confinement and care of suicidal prisoners;
(2) the removal from watch; and
(3) follow-up assessments at clinically appropriate intervals;

ASSESSMENT: Noncompliance

MENTAL HEALTH FINDINGS: Cells used for suicide prevention are in the segregation unit and are at best hazardous due to poor visibility, lack of suicide resistant measures, inadequate security staffing to provide the necessary observation, no evidence of nursing involvement in the monitoring of individuals on the high level of watch, and no evidence of mental health intervention while on watch.

Staff informed me that when they are notified of someone being placed on suicide watch the mental health counselor will arrange to see the patient. There is no written communication from mental health back to security regarding what property the inmate can have and the frequency of observation required. No suicide risk assessment tool has been implemented. The mental health staff are not following any formal guidelines for suicide watch follow-up.
There is no systemized involvement of mental health in evaluating inmates prior to placement in segregation, assessing whether there are mitigating circumstances secondary to the presence of a serious mental illness, enhanced support by mental health while people with serious mental illness are housed in segregation, no systemized review of competence to refuse treatments by the most seriously mentally ill inmates, and no programming available to aid the inmate in advancing off of segregation into general housing.

In reviewing the only case of someone placed on watch in the past nine months, it is obvious that there was no medical or mental health involvement in the case. Mental health was not notified of a person being placed on watch and therefore was unavailable to assess them and determine whether Cells used for suicide prevention are in the segregation unit and are at best hazardous due to poor visibility, lack of suicide resistant measures, inadequate security staffing to provide the necessary observation, no evidence of nursing involvement in the monitoring of individuals on the high level of watch, and no evidence of mental health intervention while on watch, they could be removed from watch. The officer that initiated the watch only conducted 30 min. checks during their shift. On the following shift no safety checks were performed. In addition, on the following shift safety checks were documented once every hour. There after no further checks were done. The current method of managing someone on suicide watch seems chaotic and idiosyncratic.

RECOMMENDATIONS:

1. The facility needs a policy that reflects the current capabilities and provides the greatest amount of supervision required to safely monitor someone on suicide watch.

2. Renovation of an intake cell may be the only immediate alternative.

3. If this environment is utilized then the facility needs to carefully monitor how readily medical and mental health staff can maintain daily contact with the inmates.

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

ASSESSMENT: Noncompliance.

MEDICAL FINDINGS: We have requested a copy of the staffing plan to be implemented on October 1, 2013, which has not been provided. Under the current arrangement, there is supposed to be a Medical Director onsite at least two days per week, but staff indicates that this is not usually happening. In fact, they also have difficulty accessing the Medical Director for urgent/emergent problems. It is a requirement that we have to know what staffing is available onsite. We believe that the Medical Director should be seeing patients at least two days per week. We are aware that a physician assistant sees patients on Saturday and Sunday and an internist/cardiologist is seeing patients on Fridays. If the Medical Director saw patients Tuesdays and Thursdays, there would never be two days in a row without an onsite clinician. We are also aware that the plan is to have nursing staff available from 8:00 a.m. to midnight, seven days per week. It is our belief that if that coverage is made available, and a nurse on call could perform midnight to 8:00 a.m. intake screens, which seem to occur about four times per month, the intake process would be completely based on health care staff screening. If that screening results in a disposition that resulted in a plan for patients to be seen based on urgency, then no patient would go without being seen for more than a day. We would like to see the staffing plan that has been proposed in the current budget request and we would like to see the plan to utilize those resources. It is our belief that the staffing for medical services may be close to where it needs to be. However, that cannot be ascertained without the necessary documents. We would be happy to help with an initial staffing analysis.

RECOMMENDATIONS:

1. Provide the staffing document to the Monitor along with the duties assigned to each staff member.

MENTAL HEALTH FINDINGS: This document was not provided to the Monitor or the team.

RECOMMEDATIONS: Refer to Mr. Ray's assessment, findings and recommendations pertaining to staffing analysis recommendations.

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;

MENTAL HEALTH FINDINGS: Refer to Mr. Ray's assessment, findings and recommendations pertaining to staffing analysis recommendations.

RECOMMEDATIONS:

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: This element is probably intended to describe a quality improvement program. We were not provided evidence of any policy and/or quality improvement activities. We will work with local staff to develop a policy and program that facilitates improvement and meets NCCHC requirements.

RECOMMENDATIONS: TBD

MENTAL HEALTH FINDINGS: There is not an operative quality improvement committee and no quality improvement activities at the time of this to work.

