United States Virgin Islands

# GOLDEN GROVE ADULT CORRECTIONAL FACILITY

St. Croix, VI

# *SIXTH COMPLIANCE MONITORING REPORT*

**2013 Federal Court Settlement Agreement**
**In re: United States of America v. The Territory of the Virgin Islands (86/265)**
Submitted February 17, 2015
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## PURPOSE

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

## EXECUTIVE SUMMARY & ASSESSMENT OVERVIEW

The Sixth onsite compliance monitoring assessment was conducted December 8-11, 2014, and included an onsite Court status conference on Wednesday, December 10th. Prior to this site visit, the Monitor coordinated communication between the Parties and monitoring team in preparation for the onsite assessment.

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

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

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

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

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

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

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

This assessment found reasonable cause for the Monitor to reverse Provision G.1.b (Incident Reporting, senior management reviews) from its Partial Compliance rating to Non Compliance. This assessment found no effort on the part of GGACF management staff to maintain the previously established incident review process. No documents were provided to demonstrate compliance with this provision, and the few management staff available to discuss this provision were unable to reasonably articulate substantive efforts to comply with this Provision. This Monitor's reasoning for this action is discussed further in Provision G.1.d D Findings. Consequently, overall assessment ratings are slightly lower from the previous assessment.108 (90%) of the 120 Provisions are now rated in Noncompliance; 12 (10%), Partial Compliance; and, none are rated in Substantial Compliance. The score card below shows current compliance ratings.

| **GGACF SIXTH COMPLIANCE ASSESSMENT SCORE CARD** | | | | |
|---|---|---|---|---|
| **Areas of Compliance Per Agreement** | **Total Provisions** | **Non Compliance** | **Partial Compliance** | **Substantial Compliance** |
| **IV. Safety and Security** | **59** | **53** | **6** | **0** |
| **V. Medical, Mental Health Suicide Prevention** | **36** | **36** | **0** | **0** |
| **VI. Fire and Life Safety** | **10** | **10** | **0** | **0** |
| **VII. Environmental Health and Safety** | **11** | **5** | **6** | **0** |
| **VIII. Training** | **4** | **4** | **0** | **0** |
| **Total Substantive Provisions** | **120** | **108** | **12** | **0** |
| **Percent Compliance** | **100%** | **90%** | **10%** | **0%** |

**SIXTH ASSESSMENT FINDINGS OVERVIEW:**

Compared to most of the previous onsite assessments, this assessment was extraordinarily disappointing, frustrating, and punctuated with unnecessary delays and disruptions. Pre-requested documents were not ready for inspection upon arrival, numerous other documents requested during the visit were not provided until weeks following the completion of this assessment requiring the USDOJ to submit several requests for documents previously requested. Additionally, most of the staff required to participate in the process were either absent, not available, or refused to take the initiative to engage the assessment process. Despite the efforts of the Director and small few key management staff, this site visit was practically devoid of complete and timely access to documents, information, and staff needed to ensure a comprehensive assessment. This, combined with observations by the monitoring team, again found virtually no progress overall.

The above stated, the Territory is to be commended for achieving substantial improvement in housing unit staffing levels following its transfer of inmates to the mainland; these transfers allowed VIBOC officials to redeploy staff from housing that were closed as a result of transferring these prisoners. Examination of supervisor shift logs, which are moderately reliable sources for measuring progress, record a significant decrease in housing units operating without staff. A provisional analysis of data abstracted from these records indicates an 84 percent decrease in the number of shifts when inmate-occupied housing units were operated without correctional staff. These records also indicate a measureable increase in housing unit staffing levels. There was no measurable improvement found in shift supervisor staffing levels.

GGACF corrections and supervisor staffing levels, nonetheless, remain insufficient to prevent and control ongoing high levels of violence against staff and inmates, contraband, to provide adequate and consistent access to medical and mental health care, maintain adequate life and health safety conditions, or provide adequate staff supervision and organizational management. Territory officials must redouble their efforts and complete and implement the required staffing plan. All staff must be properly trained to consistently perform their duties competently. GGACF management and supervisory personnel must adopt a shared vision for professional and contemporary corrections and work as an integrated, interdependent, and collaborative team. Accountability must become an unequivocal value that is consistently enforced and practiced by all GGACF leaders. Noncompliance with agency policies, procedures, and standards of professional conduct should never be tolerated; leaders must model the utmost professional competence so as to promote consistent professionalism among subordinates.

Abuse and/or neglect of inmates should never be tolerated or minimized by any corrections professional. Concomitantly, GGACF leaders must redouble their efforts to protect the safety and security of all inmates and staff. Serious assaults on inmates and staff, staff being required to suppress a fiery and dangerous housing unit riot without proper attire and breathing devices, due process hearings not being provided to discipline inmates, mentally ill inmates languishing for months or years in segregation, a broken inmate complaint system, and other serious operational deficiencies continue to stall progress toward compliance. More importantly, noncompliance with the Agreement continues to perpetuate protracted litigation, violations of inmate civil rights, human suffering, and preventable harm to staff, inmates and the community.

The following assessment describes, as best as possible considering the problems faced during this assessment process, progress toward compliance with this Agreement.

## IV. SAFETY AND SUPERVISION

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

### A. Supervision

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

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

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS:** The Monitor assisted Territory officials in developing a very basic stratification matrix for GGACF prior to this monitoring visit of December 8-11, 2014. This matrix will not be shown in this report due to security and inmate confidentiality reasons. Territory officials submitted a revised stratification matrix to the Monitor following the transfer of 78 inmates off-island and closing four (4) housing units. Completion of the stratification matrix should include total beds and cell-types in each of the housing units, i.e. single/double bunk, etc.

During the December 8-11, 2014 monitoring visit, we were able to tour and inspect all of the housing units at GGACF. We found that risky housing and supervision practices of inmates at GGAC are still evident. For example, in Housing Unit K (Housing Unit for sentenced inmates), we were informed by the assigned officer that this Unit houses inmates ranging from classification levels of minimum to maximum custody, as well as some special management prisoners, including those with mental illness. The extreme mixing of prisoners in a single housing unit exposes them to an unreasonable risk of harm as well as to the safety of the assigned staff. Equally troubling was that the sole officer assigned to Housing Unit L reported being employed at GGAC for two (2) months and was not aware as to the classification level of the inmates being supervised. The supervisor advised us that the assigned inmates to this Housing Unit were maximum custody. These types of classification discrepancies and inmate supervision deficiencies create an unreasonable risk of harm to prisoners as well as to the safety of the assigned staff.

Incident Report and Contraband Logs and classification documents continue to evidence that application of the GGACF stratification (See Classification Section) for classification housing remains inadequate and inconsistent. As detailed in other sections of this report, the lack of

appropriate screening instruments, application of housing stratification schemes, deficient inmate supervision practices and policies and procedures regarding classification continues to place inmates at risk of harm. The Monitor provided technical assistance to defendants in developing policies and procedures which were all finally completed and provided in draft form to the parties by the December 31, 2014 deadline.

**RECOMMENDATIONS:**

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

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

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS:** Post orders found on the housing units remain outdated as previously reported. There was no change with regard to previous findings or recommendations to update those documents.

No staff plan was provided that demonstrates application of the staffing analysis required under this Agreement, which was previously completed by the National Institute of Corrections.

Supervisor logs continued to report several staffing shortages and periods of time when occupied housing units are not staffed by correctional officers. These logs also continued to report very high levels of staff overtime to cover housing units and security schedules. This remains a serious concern for staff and inmates safety and security. However, these logs do demonstrate improvement in staffing of the occupied housing units. It appears that fewer units were not staffed during this reporting period.

GGACF officials report that first-line supervisors continue to visit housing units on a daily basis as directed in a memo by the previous Warden.

Supervisor logs were examined to update supervisory and housing unit staffing levels reported in the Monitor's 4th and 5th Reports. As stated in those reports, the following data analyses and findings must be considered moderately reliable due to inconsistent recording of shift staffing levels by supervisors. Data presented are only reliable to the extent the data were complete and measurable.

This Provision will remain in non-compliance until all occupied housing units and supervisory posts are continuously staffed 24/7, the staffing-analysis-based staff plan is approved, and staffing-level documents are determined by this Monitor as consistently valid and reliable sources from which to evaluate compliance.

Staffing-level data from 10/13/2014 to 12/1/2014 were abstracted from shift supervisor logs to examine. Twenty shifts were sampled (October, N=10; November, N=10; December, N=1) and compared to similar data used in the previous two monitoring reports:

1. Total shifts assessed
2. Number of housing units assessed (note: Units RSAT, Intake, I and J were closed in October, 2014 when approximately 78 inmates were move to a main-land facility to improve GGACF staffing deployments).
3. Total number of shifts housing units were not staffed
4. Est. hours housing units were not staffed
5. Est. days housing units were not staffed

Based on this comparative analysis, housing unit staffing levels have improved substantially because the total number of shifts were reduced when prisoners were transferred off-island and housing units were closed:

The number of shifts operating non-staffed housing units decreased 84 percent (84%) from 56, 4th Report; 46, 5th Report; to 9, this report.

Estimated hours that housing units operated without staffed also dropped 84 percent from 448, 368, to 72 respectively. The concomitant decrease in the number of days that housing units operated without staff is estimated at 18.67, 15.33, to 3 days respectively. Table 1 below shows these estimates.

Table 1

| **Monitoring Visit** | **4th Assessment** | **5th Assessment** | **6th Assessment** | |
|---|---|---|---|---|
| **Sgt. Log Book Date Range Reported** | **5/20-6/05/2014** | **8/22-9/22/2014** | **10/13-12/1/2014** | **Improvement** |
| **Shifts Assessed** | **30** | **29** | **21** | |
| **Housing Units Assessed** | **14** | **14** | **10** | |
| **Total Shifts Housing Units Not Staffed (N)** | **56** | **46** | **9** | **-84%** |
| **Multiplier (Shifts Reported x # Housing Units)** | **420** | **406** | **90** | **-79%** |
| **Est. Hours Housing Units Not Staffed (Nx8)** | **448** | **368** | **72** | **-84%** |
| **Est. Days Housing Units Not Staffed (Hrs./24)** | **18.67** | **15.33** | **3.00** | **-84%** |

Table 2 below shows staffing level improvements for all housing units assessed; the number of shifts that each housing unit operated without staff are shown for the reporting periods compared. This comparison indicates that only three housing units (K, L, 9B) were not staffed for nine shifts combined, whereas all but 9C were not staffed for the previous two reporting periods totaling 56 and 49 unstaffed shifts respectively. Simply stated, the number of times that housing units were not staffed dropped from 56 and 46 to 9.

Table 2 below must be cautiously interpreted due to the problems previously noted in the supervisor's log books. Although these data strongly indicate a significant improvement in staffing levels, there is no empirical basis to assume that supervisor or housing unit staffing levels are yet adequate. Staffing levels cannot be adequately measured until this Monitor is provided 1) an approved staffing plan, 2) daily shift logs provide consistently accurate and complete staffing information, and 3) GGACF is able to significantly reduce use of staff overtime as a means for supplanting fulltime staffing levels.

Table 2.

| Housing Units Reported / Shifts Not Staffed | 5/20-6/05/2014 | 8/22-9/22/2014 | 10/13-12/1/2014 |
|---|---|---|---|
| A DORM (Male Detainee Protective Housing) | 7 | 2.5 | 0 |
| RSAT (Juvenile Housing) | 15 | 11.5 | CLOSED |
| A/D & Intake (Male Detainee Protective Housing) | 18 | 19 | CLOSED |
| X or X-Ray (Female Detainee & Inmates) | 1 | 2 | 0 |
| G (Male Inmate Med/Max/Long Term) | 0 | 2 | 0 |
| H (Male Inmate Min/Med) | 1 | 0 | 0 |
| I (Male Inmate Protective Housing) | 0 | 1.5 | CLOSED |
| J (Not on Classification Matrix) | 1 | 2.5 | CLOSED |
| K (Male Inmate Protective Housing) | 2 | 1 | 4 |
| L (Male Inmate Admin/Discipline Seg) | 3 | 1 | 4 |
| 9A (Male Detainee Admin/Discipline Seg) | 3 | 1 | 0 |
| 9B (Male Detainee Med/Max) | 3 | 2 | 1 |
| 9C (Male Detainee Min/Med/Special Needs/ MH/Med | 0 | 0 | 0 |
| 9D (Male Detainee Min/Med/Special Needs/ MH/Med | 2 | 0 | 0 |
| Shifts Housing Units Not Staffed: | 56 | 46 | 9 |

Shift staffing levels were analyzed to assess changes/improvements in housing unit staffing levels for three reporting periods. This analysis estimates a 32.48 percent improvement in shift staffing levels per housing unit from .93 staff per housing unit to 1.23. Table 3 illustrates these estimates.

Table 3.

| Shift Average Staffing Level / Housing Units | 5/20-6/05/2014 | 8/22-9/22/2014 | 10/13-12/1/2014 | Improvement |
|---|---|---|---|---|
| A DORM (Male Detainee Protective Housing) | 0.77 | 0.95 | 1.00 | 30.43% |
| RSAT (Juvenile Housing) | 0.50 | 0.57 | CLOSED | CLOSED |
| A/D & Intake (Male Detainee Protective Housing) | 0.43 | 0.28 | CLOSED | CLOSED |
| X or X-Ray (Female Detainee & Inmates) | 0.97 | 0.93 | 1.00 | 3.45% |
| G (Male Inmate Med/Max/Long Term) | 1.03 | 0.93 | 1.24 | 19.82% |
| H (Male Inmate Min/Med) | 1.00 | 1.03 | 1.19 | 19.05% |
| I (Male Inmate Protective Housing) | 1.00 | 0.98 | CLOSED | CLOSED |
| J (Not on Classification Matrix) | 0.97 | 0.91 | CLOSED | CLOSED |
| K (Male Inmate Protective Housing) | 0.93 | 1.00 | 1.00 | 7.14% |
| L (Male Inmate Admin/Discipline Seg) | 1.00 | 1.45 | 1.14 | 14.29% |
| 9A (Male Detainee Admin/Discipline Seg) | 1.33 | 1.62 | 1.76 | 32.14% |
| 9B (Male Detainee Med/Max) | 0.93 | 1.00 | 1.05 | 12.24% |
| 9C (Male Detainee Min/Med/Special Needs/ MH/Med | 1.10 | 1.31 | 1.33 | 21.21% |
| 9D (Male Detainee Min/Med/Special Needs/ MH/Med | 1.07 | 1.31 | 1.62 | 51.79% |
| Averages Shift Staffing Levels: | 0.93 | 1.02 | 1.23 | 32.48% |

Shift supervision levels showed no significant improvement overall, except that all shifts were staffed with at least one supervisor for the 5th and 6th reporting periods. Supervision staffing levels remain very inadequate with an average of 1.9 supervisors per shift. Table 4 below compares shifts not staffed by the full complement of supervisors.

Table 4

| Shifts Not Staffed w/Full Complement of Supervisors | 5/20-6/05/2014 | 8/22-9/22/2014 | 10/13-12/1/2014 | Improvement |
|---|---|---|---|---|
| Est. Shift Supervisors Post Not Staffed | 78 | 56 | 44 | -34 |
| Multiplier (Shifts Reported x 4 Supervisor Posts) | 120 | 116 | 84 | -36 |
| Est. Hours Supervisor Posts Not Staffed (Nx8) | 624 | 448 | 352 | -272 |
| Est. Days Supervisor Posts Not Staffed (Hrs./24) | 26.00 | 18.67 | 14.67 | -11.33 |

Table 5 below shows the number of shifts staffed by the number of supervisors. These indicated that no shift is likely to be staffed with a full complement (4) of supervisors and about 70 percent of shifts are staffed with no more than two supervisors.

| Supervisor Shift Staffing Levels | 5/20-6/05/2014 | 8/22-9/22/2014 | 10/13-12/1/2014 |
|---|---|---|---|
| **Shifts w/ No Supervisor** | **2** | **0** | **0** |
| **Shifts w/ 1 Supervisor** | **17** | **5** | **4** |
| **Shifts w/2 Supervisors** | **7** | **17** | **15** |
| **Shifts w/3 Supervisors** | **1** | **7** | **2** |
| **Shifts w/ 4 or More Supervisors** | **3** | **0** | **0** |
| **Shifts Assessed:** | **30** | **29** | **21** |
| **Per Shift Supervisor Staffing Levels** | **1.6** | **1.9** | **1.9** |

Territory and GGACF officials are to be commended for achieving these improvements in housing unit staffing levels but is again reminded that excessive staff overtime leads to staff burnout, unsafe and poor performance. For example, some security staff reported to USDOJ and Mr. Romero (Monitor's expert) instances of them working as many as three (3) overtime shifts per week. Additionally, the supervisor log books showed excessive amounts of overtime for most shifts assessed. Using excessive overtime to supplant hiring and maintaining adequate staffing levels is operationally and economically counterproductive. Overworked staff make more and more serious mistakes and cannot consistently maintain the requisite level security-awareness to ensure facility safety. Additionally, the Territory should take the necessary steps to improve shift supervision levels. Do so will provide and maintain consistent supervisor presence that officers can rely upon for reliable and timely assistance. Development and effective implementation of the required staffing plan, based on the staffing analysis, is likely to yield rapid improvements in inmate and staff safety and security while improving overall care and custody of prisoners.

**RECOMMENDATIONS: Previous Recommendations Remain Appropriate**

1. Rapidly implement the NIC Staffing Analysis recommendations.
2. Create a staffing plan, as required under the Agreement, that reflects the NIC Staffing Analysis and provides concrete steps for hiring sufficient staff
3. Cease the practice of allowing staff to work high amounts of overtime and ensure that staff who work overtime have adequate time away from the facility before returning to work to ensure they are adequately rested.
4. Create a fast-track basic officer training program that ensures recruits are adequately trained on salient correctional topics.
5. Seek Court relief to remove any barriers to rapid remediation of facility safety and security deficiencies that expose people to harm.
6. Subsequent to policy and procedure development and revisions, conduct a complete review of existing Specific and General Post Orders to ensure they are:
   A. post specific;
   B. accurately represent post staffing needs and post resources needed to operate the post safely and consistently;
   C. are numbered, cross-referenced with policies/procedures, and formatted in a manner that makes them easy to interpret and apply;
   D. maintained at each post, kept current, and easily accessible;
   E. regularly reviewed, revised, updated;
   F. consistently enforced;

G. known to staff through pre-service, in-service, and ongoing training.

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

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

**ASSESSMENT: PARTIAL COMPLIANCE**

**FINDINGS:** Operable hand-held radios were found in all occupied housing units and for all officers assigned to those security posts. However, some officers were not wearing their radios at all times, which was reported in previous reports. Officers must keep their radios with them at all times while working within the security perimeter to ensure timely communications in cases of emergencies. It was also reported that a few radios were in need of repair, and some staff reported not knowing how to completely operate their radios.

**RECOMMENDATIONS: Previous Recommendations Remain Appropriate**

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

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

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

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

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

**FINDINGS:** Despite improvements in staffing levels previously discussed, staffing levels remain inadequate. And, despite reported daily visits to the housing units by supervisors, continued high levels contraband and violence against inmates and staff clearly demonstrate inadequacies in compliance.

**RECOMMENDATIONS: Some Previous Recommendations Remain Appropriate**

1. Refer to recommendations regarding Post Orders.

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

## B. Contraband

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

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

**ASSESSMENT: PARTIAL COMPLIANCE**

**FINDINGS:** The revised policy includes a clear definition of what items constitute contraband but requires final approval by this Monitor and USDOJ. This Provision can move to Substantial compliance once the policy is effectively implemented. Effective implementation is demonstrated with 1) all staff have been adequately trained according to requirements of this Agreement, and 2) a quality management process clearly shows that the policy produces it's intended outcomes.

**RECOMMENDATIONS:**

1. Implement the new policy according to the terms of this Agreement once approved.

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

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS:** The introduction and presence of contraband appears to remain pervasive and unfettered by GGACF efforts to comply with this provision. An examination of the Evidence Log entries (10/3-12/3) demonstrates the continued presence and high volume of dangerous and other contraband as follows:

Money – 3
Cell Phones (some with chargers): 32
Drugs (an paraphernalia): 9
Weapons (knives, sharp objects, shanks): 21
Jewelry: 1
DVD's: 1
SD Card: 1

Continued introduction and high volume of contraband is indicative of inadequate searches by staff of inmates and structures, which is symptomatic of inadequate staffing levels, staff supervision, and training. The high volume of dangerous contraband continues to place inmates and staff constant extreme risk of harm. Additionally, tours of housing units revealed evidence of fire ignition sources such as "burning wicks" and housing unit floors scorched by fire. It is obvious that prisoners continue to possess contraband for starting fires, which is further discussed in the Fire and Life Safety Section of this report. GGACF officials must increase their efforts to eliminate the introduction and presence of contraband without delay.