RECOMMENDATIONS: GGACF Mental Health Department, under the supervision of the Medical Director needs to develop a schedule of quality improvement activities and systems to measure the clinical processes and their outcomes. Currently there is a monthly report, which was not provided for our review, to the Health Services Administrator. From speaking with the Mental Health Coordinator, it appears that certain quality assurance activities may be occurring that track some of the statistics monitored through logs and case lists. We were provided no document evidence supporting this claim. This will be more closely assessed during the Dec 2013 visit.

m. Adequate dental care;

ASSESSMENT: Not assessed. However, Mr. Ray found the dental exam room in disarray, unsanitary, and unsecure with cabinets open exposing medications and dental instruments that could easily be converted to contraband by inmates.

FINDINGS: To be assessed at next visit.

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.

MEDICAL FINDINGS: We have not been provided any policy or procedure dealing with morbidity or mortality reviews. Until the issue of clinical ownership of the program is solved, this element cannot be addressed. In a morbidity or mortality review, the first step would be to construct a care chronology based on the patient's interactions with the health care program, starting with intake. This chronology is designed to be purely descriptive of the sequence of health care occurrences that are documented in the health care records. After that chronology is constructed, it would behoove the territory to utilize an external reviewer to review and critique the care provided. It is counterproductive to have clinicians review their own work. Utilizing both the chronology of care and the medical record and discussing the case with staff should allow the external reviewer to construct a final clinical summary.

RECOMMENDATIONS:

1. Utilize the above to construct a mortality and morbidity policy.
2. Contact the Monitor and his staff for any consultation or technical assistance.

MENTAL HEALTH FINDINGS: There is currently no Morbidity and Mortality Committee. The Health Services Administrator is trying to address this but has found it difficult to identify times during which the medical director is available. As of now there is no mortality review and no mortality report generated by the medical services.

RECOMMENDATIONS:

Policy and procedure modeled from national standards should be developed and implemented at the facility.

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: We saw no policy on this nor were we provided any evidence of it or of reasonable practices that ensure such rounding takes place. It does not appear, however, possible simply due to mental health staffing levels. We would strongly encourage drafting the policy based on NCCHC standards utilizing the compliance indicators and discussion sections.

RECOMMENDATIONS: TBD

MENTAL HEALTH FINDINGS: that no mental health isolation/segregation rounds are conducted at the facility.

RECOMMENDATIONS:

It is recommended that a policy be developed that incorporates the requirements of national accrediting bodies such as the NCCHC or the ACA.

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: No policy and procedure exists addressing a review process for mental health and medical clearance of inmates with serious mental illness being placed in isolation. There are no policies regulating the amount of out-of-cell time provided to special needs prisoners in segregation. Mental health staff does not perform segregation rounds. Despite the absence of policies and procedure, this practice actively violates the Agreement and any reasonable standard of care.

RECOMMENDATIONS:

1. It is recommended that a detailed policy be developed to address this issue that incorporates the requirements of national accrediting bodies such as the NCCHC or the ACA.

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: There is no policy or procedure requiring participation of mental health staff in the disciplinary process and as a result there currently is no input.
Regarding placement in segregated environments, it is unclear whether a medical and mental health clearance is done for such a housing assignment. We were also told in a meeting with the Health Services Administrator and Medical Director that medical sees everyone when there has been a use of force, and if severe enough, after hours the inmate will go to the emergency department. The medical department has to rely on the security emergency department log to determine if anyone has been taken to the hospital.

RECOMMENDATIONS:

1. A policy and procedure should be established to allow for an assessment by mental health of incidents potentially resulting in disciplinary sanctions in those inmates on the mental health caseload.

2. Input into the disciplinary process should be written and periodically monitored through a quality improvement process to determine if the disciplinary officer is collaborating with mental health staff in adjusting their sanctions when there are mitigating circumstances secondary to the person's illness.
3. Currently, there is no retrospective of use of force as part of the medical quality improvement process but such a process should be put in place.

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

ASSESSMENT: Noncompliance

MEDICAL FINDINGS: There are plans to create new space, which we have walked through. The new space will allow for so-called inpatient beds for monitoring patients as well as an outpatient area for both medical and dental patients. The new space is a substantial improvement over the existing available space, which because of the design makes it more difficult to efficiently utilize while insuring adequate privacy. We have not yet seen specific architectural drawings, but our discussions with leadership staff suggest that the conceptual plans could be a significant advancement. We certainly remain available to offer any assistance in redoing the clinical space.