**RECOMMENDATIONS:**

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

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

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS:** See above findings and discussion.

USDOJ and the Monitor's expert, Mr. Romero, were advised by staff that security searches of kitchen workers had become very lax. Staff stated that prisoners are no longer searched when entering and leaving the kitchen due to security staffing shortages. Additionally, the kitchen log book show that at least one utensil, a ladle, was missing from the inventory. Even more

troubling is that fact that there were no supervisors appeared to be present in the maintenance shop areas during this inspection. These areas, like the kitchen, contain numerous small tools and objects that can be easily smuggled into housing units are used to harm others.

**RECOMMENDATIONS:**

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

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

**ASSESSMENT: PARTIAL COMPLIANCE**

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

**RECOMMENDATIONS:**

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

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

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

**ASSESSMENT: PARTIAL COMPLIANCE**

**FINDINGS: To be assessed at the 7th site visit.**

**RECOMMENDATIONS: Previous Recommendations Remain Appropriate**

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

## C. General Security

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

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

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS:** No substantive improvement from previous assessment. Inmates continued to wear and possess personal clothing, including polo shirts, while in the housing units and in the outdoor areas of the facility. Previous recommendations do not appear to have been implemented.

**RECOMMENDATIONS:**

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

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

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS:** Identification badges were not provided to the monitoring team for each day of the visit due to there being a shortage of badges. Additionally, prisoners were observed traveling in and out of housing units, in the yard, in maintenance and kitchen areas. This problem has not been address by GGACF officials as agreed at the previous visit.

**RECOMMENDATIONS:**

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

4. Consistently enforce identification card policies and procedures.

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

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

**FINDINGS:** Policy drafts include requirements for locking and unlocking exterior and interior gates and doors. However, no documents were provided that demonstrate that all staff have been trained in protocols for properly locking and unlocking exterior and interior security access points. No documents were provided demonstrating that previous recommendations were implemented but officers continue to document in housing unit log books inoperable sally port doors. Additionally, we again observed prisoners using objects to prop open cell doors.

The Maintenance Supervisors again stated that several sally port doors at housing units have remained unrepaired for several years and that he has been unable to make needed repairs to do lack of adequately skilled maintenance staffing levels and funding.

**RECOMMENDATIONS:** Previous Recommendations Remain Appropriate

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

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

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS:** Same as above

**RECOMMENDATIONS:** Previous Recommendations Remain Appropriate.

1. Employ and maintain adequate maintenance staffing levels.
2. As requested in the previous two reports, develop an "all-locks" maintenance plan for review with the Monitor. The plan should include a complete inventory of all locks, locking mechanisms, date lock found non-functional, date repair/replacement was completed, and a list of all locks and locking systems taken offline. The plan should include, at a minimum, the following elements and should use an Excel spreadsheet: Where the lock is specifically located – (Perimeter gate, housing unit 9A, cell #, emergency door, etc.), and lock number, lock type, condition, etc.
3. Establish a deadline for developing and implementing the lock plan to include policies, procedures, training, and continuous quality assurance.

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

**ASSESSMENT: NONCOMPLIANCE**

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

**RECOMMENDATIONS:**

1. Territory officials should assess history of terminations, identify determining factors, and realign completion of pre-employment practices to avoid post-employment terminations.
2. This Monitor again requests inspection personnel records including employment applications; criminal history checks, and background investigations for all housing unit staff working Units 9A/B during the reported escape attempt occurring June 7, 2014. <u>These documents were requested for all previous visits but not provided.</u> **<u>Please have these documents at GGACF for the upcoming site visit.</u>**
3. Ensure access to applicant and staff records is adequately controlled and protected, and that access to these records is based on a legitimate, work related "need to know" basis.
4. Ensure there is an adequate centralized information tracking system in place to support periodic supervisory review of staff records for professional development, counseling, and corrective action decision-making.
5. Make records available to the Monitor for inspection and verification of compliance.

## D. Security Staffing

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

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

**ASSESSMENT: PARTIAL COMPLIANCE**

**FINDINGS:** As stated in the previous report, the Staffing Analysis was completed as required by this Provision. However, the Territory has yet to submit a staffing plan that incorporates the results of the analysis as required by the Monitor's Schedule and recent Court Order. This Monitor has provided Territory officials documents to assist them in developing such a staffing plan with no response.

A document provided to this Monitor by BOC officials during this visit show 117 correctional positions are authorized in the 2015 BOC budget. The document also shows that 88 (75%) of those positions were filled as of 11/30/14, with an additional 12 officers beginning the training academy in December. BOC officials are commended for their ongoing efforts to recruit additionally officers but must submit a staffing plan that incorporates the results of the staffing analysis.

**RECOMMENDATIONS:** Previous Recommendations Remain Appropriate

1. Complete and approvable Staffing Plan that accounts for the recent closing of four housing units and overtime.
2. Secure funding to comply with Plan staffing requirements.
3. Revise staffing hire process to improve its efficiency and timely hiring of officers.

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

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS:** Same as above.

**RECOMMENDATIONS:** See above.

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

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS:** Same as above.

**RECOMMENDATIONS:** See above.

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

**ASSESSMENT:** See above

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

**RECOMMENDATIONS:** Refer to previous recommendations.

**E. Sexual Abuse of Prisoners.**

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

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS**: The Territory has not complete the PREA self-audit. PREA draft polices are currently under review by this Monitor and USDOJ.

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

## 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:** As stated in the 5th Report - There has been no change since the previous reports. Although this Monitor assisted the Territory in the development of a Classification policy, the classification instruments require validation to ensure that the instruments and classification process is objective. However, according to Territory officials, a national expert in classification validation is expected to be onsite for this purpose by the end of 2014.

Additionally, the Territory has not responded to the Monitor's request to provide classification forms to be used in the application of the new policy in order to complete the policy.

**RECOMMENDATIONS:** Recommendations previously provided remain appropriate.

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

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

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

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

- Total Institutional Monthly Average Daily Population (Pre-sentenced and Sentenced Prisoners)
- Total Outside of Territory Contract Prisoners (BOC prisoners held off-island)
- Monthly Average Daily Population, Admissions and Releases
- Classification / Housing Stratification for all Currently Used Housing Units
- Custody Classification Level Volume Report (number of prisoners in each primary classification).
- Names of all prisoners by classification, conviction statues, and housing unit.

These documents do not, however, clarify whether the Territory conducts regular classification reviews to ensure prisoners continue to be properly housed and separated from other inmates according to changes in their classification status.

**RECOMMENDATIONS:** Previous recommendations remain appropriate:

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

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

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

**FINDINGS:** Same findings as above.

**RECOMMENDATIONS:**

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

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

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

**FINDINGS:** No documents were provided demonstrating compliance with this Provision. The Monthly Disciplinary Committee Report was not provided to fully assess compliance.

**RECOMMENDATIONS:** Previous Recommendations Remain Appropriate

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

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

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

**FINDINGS:** No documents were provided to demonstrate efforts to comply with this Provision. Additionally, the current incident reporting system remains inadequate for collecting valid and reliable data from which to evaluate any incident activities. The Incident Log does not always record all reported incidents, multiple incident numbers are being assigned to single incidents in some instances and not in other instances. Some incidents are reported on the log inconsistently using incident code numbers and incident types, and some entries are illegible.

GGACF officials will remain unable to accurately and consistently evaluate serious incident activity until a uniformed incident reporting system is successfully implemented.

**RECOMMENDATIONS:** Previous recommendations remain appropriate:

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

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

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

**FINDINGS:** Segregation and Lock-Down Review documents were provided to examine compliance with this Provision. GGACF officials represented these documents as the complete segregation-review records for prisoners housing in a segregation status. However, the quality and completeness of the documents makes assessing compliance with this Provision impossible. The majority of these records were not properly completed and information required for an adequate assessment was not recorded. The majority of the documents omitted:

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

The following was determined from those records providing enough information to draw cursory, albeit, reasonably reliable conclusions about compliance with this Provision:

There was no documentation to determine whether GGACF followed-up on recommendations made by staff who conducted the review:

1. FJ – Officer notes the prisoner is not receiving daily showers and recommends that the inmate should be returned to GP. No follow-up action recorded.
2. WA – Officer notes the prisoner should be evaluated by MH but no record was provided to verify whether a referral was submitted or an evaluation was completed.
3. PC – Officer notes the mentally ill prisoner in disciplinary segregation is concerned about disciplinary time calculations but fails to document action to investigate and resolve this concern.
4. JW – Officer notes prisoner is to return to GO but then states "Subject was not placed in G.P / To remain in A.S".
5. JT – Officer documents prisoner needs "+ Dental Cleaning" but fails to document a medical referral.
6. RC – Officer fails to record prisoner's level of "…wellbeing" (Good, Fair, Poor)
7. FR – Officer notes the prisoner "needs social help" but fails record required follow-up actions to be taken. The document does not include the second page (reverse side).
8. AP – Officer notes inmate states "being harassed by officers…" but no follow-up action is documented.
9. JP – Officer notes the prisoner "Refused" [to cooperate with review process] but fails to document any observations about inmate physical condition. This document omits reverse side of form.
10. TD – Officer notes inmate was "punched in the face [by another inmate," and "needs to see a dentist" but no follow-up action is recorded.

11. NB – Officer determines and records the prisoner's overall level of wellbeing is "poor" but does not record what the prisoner means by this statement and no required follow-up action is documented.
12. WJ – Officer notes prisoner requests a "physical checkup" but no follow-up action is recorded.
13. PS – Officer notes prisoner "needs a new bed, pain in left hand" but no follow-up action is recorded.
14. Officer notes, "[prisoner] needs to see a psychiatrist…" and records "Remains in SMU – cc: Dr. Sang." Follow-up action is not recorded, reverse page is omitted.
15. RE – Officer does not record any health and wellness information.
16. JR – Officer notes, "[prisoner] threatened by staff and inmates… staff and other staff threatens to put him in a body bag…" No follow-up action recorded. No administrative investigation provided to this Monitor regarding possible threats to inmate life.
17. DJ – Officer notes prisoner "Requested medical (Dental)" but no follow-up action is recorded other than, "CC: HSA Charles."
18. US – Officer notes on several review forms this mentally ill prisoner "Refused". This is interpreted to mean the inmate refused to participate with the review process. No health and welfare information is recorded on forms from January to July 2014.
19. MH – Officer does not document health and wellness information, notes "Refused, needs to be evaluated or assessed." No required follow-up action shown, page missing.