RECOMMENDATIONS:

1. Send the Monitor the plans as soon as a draft has been developed.

MENTAL HEALTH FINDINGS: Both the mental health coordinator and the psychiatrist see patients in the medical clinic in sound private settings. There are no private interviewing spaces on the segregation units or in the female housing units, which may create barriers to access since the entire compound would need to be shut down to enable movement of these persons.

RECOMMENDATIONS:

1. The facility needs to explore what barriers may exist to providing frequent and adequate services to inmates in special housing in sound private settings.

s. Mental health care and treatment, including:

(i) timely, current, and adequate treatment plan development and implementation;

ASSESSMENT: Noncompliance

MENTAL HEALTH FINDINGS: Medical services and mental health services at the current time lack any continuous quality improvement program, which greatly impedes their ability to self-monitor, develop, and implement effective corrective action plans or program development.

Treatment plans were only found in a few records. In most circumstances the plans were unrealistic in that they assigned activities such as educational classes and mental health groups that were not provided at the facility. The plans also recommended certain frequency of follow-up by mental health or psychiatry, which was not even approximated in the actual practice.

RECOMMENDATIONS:

1. Treatment plans should reflect the actual services rendered as opposed to idealistic suggestions.
2. Suggest the following template for crafting the inmate's plan of care:

THE INDIVIDUALIZED TREATMENT PLAN:

- Treatment plans should follow a problem-oriented format.
- Problems listed should be descriptive and meaningful with measurable goals.
- The plan should indicate time frames to complete the above goals.
- Planned interventions are documented
- A date of the scheduled review of the individual treatment plan will be listed on the chart.
- All members of the treatment team in attendance shall sign the treatment plan and indicate their professional degree.
- A notation by the team will also indicate progress made towards previous goals.
- The patient shall also sign the treatment plan indicating participation and awareness of the established goals.

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

ASSESSMENT: Noncompliance

MENTAL HEALTH FINDINGS: Currently there are no programs in mental health for prisoners with serious mental illnesses. The only services currently provided are occasional contacts with the Mental Health Coordinator and infrequent visits with the psychiatrist with lapses between visits of up to a year.

RECOMMENDATIONS:

1. GGACF Mental Health Department should conduct a needs analysis and make recommendations to the Health Services Administrator, Medical Director, and Bureau of Corrections regarding required staff and other resources necessary to provide adequate services in both general population and segregated areas.
2. Comparable programming should be provided for female inmates and detainees as well.

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

ASSESSMENT: Noncompliance

MENTAL HEALTH FINDINGS: GGACF lacks sufficient psychiatry hours to provide adequate oversight of this requirement (although we were not provided with the staffing schedule, it appears that GGACF has fewer than eight hours per week of psychiatric time) to perform comprehensive initial psychiatric assessments and chronic care follow-ups at clinically

necessary frequencies. There was a surprising underrepresentation of the treatment of mood disorders on the caseload and women.

A continued finding of dependence on long acting injectable neuroleptics rather than oral agents seems a variance from customary practice. This may be a clinical choice designed to increase medication compliance. There was no evidence of a policy that addresses the use of emergency and involuntary medication.

RECOMMENDATIONS:

1. Improved methods of practice and a staffing and programs analysis needs to be completed.

2. GGACF may wish to consider adding telepsychiatry to increase the availability of psychiatric resources by contracting with psychiatrists on the mainland who obtain licenses in the USVI. Of course, the latter would require capital investment in equipment and the development of a policy and procedures that would structure this type of service.

3. A reasonable informed consent form should be developed and patient education documented.

4. A policy addressing the use of emergency and involuntary medication should be developed.

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

ASSESSMENT: Noncompliance
FINDINGS: See assessment of findings of Mr. Ray regarding training provision below.
RECOMMENDATIONS:

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

ASSESSMENT: Non-Compliance

FINDINGS: Currently, seriously mentally ill inmates are housed in segregation and by policy may be placed there until their conditions are stabilized. However, the decreased capacity for observation, lack of availability of potable water in their cells, hot conditions with poor ventilation, absence of mental health rounds, absence of any structured therapeutic programming places these individuals at risk for serious life threatening physical illness and behavioral decompensation.

RECOMMENDATIONS:

1. GGACF should consider alternative housing and as recommended above, develop a plan to introduce adequate programming for this population.
2. Increased out-of-cell-time and life skills activities should be considered.