The GGACF segregation review process is inadequate and non-functional. It is likely that some inmates are kept in segregation…

1. without being afforded their legal due process rights;
2. for unnecessary and/or extended periods;
3. are not being provided adequate health care services;
4. are not being properly and routinely monitored and assessed for physical and mental health needs;
5. are not have their reported complaints, needs, concerns resolved;
6. prisoners with serious mental illness are being held in segregation in violation of the Agreement.

**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. A routine schedule for conduction these rounds must be regularized and continuously monitored for compliance.
3. Develop and implement a monthly segregation housing unit log that tracks lengths of stay and compliance with this provision.
4. Defendants are reminded that segregation should never be used to punish or as a treatment for inmates who are mentally ill.
5. Improve the quality and completeness of segregation review documentation.

## G. Incidents and Referrals

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

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

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

**FINDINGS:** Draft policies and procedures are currently under review by this Monitor and USDOJ. That said, the current incident reporting system remains disorganized, unreliable, and not well managed based on examination of incident reports and logs since the Baseline Report:

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

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

**RECOMMENDATIONS:** Previous Recommendations Remain Appropriate

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

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

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

**ASSESSMENT: NONCOMPLIANCE (from Partial Compliance)** - No substantive improvement from previous assessment.

**FINDINGS:** This Provision returns to Non Compliance. As stated above, the current incident reporting system is incapable of producing consistently reliable information from which to identify, ascertain, and address incident trends. Additionally, previous recommendations were not implemented and no documents have been provided to this Monitor demonstrating efforts to improve the current incident reporting system or administrative review system.

**RECOMMENDATIONS:**

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

**c. Requirements for preservation of evidence; and.**

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS:** No substantive improvement from previous assessment.

**RECOMMENDATIONS:**

1. Refer to similar recommendations regarding contraband.

**d. Central tracking of the above incidents.**

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS:** No substantive improvement from previous assessment.

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

**RECOMMENDATIONS:**

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

## H. Use of Force by Staff on Prisoners

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

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

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS:** Policies and procedures were submitted to the Territory for review as ordered by the Court; that document remains under review by the Monitor and USDOJ.

Use of force used by GGACF staff appears questionable and possibly in violation of prisoner rights. A recent housing unit riot involving several inmates was quelled by use of force by several officers. Several inmates involved in this incident reported to monitoring team members that officers used unjustified physical force that resulted in physical injuries. This information was forwarded to the United States Department of Justice for investigation.

**RECOMMENDATIONS:**

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

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

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS:** Same as above. No improvement.

**RECOMMENDATIONS:**

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

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

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS:** See above findings.

**RECOMMENDATIONS:** Same as above, and

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:** No use of force training has been provided to staff as described in this Provision. The Territory continues to be nonresponsive to this Monitor's several requests for all training curricula. This Monitor requested these documents prior to each onsite visit and several times between visits. The Territory's non-responsiveness to the Monitor's request prevents the Monitor from adequately assessing compliance with this section specifically, and all Provisions involving training.

**RECOMMENDATIONS:**

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

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

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

**FINDINGS:** Same as above. Not change.

**RECOMMENDATIONS:**

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

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

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

**FINDINGS:** Despite several incident reports documenting several incidents involving staff use of force on prisoners, the Territory did not comply with this Monitor's request for documents; all use of force reports and administrative reviews of force were not provided. This Monitor was unable to assess compliance with this Provision.

**RECOMMENDATIONS:**

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

**g. Supervision and videotaping of planned uses of force;**

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

**FINDINGS:** GGACF officials continue to not videotape planned uses of force. For example, the recent riot was not officially videoed by any GGACF supervisor but was videoed privately by an officer using their personal phone. During this visit, received conflicting information from GGACF officials about this recording. The GGACF Security Administrator stated this incident was not videotaped but a supervisor involved in the incident stated that it was. Based on this supervisor's statement we requested a copy of this videotape; the Territory provided this video to the Monitor and USDOJ January 30, 2015, 50 days after it was requested by this Monitor and USDOJ.

This Monitor's cursory review this video found much of its content very troubling as listed below:

1. In a November 10, 2014 internal report to the VIBOC Director, the GGACF Acting Warden refers to this incident as a "Semi Riot". The video clear demonstrates this incident was a full riot involving many prisoners who were destroying property, burning objects, and flooding the housing unit.

2. While some prisoners threw objects at the officer station windows, other inmates stoked burning mattresses they placed over the entrance gate intending to prevent staff from entering the housing unit and seriously harm them if they tried to do so.

3. Fires were burning on the upper tier of the housing unit.

4. The housing unit was filling with smoke. Officers observing the violence in the officer station were not adequately protected from smoke inhalation and had no ability to stop the fires or the violence. Inmates who were locked in their cells could not escape the smoke nor could they safely enter the day room without risk of serious violence from inmates engaged in the riot.

5. Officers entering the housing unit to stop the violence were not adequately equipped with the proper equipment to protect them from physical harm from inmates, the fires or smoke. Many officers were seen leaving the housing unit covering their faces with their shirts and choking from smoke inhalation. None of the officers involved in responding to the fire wore proper breathing equipment or smoke-filtering masks.

6. There was no security containment perimeter established within the housing unit while the entrance gate, officer station entrance, and external slider remained open simultaneously.

7. There appeared to be no command and control of the GGACF response; many officers were seen walking about the smoky housing unit for no apparent reasons, others came in and out of the housing unit with no direction from supervisory staff. Staff response appeared disorganized, chaotic, and not directed. Staff who were obviously overcome by smoke were allowed to reenter the housing unit and there were not oxygen tanks observed to assist staff or inmates who were experiencing respiratory difficulties.

8. The prisoners appeared to have been locked back in their cells rather than evacuated into a secured containment location. These inmates continued to inhale smoke and any toxic fumes produced from the burned mattresses.

9. None of the forced used by GGACF was observed in this video.

Despite the fact that this video cannot be used to demonstrate compliance with this Provision, VIBOC officials should use its content for emergency management planning and response training purposes. This recording clearly demonstrates the degree to which GGACF is not prepared, equipped, staffed, and managed to effectively respond to such emergencies.

**RECOMMENDATIONS:**

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

***This Monitor respectfully urges the Court to review this video in chambers to better understand the Monitors concerns.***

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

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS:** No change.

**RECOMMENDATIONS:**

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

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

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS:** Not change.

No photographic documentation was provided from inmate injuries sustained when physical force was used by staff to quell the recent riot. Photographs of inmate injuries were published in the local newspaper. Documentation was inadequate to determine if and to what extend injured prisoners were provided medical treatment for injuries sustained from staff use of force.

**RECOMMENDATIONS:**

1. Provide Monitor documentation of Compliance with this Provision.

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

**ASSESSMENT: NON COMPLIANCE**

**FINDINGS:** This Monitor was not provided with "ALL previous use of force incidents as requested" (Recommendation 2 below and in the Fifth Assessment Report). As such, this Monitor was unable to adequately asses this Provision and believes that administrative reviews of staff use of force remains inconsistent, incomplete, and/or non-existent. This Monitor was provided several administrative review documents regarding use of force used during the recent housing unit riot.

**RECOMMENDATIONS:**

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

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

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS:** This Monitor was not provided requested documentation to adequately assess compliance with this provision.

**RECOMMENDATIONS:** Same as above

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

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS:** Same as above.

**RECOMMENDATIONS: Same as above**

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

**ASSESSMENT: NONCOMPLIANCE**

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

**RECOMMENDATIONS:**

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

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

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS:** Same as above.

**RECOMMENDATIONS:**

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

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

**ASSESSMENT: NONCOMPLIANCE**

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

It is impossible for GGACF to fully comply with this Provision until supervisors comply with use of force review requirements.

**RECOMMENDATIONS:**

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

## I. Use of Physical Restraints on Prisoners

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

**a. Permissible and unauthorized types of use of restraints**;

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS:** Same as above. The draft policy remains under review. Documents were not provided to assess compliance with this Provision.

**RECOMMENDATIONS:**

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

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

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS:** Same as above

**RECOMMENDATIONS:**

1. Same as above.

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

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS**: Same as above.

**RECOMMENDATIONS:** Same as above.

**d. Required observation of prisoners placed in restraints;**

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS:** Same as above.

**RECOMMENDATIONS:** Same as above.

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

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS:** Same as above.

**RECOMMENDATIONS:** Same as above.

**f. Required termination of the use of restraints.**

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS:** Same as above.

**RECOMMENDATIONS:** Same as above

## J. Prisoner Complaints

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

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

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS:** Staff who maintain the complaint system did not participate in this assessment and this Monitor was unable to adequately assess compliance with this Provision.

The Inmate Grievance Log was provided for examination but no staff were available to clarify log entries and document deficiencies. The log shows no substantive improvement from the previous report. This Monitor is very concerned that many inmate complaints continue to go unresolved, providing inmates no access to relief from alleged rights violations and safety and security concerns.

**RECOMMENDATIONS:**

1. Conduct monthly administrative reviews of the inmate complaint reporting and tracking process to measure and verify program compliance, take timely and appropriate remedial and correction action.
2. Ensure tracking log is consistently completed and accurate.

3. Assign oversight of the inmate complaint process and logs to a staff person who will provide the process consistent, dedicated, and comprehensive attention.
4. Develop from a valid and reliable tracking a quality management statistical report for monitoring inmate and facility needs and problems.
5. Ensure staff are available during onsite visits to allow this Monitor to adequately assess this Provision.

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

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS:** Same as above.

**RECOMMENDATIONS:** Same as above.

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

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS:** Same as above.

**RECOMMENDATIONS:** Previous recommendations remain appropriate.

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

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

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

**FINDINGS**: Same as above.

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

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

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

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS:** This review process continues to not exist.

**RECOMMENDATIONS:** Same as above.

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

## K. Administrative Investigations

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

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

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS:** The elements of this Provision were included in this Monitor's policies and procedure drafts.

Administrative investigation documents involving the recent housing unit riot demonstrate a troubling lack of concern for staff and inmates. The documents provided demonstrate a systematic failure to adequately investigate event by any measure of adequacy. This event involved several obvious operational failures regarding:

- Effective inmate communication
- Key control
- Housing unit security and prisoner control
- Fire response, suppression, and follow-up
- Staff and inmate health and welfare
- Emergency management, command and control
- Constructive/objective post-event assessment and corrective-action planning
- Staff training

- The investigator position remains vacant.

**RECOMMENDATIONS**:

1. Fill the vacant investigator position.

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

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

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS:** Same as above.

**RECOMMENDATIONS:**

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

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

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS:** No substantive change since previous visit.

**RECOMMENDATIONS:**

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

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

**ASSESSMENT: NONCOMPLIANCE**

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

**RECOMMENDATIONS:** Fill the currently vacant Chief Investigator position.

1. Create a formal pre- or in-service training program to train staff who are involved in initial and/or administrative investigation.

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

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

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS:** This Monitor was not provided requested documents to adequately assess this Provision. Monthly disciplinary hearing records were not made available for review. One GGACF staff person stated that disciplinary due process hearings had not been conducted since July 2014. This Monitor is very troubled and concerned that various forms of disciplinary sanctions are being imposed on prisoners without due process.

The Territory provided no documents, as requested, regarding staff discipline except for a document dated October 10, 2014 that directed an officer to a disciplinary hearing. This document articulated no other information about the reasons for this hearing.

**RECOMMENDATIONS**: Previous recommendations remain appropriate.

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

## V. MEDICAL AND MENTAL HEALTH CARE

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

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

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

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

**MEDICAL FINDINGS:** We have been working with the Health Service Administrator since our last monitoring visit. A number of policies have been completed and seven requiring some additional modifications are now complete and currently under review by the Monitor and U.S. Department of Justice. Those seven policies include receiving screening, chronic disease, infection control, urgent and emergent care, non-emergent care, grievance mechanisms and emergency response plan.

With regard to the receiving screening, we have redesigned the nurse-utilized receiving screening form so that the design of the form facilitates appropriate completion. During this visit we reviewed approximately 10 records with regard to the receiving screening process. We were encouraged by the fact that almost all of these forms were completed by a registered nurse and most were completed within 24 hours of the patient's arrival at the facility. However, the professional performance does not show improvement. Some of the problems found were sections that did not appear to be completed because there were no items circled, either as positive or negative within that section. In addition, there were several forms that were completed but the acuity scale was not utilized, so there was no assigned acuity and therefore no sense of urgency with regard to the completion of the health assessment. There was an improvement in the planting and reading of the tuberculosis skin test; however, a few of the forms lacked the documentation with regard to the reading. This area clearly needs work and that begins with the approval of the policy followed by the appropriate training. Some examples follow.

**Patient #1**
This is a 44-year-old who arrived on 10/20/14. The screen lacked an acuity scale and there also was no physical assessment. However, the TB skin test was planted on 10/21 and was read as 0.0 mm on 10/23.

**Patient #2**
J.L. This is a 57-year-old male who had a nurse screen on 11/1. There was no physical exam. There was a recent TB skin test which was 0.0 mm in August 2014. The acuity scale was not utilized and there was no physical exam.

**Patient #3**
H.O. This is a 48-year-old who arrived on 11/2/14. The screen was performed but there was no signature and no physical assessment. An acuity scale was listed as 3, but there did not seem to be any basis in the screening data that would suggest acuity level 3.

The following problems exist with the medical process:
1. As cited in the last visit, screens are to be conducted as soon as possible after entry. Our understanding is that there is nursing coverage only between 8:00 a.m. and 8:00 p.m. seven days a week and therefore the longest duration without a screen should be no more than 12 hours. We have also discussed with the Medical Director designing a form that will allow a nurse who is on call to address questions over the telephone with the patient who is newly arrived. This is for patients who arrive between 8:00 p.m. and 8:00 a.m. If these questions contain positive answers that suggest instability, the nurse will call the doctor on call who can then determine if the patient can wait or needs to be sent to the hospital. The physician could also speak with the patient. If all the answers are negative, the patient should be seen first thing in the morning when the next RN arrives on duty and that will be the time that the receiving screening is completed.
2. It was clear from this visit that although training may have been provided, the performance was not consistent with the requirements. Therefore, we redesigned the form in a manner that should facilitate improved performance.
3. The acuity scale did not always assess the patient correctly and this of course is a matter of training and feedback to the individual nurses.
4. Without a regularly scheduled advanced level clinician, physician, PA or nurse practitioner available regularly, there cannot be compliance with the requirements with regard to the timing of the health appraisal.

**RECOMMENDATIONS:**

1. Continue to refine the screening policy, including utilization of the acuity scale.
2. Develop the questionnaire for the telephone triage to be used between 8:00 p.m. and 8:00 a.m.
3. Continue to recruit for the nursing staff and fill the remaining vacancies.
4. Establish predictable and regular hours for the advanced level clinician services so that the acuity scale based on the screen data can be achieved for patient care.

**MENTAL HEALTH FINDINGS:** Medical staff are performing intake health screenings in a timely fashion. Positive mental health findings did initiate referral to the psychiatrist by security and medical intake screeners. As mentioned elsewhere, a freestanding mental health intake screen will be developed and implemented with the assistance of this monitor.

A review of the intake screening log was performed in order to study the health of the referral process by the intake screeners to a mental health professional. Between October 1 and

December 4, 2014 there were a total of 79 intakes. Of these, 8% (n=6) were referred to the psychiatrist because of positive responses on their intake screening of mental health issues. All of these charts were reviewed. Of the six, all were seen within 3 business days of referral by the psychiatrist (with the longest delay being 5 days since time of identification). It should be noted that if the facility had a Qualified Mental Health Practitioner ("QMHP") on staff they would be the professional who would complete the initial psychological evaluation and then determine who required referral to the psychiatrist. The current time frames for referral represent excellent responsivity by the psychiatrist.
Results of the review with concerns are as follows:

Concern: Inmate number 1 was not screened as lacking mental health issues on admission. However, two days later a correctional officer issued a behavioral checklist referring the inmate to the psychiatrist for depression. In this case, the inmate was seen nine days later by the psychiatrist who noted that he did not speak English and referred him to see a physician with whom he could communicate. This second clinician only addressed the inmate's complaint of elbow pain and not the referral issue of depression. This case is a vivid showing on noncompliance with the Agreement as it demonstrates how care for this inmate was impaired by language barriers.

Significant concern: Inmate number 3 was referred from intake for a diagnosis of bipolar disorder. The medical intake screen noted no suicidal ideation. He was seen by the psychiatrist five days later who noted he was psychotic. Concerns with this record are the follow-up date set for two weeks hence (being too lengthy period of time to reevaluate someone recently hospitalized prior to booking and diagnosed with an acute psychosis); and the fact that the inmate was not placed on any observation status pending reevaluation or referred for any kind of special mental health housing (the latter is not yet available at GGACF).

Between psychiatric appointments he was seen by a general clinician who noted a history of significant self-induced trauma with injury but when he was assessed by the psychiatrist this behavior was not specifically addressed although the assessment indicated no suicide risk. When reevaluated by the psychiatrist two weeks later there was no evidence of psychotic symptomatology and a follow-up appointment was scheduled for one month. However, there was also no specific comments regarding suicidal or homicidal risk despite his positive history of self-injury. (It should be noted that some of this is a product of the formatted progress note which only requires the psychiatrist to make an entry when there are positive signs of suicidal ideation as opposed to a general statement indicating no risk. New mental health forms were drafted by this monitor for review by the psychiatrist prior to implementation to remedy some of the inefficiencies of the current forms formatting.)

Concern: Inmate #5 had a negative officer intake screen but a positive medical screen for suicidality six days later. He was referred to the psychiatrist and seen within two days. Documentation was sparse and only recorded on a progress note as opposed to a complete initial assessment form.

Significant concern: Inmate #6 was noted to have psychotic symptoms at the time of intake. This was again noted by the psychiatrist at the time of her review. She appropriately increased the dose of the inmate's medication but follow-up was 30 days later. Considering there is little to no

mental health programming, supervision, or specialized housing, a follow-up with one month on the inmate with psychotic symptoms is too long a time frame in the judgment of this reviewer.

A second review was done of all detainee bookings for the month of November 2014 to see if any inmates with positive mental health issues were not identified for referral to the psychiatrist. 16 records were reviewed and all inmates with any positive mental health issues were identified. The monitor observed that there were no 14 day history and physicals in any record. There were some timeliness issues but the Health Services Administrator reported they were down 2 RNs that month and stated that it was unknown when or if these positions would be filled.

**RECOMMENDATIONS:**

1. The psychiatrist is attempting to see people quickly upon their referral to her. However because of the absence of a QMHP, the psychiatrist is only doing focused intakes and there are few documented comprehensive initial assessments which with the appropriate staffing would have been performed by the mental health professional. Many of the documentation deficiencies appear to be related to the formatting of the medical record forms as well as the lack of any assistance for the psychiatrist by mental-health professionals. It is critical that GGACF make every effort to offer competitive salaries in order to hire the necessary number of QMHPs to accommodate the mental health needs of the inmates housed within this facility.

2. Renovations to the secure observation area for mental health with the appropriate correctional and nursing staffing to monitor these inmates must expeditiously continue in order to provide the required level of care and safety for inmates entering or developing critical mental illness symptomatology on site at GGACF. This is especially needed considering this island lacks any inpatient psychiatric facility that can receive these inmates and the Bureau of Corrections still has the legal and moral obligation to meet the basic mental health needs of these seriously ill individuals.
3. GGACF must also develop basic mental health programming to support these individuals in achieving and maintaining remission. This will be discussed further in the preceding section on mental health programming.