3. It is also recommended that all inmates with a serious mental illness should be seen in a confidential setting at a minimum of at least monthly by a psychiatrist and monthly by a mental health counselor.
4. Weekly mental health rounds are also required for this population.
5. Suggest the following template for progress monitoring of inmates in segregation (may also be used for general population):

THE GENERAL POPULATION AND SEGREGATION MENTAL HEALTH PROGRESS NOTE

SUBJECTIVE/OBJECTIVE

- The subjective portion of the note should contain descriptions of any current problems, the inmate's level of activity and function, programs participation, job assignments, family issues, and any other pertinent information.
- Documentation of any reports of medication issues or side effects
- A brief mental status examination unless the template does not require that information.

ASSESSMENT

- A DSM (current version) diagnostic list as well as an estimate of the current global assessment of function
- An assessment pertinent to the data documented

PLAN

- A clinically appropriate follow-up appointment
- A description of the recommended, if any, appropriate psychosocial intervention and an estimate of the timeframe to complete such treatment. For example, "The inmate will be seen weekly for four visits focusing on cognitive behavioral therapy for bereavement counseling."

ENVIRONMENT OF CARE

- As a general rule, all psychiatric and counseling encounters, including face to face encounters in response to a sick call request and pre-segregation interviews, should be conducted in an area guaranteeing sound privacy.
- Only segregation rounds may routinely be conducted at the cell front or in a day room area.
- Variance may be permissible during extended states of lock down, if the inmate is deemed to lack behavioral control, and other crisis situations.

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

FINDINGS: General Emergency Plans and Procedures were provided following the onsite assessment. However, an examination of these documents found no life-fire safety program, policies or procedures as indicated in VI.1 above. Therefore, no written life-fire safety program has been reviewed by the local Fire Marshal.

This assessment process involved inspection of inmate housing, medical, kitchen, storage areas, workshops, and administrative areas. A lengthy interview was also conducted with GGACF fire safety officer, who seemed well-qualified and committed to an effective fire safety program.

Officials report that two (2) fire emergencies occurred in the past 12 months. GGACF does not have a functional fire detection or suppression system in place at this time. The fire suppression system (sprinklers) in the housing area is inoperable; inmates are allowed to use the sprinkler heads to anchor clotheslines for drying apparel and linens. Access to certain living units (X Pod) cell doors were padlocked i.e., X pod. Comprehensive fire drills for housing units or other occupied structures are not conducted; quarterly fire drills must be conducted of all facility areas and on all shifts.

Additionally, housing unit and cell inspections revealed exposed electrical wiring, some showing burn traces on receptacles indicating electrical shorting and fires occur and standing water near shower areas and in certain cells. Many inmate cells presented with clutter of combustible materials, which should be removed. Interviews with housing unit staff revealed that they do not know how to operate fire control panels and would not know how to effectively respond under fire or emergency conditions. The fire control panels show no test/maintenance logs, which is required for consistent inspection of operability. The workshop and kitchen areas were inspected for fire safety conditions. There appears to be adequate operable fire extinguishers located strategically. All extinguishers inspected show current inspection tags and pressures. However, the woodshop presented with a considerable amount of combustible wood bi-products that should be kept clear from ignition sources. There appears to be a lack of breathing devices (SCBA, etc.) for staff to safely and expeditiously respond to fire events. Although the kitchen is scheduled for renovation and new equipment, I found exposed electrical connections for some equipment, and potentially serious burn hazard related to the height of an open-flame stove. This stove was boiling a 5-gallon pot of liquid on an open flame;

the position and height of the stove would make it very difficult to remove the pot safely and should be corrected.

Overall, the fire safety official I interviewed seemed to be a well-qualified expert in fire safety. He seemed cognizant of related provisions in the Agreement, how to comply with all requirements, and fully intends to do so. It is, therefore, essential that Territory and GGACF officials provide the necessary support and resources needed to comply with this provision.

RECOMMENDATIONS:

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

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

ASSESSMENT: Noncompliance

FINDINGS: Refer to previous findings.

RECOMMENDATIONS:

1. Refer to previous recommendations.
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: Refer to previous findings for this provision. Additionally, there are no formal policies or procedures regarding an emergency key system, which is a critical component of any credible correctional fire safety program. An effective emergency key system ensures rapid access to emergency keys to evacuate people from structures where fire threats are present or expected.