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

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

**MEDICAL FINDINGS:** Just as we have redesigned the intake screening form, we have also redesigned the practitioner health assessment form. The redesign was an effort to facilitate capturing sufficient data to achieve compliance with the requirements. A bigger challenge for the program, however, is to achieve stable, predictable advanced level clinician coverage such that the requirements of the acuity scale can and will be met. We learned that during our visit Dr. Burton's contractual obligations finally had been met, which should result in more stable and predictable advanced level clinician scheduling. Dr. Burton was present during part of our monitoring visit and we continue to look forward to working with him on an ongoing basis. Our review of the intake process revealed that a majority of the records we reviewed either did not contain an initial practitioner health assessment at all or contained a practitioner health assessment that was not

completed within the required timeframe. We cannot emphasize enough the need for several of the service requirements covered in this agreement to insure timely, predictable advanced level

**RECOMMENDATIONS:**

1. Stabilize the advanced level clinician schedule so that each week there is advanced level clinician presence on at least three days.
2. Develop a system, possibly utilizing a logbook that enables the Medical Director to review acuity level 1 and 2 intakes to insure that their problems are being appropriately addressed and adequately followed up. This should be part of the quality improvement program.

**MENTAL HEALTH FINDINGS:** Currently no inmates are receiving comprehensive initial assessments by a mental health professional. The psychiatrist is the only mental health professional on staff and sees everyone referred from intake. Most individuals are receiving a focused interview at the time of their initial visit documented on a mental health progress note rather than a comprehensive assessment, most likely due to the absence of additional QMHP who would ordinarily perform this task prior to referral to the psychiatrist.

**RECOMMENDATIONS:**

1. This monitor will assist GGACF in developing standardized mental health intake screening, initial behavioral health evaluation, and progress note forms for implementation in the coming months.
2. See recommendations under paragraph V.1. J.

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

**ASSESSMENT: NONCOMPLIANCE**

**MEDICAL FINDINGS:** We have used this section to address medical sick call; therefore it focuses on acute care needs, since chronic care services are covered in another section. We continue to discuss with the staff modifications to the log that include, when patients are not seen, the reason why they are not seen. We reviewed 10 records of patients who requested sick call services. We identified records in which we believe the nurse who did the triaging determined that the patient was going to require advanced level provider assessment and therefore skipped the nurse assessment. The requirement is independent of the credentials; the assessment must take place within 48 hours during the week and 72 hours on the weekend. Therefore, in order to achieve compliance with this aspect of the agreement, nursing staff should not be permitted to skip their assessment, even when they believe that an advanced level clinician assessment is required. Thus, every symptom containing health services request must have a timely nursing assessment conducted by a registered nurse in an appropriately designed and equipped space which allows for confidentiality.

The problems continue to persist with regard to accessing patients in the clinic because of lack of custody escort services. We have already described a solution, which is to utilize the potential exam rooms built into the housing units. These rooms need to be cleaned, sanitized and appropriately

equipped. Nursing leadership has developed a list of required equipment and supplies for these exam rooms. We would expect that before our next visit, prison leadership will make these rooms available for health care assessments.

Here are some examples of patient records.

**Patient #1**
A.L. This is a 24-year-old who complained of severe neck and back pain on 10/5/14. He was seen four days later by the physician, whose documentation does not address the neck and back pain.

**Patient #2**
D.R. This is a 39-year-old who complained on 11/19/14 of fever and constipation. We could not find a note in his chart addressing these items.

**Patient #3**
J.R. This is a 42-year-old whose record lacks a problem list, who complained on 11/14 of pressure in his chest and chest pain. There was no nurse assessment. There is an indication that he was to be seen by the cardiologist on Friday, December 12. The patient is currently being treated by Dr. Galibare for hypertension.

**RECOMMENDATIONS:**

1. Continue your efforts to fill the nursing vacancies in order to facilitate timely assessments.
2. The head nurse should continue to review and provide feedback with regard to the quality of the nursing performance during the sick call process.
3. The sick call log book should contain patient identifiers, date of request, date of nursing assessment, if the assessment did not occur, a field for the reasons why and date for reschedule if the reasons were other than patient refusal and finally, disposition, that is referral to a clinician, yes or no and date that the referral takes place.
4. A patient who submits a request with multiple complaints must have each of these areas assessed by the nurse at the visit.

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

**RECOMMENDATIONS:**

1. It is recommended that the health services and correctional leadership develop a corrective action plan to ensure improved access to medical and mental health care by inmates with following tracking to establish efficacy of the plan.

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

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

**MEDICAL FINDINGS:** The issue with the pharmacist has still not been completely resolved as of the current visit, but I am told that there is a commitment to resolve it, so we will wait to see. The pharmacist did stop in for the first time in several months the weekend before our tour, but I am awaiting the report that her appearances will be regular. We did not observe medication administration during this visit. However, we do remain concerned about the medication administration practice and its documentation. Because of the delays, especially in access to advanced level clinicians, and sometimes due to the absence of escort officers, it is our understanding that assessments are delayed and therefore on that basis alone, access to medications are delayed.

**RECOMMENDATIONS:**

1. Submit the medication administration policy for approval by the Monitor and USDOJ.
2. Fill both the nursing and advanced level clinician hours and regularize them so that there is timely access to assessments as well as medications.
3. The head nurse should work with the Medical Director in order to develop a procedure that allows the nurses not only to carry the medications with them, which is occurring, but also to bring the medication administration records so that at a minimum the administration of the medications is recorded no later than when the nurses are about to leave each housing unit.

**MENTAL HEALTH FINDINGS:** The medication administration records did not indicate a problem with the administration of medication. However, we were informed that at least one inmate was refused medications because he was not wearing his shirt when the medication was being administered at the housing unit. This is unacceptable. Inmates must be provided their medications as directed by the responsible prescriber. However, no quality improvement data was available to dispute previous observations of medications being distributed without observation of ingestion. Additionally, the log book for housing unit 9C notes a complaint that a detainee's seizure medication was withheld. Additionally, one inmate who was admitted to the facility on a Saturday reported not receiving prescribed seizure medication until the following Wednesday, five days later. This inmate reported having several seizures during this period of time.

**RECOMMENDATIONS:** defer to Medical recommendations

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

**ASSESSMENT: NONCOMPLIANCE -**

**MEDICAL FINDINGS:** During this visit I have approved the medical records policy. There is clerical staff available but that staff's contract is about to expire. The charge is to fill the medical record position on a permanent basis. Although there are some improvements, certainly in access to the records and in the diminution of loose filing, we still found documents within a section not being filed chronologically and some documents were not filed in the appropriate section. In addition, several records lacked problem lists and the problems lists, when present, were not available on the top of the side in which they were filed.

**RECOMMENDATIONS:**

1. Hire a medical records technician as soon as possible, hopefully before our next visit.
2. The medical records policy should include timeframes for filing of documents and for reviewing, initialing and dating by clinicians.
3. There should be guidelines for thinning the records and in particular, what documents from the inactive record need to be moved to the active records. Those documents that should be in the active record include intake information and documents in progress notes, consultations, laboratory and x-ray from at least the most recent year.

**MENTAL HEALTH FINDINGS:** The facility has yet been able to hire a permanent medical records clerk. In the interim two retired employees are currently being utilized to organize the medical records department. Since the time of our last site visit they have assigned a medical record number to every chart and have begun filing charts numerically. All old records have been removed from boxes and organized in file cabinets for easy access. Records that are currently in use are still in the process of being shifted over to the new system. Most of the records, other than mental health records, have been placed in file cabinets in numerical order. However, most of the mental health records are filed loosely on a records cart.

42 medical records were reviewed during the course of this visit. Significant problems were identified in many of those records as follows:

- The practice of using identification labels which were pre-printed for ease-of-use appears to have stopped.
- Clinical records occasionally had no identifiers including inmate name, date of the transaction, or the name of the clinical staff person delivering the service.
- Many records are completely out of sequence, for example, medical record entries from 2013 are on top of entries from 2014.
- Charts are unthinned.
- Loose papers are in the records.
- Unfiled medication administration records (MARS) were seen dating back as far as 2012. MARS should always be within the first half of the next month.
- Loose filing was placed in the wrong inmate's chart.

**RECOMMENDATIONS:**

1. GGACF continues to have a vacant full time medical records position that needs to be filled with a qualified person.
2. Once all records are appropriately organized and filed, a quality improvement tool needs to be developed to track compliance with this provision.

**f. Prisoners' timely access to and the provision of constitutional medical and mental health care to prisoners including but not limited to:**
**(i) adequate sick-call procedures with timely medical triage and physician review along with the logging, tracking and timely responses to requests by qualified medical and mental health professionals;**

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

**MEDICAL FINDINGS:** This item was dealt with under letter (c), including recommendations for this provision.

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

**MENTAL HEALTH FINDINGS:** The Sick Call Log was reviewed from September 16, 2014 through December 5, 2014. During this time 255 inmates submitted a sick call request. Of those only five (2%) had a mental health complaint, representing an unusually low rate of self-referrals. Of these, one was seen within 72 hours of submitting the request. Four were seen in more than three days. All 5 charts were reviewed. Results with concerns are as follows:

1. One record of a 37 year old man contained a security log entry in the unit log that he was moved to cell 1 and placed on a suicide watch by Dr. Sang. There are no other notations in the log indicating a 15 minute or direct observation status. Dr. Sang told me she had placed no one on a suicide watch so this indicates a communications misunderstanding. Also, the inmate's request concerned his feeling depressed and losing his mind yet it was handled as a routine request and not urgent with a 5 day delay to be seen by nursing.

2. A second inmate's sick call request could not be found in the medical record which was 3-4 inches thick with quite a bit of unfiled paperwork.

3. Another inmate had been allowed to sign a carte blanche refusal to see the psychiatrist who he had last seen on 10/18/14.

**RECOMMENDATIONS:**

1. If the officer's understanding was that an inmate was on a suicide watch, then whatever instruction was given regarding how to document observation of such an inmate is inadequate. GGACF needs to develop performance measure tools to track the effectiveness of training.

2. I discussed with medical staff and the psychiatrist reasons why inmates cannot sign a carte blanche refusal for care but rather can only refuse a specific treatment. Since inmates have no other avenue for treatment due to their confinement the psychiatrist should still continue to schedule the necessary treatment and counsel the inmate on the risks of their refusal. Inmates

should also be evaluated for their capacity to make treatment decisions if they suffer from a serious mental illness and are continually refusing care.

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

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

**MEDICAL FINDINGS:** For this response, I am interpreting this to refer to the tracking of chronic care patients but other care-tracking is ultimately required for full compliance with this Provision.

There is a chronic care notebook but it is not maintained in such a way that newly identified patients are immediately placed in the logbook and patients released are immediately deleted from the logbook. Many facilities use an Excel spreadsheet and compare it to daily lists of releases. They also have a process which at the time of the initial practitioner assessment is used to identify the chronic disease, and notify the nurse who is managing the Excel spreadsheet so that the newly identified patient can be entered into this tracking log.

**RECOMMENDATIONS:**

1. Establish an Excel log with one nurse responsible for adding and deleting names as appropriate. This log should contain patient identifiers, the types of chronic problems by disease as well as the most recent degree of control at the specific clinic visit and the date of the sequence of chronic care visits, including the most recent chronic care visit.

**MENTAL HEALTH FINDINGS:** During the site visit the psychiatrist was on leave. No one else at the clinic was able to provide a current copy of the chronic mental health care list. At the time of our previous visit the psychiatrist and I did review the tracking form and this monitor was able to make recommendations to improve the comprehensiveness of the database. It is my understanding that the psychiatrist continues to use this updated database, however no one else at the clinic had access to that computer file.

**RECOMMENDATIONS:**

1. Currently the psychiatrist is the only mental health professional working for the facility. In the past the chronic mental health care list was maintained by the mental health coordinator who was a QMHP. In general, the maintenance of current clinical logs should have a central and accessible record available to all medical and mental health staff, especially in the absence of any single individual. Therefore, I would recommend that the Health Services Administrator develop the means for all clinic entries (medical, mental health and dental) to be shared and stored in a common computer file that she or her designee can access.

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

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

**MEDICAL FINDINGS:** We have reviewed and approved the chronic disease guidelines. However, our record review indicated that patients were not being seen necessarily within the timeframe that the clinician recommended. We were told that this was due to the inconsistency of the presence of the chronic disease physician. He is supposed to be on site two days a month, but many months he is only on site one day. If there were consistent Medical Director or other physician presence, they could see the patients who were supposed to be seen by the chronic disease physician when he did not appear. Our review of patients with chronic diseases demonstrated sometimes inadequate histories, sometimes delays in follow-up visits for the reasons previously mentioned as well as incorrect assessment of degree of control. Examples of patients follow.

**Patient #1**
S.S. This is a 59-year-old who has been in the facility since 1996. He was diagnosed with both asthma and diabetes type 2. His baseline visit was on 11/29/13 and his most recent visit was 8/15/14. He should have had a chronic disease visit since the August visit but has not. At that time, his blood pressure was143/83, elevated for a diabetic, but he has not been seen since.

**Patient #2**
R.M. This is a 58-year-old who arrived in July of 2012 and was assessed as having diabetes mellitus type 2 as well as hypertension. His baseline chronic disease visit was on 9/20/13. However, the assessment page in the initial baseline visit form was missing. Unfortunately, this patient has not been seen since September 2013 in the chronic disease program.

**Patient #3**
J.F. This is a 48-year-old who arrived at the prison in March of 2011. He was seen and diagnosed as having hypertension within one week. He was not seen by the chronic disease physician until September 2013, which is two and a half years later. His blood pressure was quite elevated and the chronic disease physician ordered an increase in his medications. However, he was not seen until a year later for reasons that are unclear.

**RECOMMENDATIONS:**

1. The Medical Director must retrain the chronic disease physician on the use of the chronic disease forms and what the expectations are with regard to documentation.
2. As referred to under section f (ii), develop an Excel spreadsheet for monitoring the chronic disease program that includes patient identifiers, names of diseases, the date of the baseline visit, the assessment for control for each disease and the date of the subsequent visits.
3. In addition, there should be a field that indicates if a patient's visit was cancelled, the reason why the visit was cancelled and whether the visit has been rescheduled.

**MENTAL HEALTH FINDINGS:** See section V.s.1.Dr. Shansky for items v, vi, g. and h.

**RECOMMENDATIONS:** Develop and implemented evidence-based, written mental health clinical practice guidelines for assessment, treatment, and follow-up as stated in the 5th Report.

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

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

**MEDICAL FINDINGS:** We have approved both a draft emergency services policy and an urgent/emergent care policy. However, there has not been approval from all the parties as well as training for implementation yet. We reviewed several records of patients sent offsite on an emergency basis. We identified the following types of problems: We found records in which there was no note prior to send out, which may be attributable to the hours when there are no staff onsite. We also found records in which although there was nurse staffing onsite, the patient was never brought to medical for the nurse to insure that the proper documentation was available and to see the patient. We also learned that for patients who return during periods when there is no nursing staff onsite, the officers drop the paperwork in a box which is checked by one of the senior nurses each morning. We also found there were not consistently follow-up visits with the primary care clinician after the unscheduled offsite services. Of the records we reviewed, here are some examples.

**Patient #1**
J.R. This is a 27-year-old with seizures who complained of abdominal pain on 10/21. She saw the physician and complained of blood in her stool and epigastric discomfort. She also indicated her commode had been filled with blood. The physician's plan was to send her to the ER; however, when she arrived in the ER, she ultimately refused because of the long waiting time in the ER. She has had no follow up since and was finally released on 11/26.

**Patient #2**
G.E. This is a 42-year-old patient with asthma sent to the emergency room for shortness of breath on 10/11/13. This patient had a PPD that was planted but not read. Despite the identification of the asthma in May of this year, there has been no chronic disease follow up. When the patient returned there has been no ER report in the record and no chronic disease clinic.

**Patient #3**
J.L. This is a 29-year-old who on 11/11 was sent to the ER after complaining of pepper spray in his mouth. There is no ER report in the record and there has been no follow up.

We were not informed that the Medical Director has provided training to both medical and nonmedical staff regarding recognizing serious injuries and life-threatening problems. We do know that the basic officer training does include some of that material.

**RECOMMENDATIONS:**

1. The offsite services coordinator must insure that emergency room reports are available and reviewed by the Medical Director before patients are scheduled for a visit with the Medical Director.
2. The Medical Director should provide training to officers and this should be documented in their training file.
3. The unscheduled services log should contain a field for whether the patient was seen in follow up and if not, an explanation as to why not. If the explanation is due to absence of clinician or custody the patient must be rescheduled.

**MENTAL HEALTH FINDINGS:** see section V. i.

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

1. Future training curricula will need to be presented to the monitoring team for review and approval.
2. Continue tracking timeliness in response to behavioral checklists.
3. A continued reminder by supervisory staff regarding the location and use of cut down tools is needed and can be enhanced by incorporating these tools into disaster drill scenarios.

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

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

**MEDICAL FINDINGS:** We did continue to find problems with both the availability of the offsite service documents as well as the follow-up visits with the clinicians. There was a little improvement but not sufficient yet to give us confidence that the service is provided well. Patient examples follow.

**Patient #1**
N.P. This is a 36-year-old with asthma who had an appointment with a surgeon on 9/19/14 for his left zygamotic fracture that was depressed. The surgeon saw him and his note indicates he is planning to do surgery. When the patient returned there was no discussion between the patient and the primary care clinician. However, the patient was seen by the surgeon and did have the surgery. He had a discussion with the Medical Director after the surgery was completed as well as a follow-up visit with the surgeon post-operatively.

**Patient #2**
J.E. This is a 57-year-old with hypertension and HIV and there was a referral to ortho for bilateral lower extremity numbness as a result of spinal stenosis. The orthopedist was seen on 10/20; however, there is no nursing note on return even though the return occurred during hours when nurses were on site. The orthopedist recommended an MRI and physical therapy. The MRI was performed and the report reveals multilevel spinal stenosis, especially at L4 and L5. The patient was to see a surgeon on 12/23/14. After the MRI, there was no visit between the Medical Director

and the patient. Apparently, the visit with the surgeon is to determine whether physical therapy is in fact needed.

**Patient #3**
N.W. This is a 19-year-old who was sent to gyne for an initial visit. There is a report from the specialist in the chart and lab tests were ordered, but the lab reports are not in the chart and there has been no follow-up visit with the Medical Director or primary care physician.

**RECOMMENDATIONS:**

1. The offsite service coordinator must obtain the reports and bring them to the physician or Medical Director for review and signature, after which a follow-up visit with the physician and the patient must occur.
2. The offsite service coordinator should also be in touch with the chronic care physician's office, since some procedures are performed at his office.
3. The chronic care log should be created and should include a field for whether the patient was seen as scheduled and if not seen, the reason for the patient not being seen. If that reason is absence of custody or of clinician, the patient must be rescheduled.

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

**RECOMMENDATIONS:** defer to Dr. Shansky's report

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

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

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

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

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

**RECOMMENDATIONS:** defer to Dr. Shansky's report

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

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

**MEDICAL FINDINGS:** We have discussed with the Medical Director and provided him draft examples from other facilities. He indicated he has not yet completed the guidelines with regard to alcohol and other substance intoxication and withdrawal.

**RECOMMENDATIONS:**

1. The Medical Director in working with the HSA should draft both a policy on intoxication and detoxification from substances including alcohol, opiates and benzodiazepines.

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

**RECOMMENDATIONS**: defer to Dr. Shansky's report

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

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

**MEDICAL FINDINGS:** We are in the process of reviewing and approving the infection control program. We discussed with the nursing staff the documentation of the TB skin tests and reviewing the presence of the planting and result by the quality improvement program. We also discussed the need to notify the infection control nurse with regard to patients presumptively treated for MRSA so that this nurse can report on the frequency of MRSA cases.

**RECOMMENDATION:**

1. The head nurse should assign a nurse to be responsible for the infection control program.

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

**RECOMMENDATIONS:** defer to Dr. Shansky's report

**i. Adequate suicide prevention, including:**

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

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

**MENTAL HEALTH FINDINGS:** Inmates entering with identified risk factors for increased risk of suicidal ideation and behavior were identified in the review of the intake screening log. 50% (4 inmates) should have qualified for some level of enhanced observation in a well-functioning system. However, none of these inmates were placed under observation. One inmate had a positive history serious self-injurious behavior and was never placed on suicide prevention observation prior to being seen by the psychiatrist at the facility.

**RECOMMENDATIONS:**

1. The Quality Improvement Committee should meet regularly, per policy, and monitor the intake screening process for accuracy of detection of inmates with risk factors and implement systems of care to address those needs, especially for potentially suicidal or aggressive inmates (either due to withdrawal, psychosis or other conditions).

**(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:** Only one instance, a 37 year old male, mentioned previously, was noted to be placed on a suicide watch by the correctional officer. There is no documentation of and enhanced observation offered to this inmate.