Padlocks continue to be used to secure inmates in some cells and housing units. For example, the door to the women's dorm was chained shut and secured with a padlock. The women there told us they are often left unattended. According to them, one night there was a storm and the cells were flooding. One woman had exposed wiring in her cell and there were sparks flying. The women were screaming for someone to help them. One of the women finally got the attention of a prisoner worker, who ran and got help. This is an extremely dangerous practice and places inmates and staff risk of harm.

Staff must be well-trained and drilled on the use of emergency keys use to ensure they are consistently ready and able to manually unlock all doors under any circumstance involving real or potential threats to life safety. All staff must be competent and proficient in performing these functions. Additionally, all locking mechanisms, manual and electronic must be regularly inspected and tested to ensure reliable operability. All inspections and testing must be documented, recorded, and records maintained. Timely repair and/or replacement of keys/panels/electronics must occur.

I found no evidence of an onsite, competency-based fire safety training or testing program. Competency-based training and testing must be provided within the environments where the life-safety response actions will or may occur. This means that staff must be trained on campus and under simulated emergency response conditions involving realistic scenarios, conditions, actual equipment, etc. The fire safety officers should oversee this process and involved community responders as needed to ensure comprehensive coordination of life safety events.

RECOMMENDATIONS:

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

d. Regular security inspections of all housing units that includes 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: As previously stated.

RECOMMENDATIONS:

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

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

ASSESSMENT: Noncompliance.

FINDINGS: As previously stated.

RECOMMENDATIONS:
1. Refer to previous recommendations for this provision.

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

ASSESSMENT: Noncompliance.

FINDINGS: As previously stated.

RECOMMENDATIONS:
1. Refer to previous recommendations for this provision.

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

ASSESSMENT: Noncompliance.

FINDINGS: As previously stated.

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

h. Fire suppression;

ASSESSMENT: Noncompliance.

FINDINGS: As previously stated.

RECOMMENDATIONS:

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

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

ASSESSMENT: Noncompliance

FINDINGS: As previously stated, and as indicated in current medical/mental health program deficiencies in resource levels, policies and procedures.

RECOMMENDATIONS:

1. Refer to previous recommendations for this provision.
2. The comprehensive fire safety program development must involve health care leadership to ensure that policies and procedures include adequate provisions for timely medical and mental health response to persons injured during a fire event.
3. Medical and mental health staff should be appropriately trained in relevant fire safety program components and drilled quarterly to ensure compliance with program response requirements.
4. Policy components involving medical and mental health staff should provide for their safety and security when involved in fire incident responses.
5. Qualified medical staff should participate in the development of fire program training topic that involved 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: Refer to previous findings regarding contraband, clutter, combustible materials near fire ignition sources, wiring, water, etc.

RECOMMENDATIONS:

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

VII. ENVIRONMENTAL HEALTH AND SAFETY

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

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

GENERAL COMMENT: The following is a list of specific findings during this assessment.

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

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

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

ASSESSMENT: Noncompliance

FINDINGS: There is no formal written facility sanitation, housekeeping, and/or hygiene plan or program. Policies and procedures related to this provision are incomplete, difficult to find, and scattered illogically throughout inmate handbooks, rules, and regulations.

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.

b. Adequate ventilation throughout the facility;

ASSESSMENT: Noncompliance

FINDINGS: GGACF officials have placed "swamp coolers" in housing units for cooling and ventilation, which is a positive effort but ineffective in controlling high temperatures, high humidity, and preventing transmission of allergens and infectious pathogens. The cells remain very hot and stuffy despite access to outside air though broken windows and/or other wall penetrations. Several inmates, included those with serious and chronic medical and mental health problems, described the heat and airflow as "inescapable", "can't breathe", or "torturous." Several inmates locked in segregation cells appeared to be very lethargic, which is symptomatic of heat exhaustion and/or dehydration. These temperature levels combined with limited access to water can result in serious harm or even death and must be mitigated without delay.

RECOMMENDATIONS:

1. Timely complete an air quality assessment performed by a qualified provider. Implement necessary improvements that reduce housing area temperatures and increase air flow.
2. Ensure inmates have constant access to drinkable water.
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. Ensure that adequate amounts of drinkable water is always available to inmates.
7. 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: Noncompliance

FINDINGS: Lighting throughout the external and internal security perimeter, housing units and cells, and other buildings need repair. Some simply need bulbs replaced, others require electrical work. In general, the poor lighting conditions on this campus and within buildings, especially housing units, creates serious safety and security risks for staff and inmates and must be addressed immediately and consistently.

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.

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

ASSESSMENT: Partial Compliance

FINDINGS: There is no formal written pest control/mitigation plan currently. Environmental sanitation and air conditions are conducive to insect problems and infestations. Athough I did

not observe any pest infestation problems during this assessment, medical staff did report and showed a photograph of a "bug in a meal tray." I will reassess this condition at the December assessment.

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. This provision will be assessed more closely during the December assessment.

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

ASSESSMENT: Partial Compliance

FINDINGS: Several housing units/cells and staff washrooms did not have hand soap and/or hand sanitizers. I did observe some cleaning supplies in housing units being used by inmates engaged in cleaning floors and shower areas. However, it is unknown whether inmates are trained in the proper use and storage of those chemicals. Based on bacterial odors emitting throughout housing unit areas, the high presence of mold and mildew, and grime on cell doors and walls, deep and more regular cleaning is required to improve unsanitary conditions.

Not all inmates had personal hygiene products in their possession and some stated that they were not provided any. Consultation with housing unit staff indicated that inmates have ready access to personal hygiene supplies upon request..

RECOMMENDATIONS:

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

FINDINGS: There is no formal infection control plan or biohazard control plan. There are no specific comprehensive written policies or procedures addressing the topic. This is further evidenced by a foul odor of bio waste emitting from certain cells and trash receptacles in the medical clinic. Additionally, medical/dental clinic exam rooms had used syringes setting on counters, blood-stained gauze in trash cans, and full sharps containers. I observed no presence of designated biohazard refuse bags or educational posters providing safety/heath information for staff or inmates about this topic.

RECOMMENDATIONS:

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

g. Mattress care and replacement;

ASSESSMENT: Noncompliance

FINDINGS: As previously stated.

RECOMMENDATIONS:

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

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

ASSESSMENT: Partial Compliance

FINDINGS: Bulk cleaning supplies and chemicals are stored in the maintenance building and warehouse. An inspection of the maintenance buildings found this stock to be well organized with MSDS posted. Additionally, these areas are typically locked but I observed no inventory logs in each room storing chemicals. Additionally, there is no documented formal training

program for inmates in the proper use of these supplies or chemicals. I found no incidents involving inmate misuse in handling of cleaning chemicals in the Unit or Incident logs examined. Maintenance supervision staff appeared attentive to inmate workers, which suggests that supervision is likely adequate. However, storage spaces were not vented and may need to be.

RECOMMENDATIONS:

1. Develop comprehensive control plans for cleaning supplies and chemicals, chemical inspections, inventory control, and inmate training in use of supplies. Ensure adequate record keeping, monitoring, and property control logs.
2. Ensure the cleaning chemical control plan is coordinated with medical staff for harmful exposure mitigation, response, and recovery protocols.

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

ASSESSMENT: Noncompliance

FINDINGS: Refer to previously discussed issues involving sanitation, clothing, and linens. I will closely assess the laundry area during the December assessment.

RECOMMENDATIONS:

1. Review, revise, develop, train, implement, and evaluate a comprehensive laundry management plan that governs total laundry operations.
2. Develop specific policies and procedures for handling, containing, and washing contaminated clothing, linens, and mattresses.
3. 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.
4. 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.
5. 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.
6. Staff and inmates involved in the laundry work progress should be properly training and supervised.
7. 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; and

ASSESSMENT: Noncompliance

FINDINGS: I inspected the kitchen areas, food preparation process and methods, and interviewed the food service supervisor. I was advised that kitchen flooring and an oven were scheduled for replacement. The food service supervisor stated that she specifically came to the facility that day for this inspection but was suffering from "pneumonia." I found that very strange and quite unsettling considering the need to protect the kitchen environment, other staff and inmates from infectious pathogen exposure.

The kitchen, in general, seemed unsanitary and in need of deep cleaning and repair. It was reported that only one of four ovens operate, hood vents have occasional electrical problems, bathrooms were unsanitary and without toilet paper, and the soap or water for hand washing. The utensils room was unlocked with removed items but there were no "chits" replacing taken items to track their whereabouts. Major cooking equipment, functional or not, seemed greasy and vent hoods appeared to have long standing layers of grease and dust on tops and underneath. One of the two freezer/coolers is not operating and the cooler that is operational registered an internal temperature of 48 degrees Fahrenheit. Inmates were busy preparing food and several filled food trays recently washed had not completely dried. Although not an infestation, several flies were observed on recently cooked food and filled food trays. None of the inmates or staff seemed to notice the insects and/or give their presence much concern. Additionally, there are no temperature logs maintained for the dishwasher, cooking, food distribution, or refrigeration, all of which are expected and standard correctional food service program practices. There is no system in place for conducting regular health screening of inmates and staff assigned to the food service program. There is no formal inmate kitchen worker training program nor any comprehensive food service program policies and procedures manual to govern the program.

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 basin 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: Refer to previous findings regarding sanitation and this provision.

RECOMMENDATIONS:

1. Refer to recommendations regarding sanitation and this provision.
2. Develop and implement a corrective action plan for that ensures inmates have consistent and reliable access to safe 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: A formal training program appears to be under development, though formal written training policies and procedures regarding implementation of this Agreement either do not exist and/or were not provided. The Monitor met with a training program assistant and was provided a three-page document outline pre-service and in-service training provided to correctional officers as shown below:

PRE-SERVICE TRAINING	IN-SERVICE TRAINING
Introduction to Law Enforcement (22 hrs.)	No Hours Listed Policies and Procedures
Rules, Protocols, and Administrative Duties (17hrs) Criminal Investigation (11hrs) Facility Procedures and Protocol (247hrs) Juvenile Procedure (4hrs) Officer Mental Health & Well Being (30hrs) General Topics (40hrs) Emergency Procedures (18hrs), note, Suicide Prevention is for 1hr Equipment Use (16hrs)	First Aid/CPR Sexual Harassment Suicide Prevention Gang Prevention Unarmed Self Defense

According to the training assistant providing information about the training program, pre-service training is provided by a qualified local contractor. However, the assistant was unable to verify trainer credentials or produce training agreements between the Territory and the training organization. No curriculum was available for review at the time of this assessment but an officer "training manual" was provided and included several basic training topics appropriate for pre-service correctional staff, but much of the narrative was underdeveloped and spoke mostly to agency General Orders and Rules, Standard Operating Procedures – Employee Rules of Conduct, Code of Ethics, Dress Code, and Inmate Rules of Conduct.

RECOMMENDATIONS:

1. Written training policies and procedures should be developed and implemented to govern pre-service, in-service, and ongoing training or corrections and civilian staff.

The following are a few recommended elements for training program policies and procedures:

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

AA. Chemical agent training covers the use and handling of chemical agents, as well as the treatment of persons exposed to a chemical agent;

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

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

b. Pre-service training for all new employees;

ASSESSMENT: Noncompliance

FINDINGS: No pre-service training curricula or lesson plans were provided as requested. Pre-service training has been provided by a third party contractor, but BOC is in the process of working to develop its own training program. I am unable to accurately assess compliance.

RECOMMENDATIONS:

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

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

ASSESSMENT: Noncompliance

FINDINGS: No training curricula or lesson plans were provided as requested. I am unable to accurately assess compliance.

RECOMMENDATIONS:

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

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

ASSESSMENT: Noncompliance

FINDINGS: Training program policies and procedures were not provided to the Monitor as requested. Also no logs or programs were evidenced that would track who took training and no competency based assessments were provided.

RECOMMENDATIONS:

1. Provide the Monitor all training program policies and procedures.

2. In the absence of training program policies and procedures, develop such policies and procedures.

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: Little tangible evidence was provided before, during, or following the baseline assessment that clarified if or what steps have been taken to implement the requirements of this Agreement. However, Territory officials voice a serious commitment to comply with the Agreement and did provide on June 20, 2013 the outline exactly as shown below for when they intend to have policies and procedures developed, training, and implemented.

Golden Grove Adult Correction Facility

Drafting of Policies	120 days
Training on Approved Policies	180 days after the policies are drafted.
Implementation	One year after training is complete.

The above implementations schedule, in general, is inadequate for several reasons. First, the implementation of this Agreement requires much more systematic planning and roll out. All staff should be aware of the Agreement and possess a working understanding about its content, expectations, purposes, intended outcomes, etc. This did not seem to exist during our baseline visit. Line staff interviewed stated that they had not been apprised of Agreement contents nor had they seen the Agreement. The successful implementation of this Agreement will benefit tremendously by making staff explicitly aware of the Agreement, its content and the role they play in meeting all substantive provisions. Another reason that this implementation schedule seems anemic is that it does not present more specifically what will be done, how it will be done, when it will be done, and who will do what by when. A more detailed and specific implementation plan/schedule is required to ensure systematic planning, execution, and evaluation of Agreement implementation and whether compliance actions 1) comply with the Agreement, and 2) cause improvements that eliminate unconstitutional conditions, care, and custody for inmates. Thirdly, the proposed implementation is unrealistic for the scope and breath of this Agreement. Institutional reform of this type and size necessitates careful and deliberate planning and execution. It is the opinion of this Monitor, based on over 30 years of experience in organizational change, policy and program development implementation, and evaluation, that it is impossible to meet the timelines presented here without additional resources that would far exceed what Territory officials report are available for this work. The Monitor provided feedback about this schedule and gained agreement that we would discuss this schedule and planning process further but that the Territory should move forward to the extent possible to implement the schedule provided. Additionally, the Monitor offered technical assistance in the development of a realistic implementation plan and schedule.

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: Please refer the findings discussed above. The Monitor has not agreed to the Territory's implementation plan or schedule. However, it is my belief, based on verbal and written communications with Territory officials, that a more explicit, specific, and detailed implementation plan is underway. Therefore, I believe it is important to consider these stated positive efforts and review progress toward this requirement in more detail at the December 2013 visit. Again, the Monitor will provide any requested technical assistance to the Territory in this matter.

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 discussed throughout this assessment report, the Territory provided no evidence that any policies or procedures are in revision. No new policies or procedures or revisions have been provided to the Monitor or DOJ for review and approval as required. My only conclusion, based on this, is that there have been no new polices and/or procedures developed and/or new regulations have been developed and/or implemented but were not submitted for review and approval as required.

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: Prior to the baseline assessment visit the Monitor provided Parties with documents intended to assist the Territory in developing means and measures for evaluating progress and compliance and offered technical assistance is developing a quality assurance management process. Accordingly, there has been no further communications from Territory officials about this requirement and the first impact evaluation study is due by the end of January 2014. Furthermore, the Monitor provided a basic illustration of how to descriptively measure contraband control compliance in this report when discussing contraband control provisions. Territory officials should review that section from both compliance and

compliance evaluation contexts. The Monitor again offers technical assistance with this requirement.

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 submitted no requests, proposals or recommendations to modify policies, procedures or the plan. The Monitor looks forward to reviewing proposed changes and provided requested technical assistance if requested. It is believed, however, that the creation of a better development implementation plan will greatly facilitate the Territories compliance with this requirement.

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

FINDINGS: The Monitor has received no status reports or any communication from Territory about this requirement. To reiterate, the development and a more systematic planning process will afford Territory officials evidenced-based tools and documentation for complete quarterly status reports. These reports should be very detailed, specific, fact-based, and apply qualitative and quantitate principles for evidencing progress with all provisions and requirements of the Agreement. Below is a basic format this Monitor has found very practical and useful in other large Settlement Agreements he monitors:

Section/Subsection	Provision	Accomplishment/Progress	Proof of Accomplishment, Progress, Practice	Comments
Shows Agreement Section and wording	Specific provision wording	Succinct description of what has been accomplished, can include what actions are underway.	Comprehensive description using qualitative, quantitative, and narrative information, specific reference documents or other evidence	As needed to clarify information provided previously, challenges, barriers, opportunities, etc.

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: At least one incident involving inmate violence were not reported in a timely manner. The first incident involved an inmate-on-inmate homicide that occurred on 07/12/13, the Monitor and DOJ were notified of this event via email on 07/15/13. This delay in reporting the event

timelier prompted DOJ to issue a complaint Territory officials reminding them of this reporting requirement. Territory officials responded with a commitment to comply with this requirement but stated that the circumstances surrounding the event made it unreasonable to provide more timely notification.

Another event involving violence and serious physical injuring to an inmate on 09/05/13. The Monitor and DOJ were notified within 45 minutes of the event. This action evidences the Territories intent to comply with this requirement.

During the December 2013 site visit the Monitor will review all incident reports and logs to determine the degree to which this requirement is being met.

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: Documents provided before, during, and following the baseline visit are not sufficient to document that requirements of the Agreement are being properly implemented or met as previously discussed. Although Territory officials did provide many of the requested documents, the quality and content of those documents provided little or no evidence of compliance with the Agreement. It is therefore, incumbent upon the Territory to make identification and/or development and maintenance of such records a top priority throughout the life of this Agreement.

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: Territory officials provided reasonable access to the facility and staff during the baseline visit.

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: Territory responses to specific questions regarding compliance with the Agreement have complied with this requirement according to the Monitor's best estimate.