**RECOMMENDATIONS:**

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

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

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

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

**RECOMMENDATIONS:**

1. An Internet search for a suicide risk assessment tool will provide links to multiple websites. Staff can review the assessment tools located on the Internet and determine if any would be pertinent to the facility as is or with modifications. The SAMSHA website has links to several free instruments including the Columbia suicide risk assessment tool which has Internet training available. It is important, however, that suicide detection assessment tools used are validated for jail settings and the specific population being assessed.

2. Screening Tools Assessing Risk of Suicide and Self-Harm in Adult Offenders: A Systematic Review at: http://ijo.sagepub.com/content/early 2010/03/11/ 0306624X09359757. abstract

   This systematic review assessed the validity of screening instruments to identify the risk of suicide and self-harm behavior in offenders. A search of 11 electronic databases and grey literature resulted in the inclusion of five studies. The five studies revealed four screening instruments, including the Suicide Checklist, the Suicide Probability Scale, Suicide Concerns

for Offenders in Prison Environment (SCOPE), and the Suicide Potential Scale. Two instruments, SCOPE and Suicide Potential Scale, shared promising levels of sensitivity and specificity. The reporting of information was generally varied across items on the Standards for the Reporting of Diagnostic accuracy (STARD). Research is needed to assess the predictive validity of tools for offender populations in the identification of those at risk, particularly those in probation and community settings.

3. Develop for approval valid suicide screening and assessment tools for initial and follow-up screening purposes.

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

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

**ASSESSMENT: NONCOMPLIANCE** - No Substantive Improvement from Previous Visit.

**MENTAL HEALTH FINDINGS**: Cut down tools were available in the units visited by this reviewer. The Monitor reports that cut down tool was not found in A Dorm as reported in all previous reports.

**RECOMMENDATIONS:**

1. Cut-down tools must be readily available in all housing units and all officers must be able to rapidly locate and obtain those tools when needed. The tools should be stored in exactly the same location in each housing unit. This will help to ensure consistent and reliable access by staff
2. Cut down tools should be available in all housing areas, and areas where inmates could have an opportunity to harm themselves, i.e. kitchen, medical building, etc.
3. All staff required to use this tool should be well-trained and emergency drills demonstrating proficient use of the tool should be conducted on a regular basis.
4. Supervisors should regularly inventory and audit tool location and make immediate provisions to replace missing or non-functioning tools when found.

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

**ASSESSMENT: NONCOMPLIANCE**

**MENTAL HEALTH FINDINGS:** No change since 5th Report. Appropriate training curriculum has not been provided as required. Staff remain inadequately trained.

**RECOMMENDATIONS:** In addition to the previous recommendations reiterated below, all suicide prevention training must:

1. Comply with the elements of this Provision as stated above;
2. Be corrections-specific;
3. Base lesson plans on current research with regard to:

a. Inmate populations and characteristics relevant to suicide risks
b. Prevalence of suicides and suicidal behavior in correctional settings
c. Conditions and circumstances relevant to risk of suicide
d. Locations in facilities
e. Effects of solitary confinement
f. Methods of suicide in correctional settings
g. Instruments and items used to attempt/commit suicide
h. Safe housing

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

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

**MENTAL HEALTH FINDINGS:** Per the Monitor's review of training records, and because no approved suicide prevention policy exits, staff have not been trained as required under this provision.

**RECOMMENDATIONS:**

Previous Recommendations Remain Appropriate:

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

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

**ASSESSMENT: NONCOMPLIANCE** - No Substantive Improvement from Previous Visit.

**MENTAL HEALTH FINDINGS**: There has been no change regarding the provision of suicide resistant cells for inmates on mental health observation, meaning; there are no suicide resistant cells in use at GGACF. Renovations to the infirmary area have been on hold since the time of our prior site visit. Thus, any inmate placed on observation would most likely remain in their current cell or be transferred to a segregation cell.

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

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

Previous Recommendations Remain Appropriate:

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

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

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

   In older, antiquated facilities with cell fronts, walls and/or cell doors made of steel bars, Lexan paneling (or low-abrasion polycarbonate) or security screening (that has holes that are ideally

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

1/8 inches wide and no more than 3/16 inches wide or 16-mesh per square inch) should be installed from the ***interior*** of the cell.

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

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

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

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

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

6. Beds should ideally be either heavy molded plastic or solid concrete slab with rounded edges, totally enclosed underneath. If metal bunks are utilized, they should be bolted flush to the wall with the frame constructed to prevent its use as an anchoring device. Bunk holes should be covered; ladders should be removed. (Traditional metal beds with holes in the bottom, not built flush to the wall and open underneath, have often been used to attach suicide nooses. Lying flat on the floor, the inmate attaches the noose from above, runs it under his neck, turns over on his stomach and asphyxiates himself within minutes.);

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

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

9. CCTV monitoring does ***not*** prevent a suicide, it only identifies a suicide attempt in progress. If utilized, CCTV monitoring should ***only*** supplement the physical observation by staff. The camera should obviously be enclosed in a box that is tamper-proof and does not contain anchoring points. It should be placed in a high corner location of the cell and all edges around the housing should be caulked or grouted. Cells containing CCTV monitoring should be painted in pastel colors to allow for better visibility. To reduce camera glare and provide a contrast in

monitoring, the headers above cell doors should be painted black or some other dark color. CCTV cameras should provide a clear and unobstructed view of the entire cell interior, including *all* four corners of the room. Camera lens should have the capacity for both night and low light level vision;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**MENTAL HEALTH FINDINGS:** A draft protocol has been submitted to the parties for review and approval. Therefore, this provision remains in noncompliance since there is not an adopted and approved policy in place, training has not begun and no measurements of efficacy of the training exists. And in fact, as mentioned previously, there is observable evidence that little if any observation is provided and documented currently.

**RECOMMENDATIONS**:

1. Complete the process of policy approval, implementation and monitoring.

Previous Recommendations Remain Appropriate:

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

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

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

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

**MENTAL HEALTH FINDINGS:** A draft protocol has been submitted to the parties for review and approval. Therefore, this provision remains in noncompliance since there is not an adopted and approved policy in place, training has not begun and no measurements of efficacy of the training exists.
Also, according to the psychiatrist's report, there have been no cases of some moist on suicide watch for this monitor to be able to assess this provision.

**RECOMMENDATIONS:** The suicide prevention policy directing this process is currently under review. Complete the process of policy approval, implementation and monitoring.

Previous Recommendations Remain Appropriate:

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

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

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

**MEDICAL FINDINGS:** Since our last visit, two registered nurses departed and one registered nurse was added along with a part-time nurse. There also was one LPN departure. Our understanding is the complete staffing should include four registered nurses and three LPNs. Therefore, there is at least one full-time and a part-time registered nurse vacancy along with two LPN vacancies. In addition, there has not been at least three days a week onsite advanced level clinician coverage. That presence includes the Medical Director. The program needs to insure that

at least that level of nursing and advanced level clinician staffing are available. Finally, the clerk position, which has been filled by a temporary staff member, is going to be vacated. We understand interviews are to be conducted the week following this assessment, and it is important to fill that position as expeditiously as possible.

**RECOMMENDATIONS:**

1. Fill the two LPN positions.
2. Fill the 1.5 vacant RN positions.
3. Fill the clerical position.
4. Complete the pharmacy contract situation.

**MENTAL HEALTH FINDINGS:** Mental health staffing remains inadequate to provide even the most basic services required by a jail and prison. The only mental health professional currently on-site is the psychiatrist. Because of her other obligations, she has only had the time to do focused interviews on new referrals and complete her follow-up chronic care visits. It has been the monitoring team's recommendations that GGACF require a minimum of two full time QMHPs. Only after providing this level of staffing can it be determined what the need may be for a third professional. The obvious lack of professional staff remains any critical obstacle to the development of any mental health programming within the facility. Currently those inmates identified as seriously mentally ill receive only psychiatric chronic care appointments.

**RECOMMENDATIONS:**

Hiring of two qualified mental health professionals with the development and implementation of appropriate psychosocial programming essential to the maintenance and treatment of the seriously mentally ill inmates within the facility is an essential requirement for the facility to advance out of noncompliance status.

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

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

**MEDICAL FINDINGS:** There has been no change in either the demand for services to be performed in the clinic or the staffing to facilitate access. We have indicated that if the housing unit exam rooms are cleaned, sanitized and appropriately equipped, they can be available to reduce the need for escorts to bring patients for assessments up to the clinic. However, this has still not occurred. In addition, the escort staffing has not improved.

**RECOMMENDATIONS:**

1. Clean and appropriately equip the exam rooms in the housing units.
2. Provide a second correctional officer for the clinic/infirmary area.
3. Insure that a physician other than the one who works in the clinic accompanies the medication nurses on their rounds.

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

We also are aware that mental health services, limited as they are, are still obstructed by the absence of security staff to transport inmates to the clinician as scheduled. One can extrapolate from this statement the fact that adequate staffing by correctional officers to meet the mental health needs of the inmate population are grossly inadequate since the needs of a single mental health provider cannot be met at the current time and; therefore, the needs of at least two additional qualified mental health professionals could not be met either.

Indeed, there exists an egregious clinical example of an elderly inmate with a chronic and persistent serious mental illness who sustained a hip fracture while in segregation (most likely on June 20, 2014) which was unidentified for sufficient time for him to develop a large and obvious decubitus. This advanced tissue breakdown went undiscovered until an inmate helper was called to assist the inmate (July 8, 2014). Most remarkably, he was on daily medications and should have been observed regularly by nursing staff. However, his immobility and probable verbal refusals did not raise suspicion in the nursing staff and were not reported to the psychiatrist by nursing staff or the unit officer. The absence of mental health rounds in segregation also contributed to the delayed identification of this man serious health issues. During his period of confinement there is documentation by the psychiatrist of the scheduled visit that indicates there was no security staff available to transport him to the clinic, and therefore the inmate was not seen. This case also demonstrates irreparable harm to this individual who, as a result of not receiving timely medical intervention, remains permanently non-ambulatory due to contractions of his leg muscles--put simply, he will never walk again. Also very troubling was the fact that this inmate was taken into the yard and showered using a hose, rather than using the shower that was available inside the medical building. These actions demonstrate an unconscionable and deliberate disregard for this inmate's personal integrity and privacy.

**RECOMMENDATIONS:** No change from baseline assessment. GACCF will need to develop approved training tools and curricula. These will be presented to the monitoring team for approval and then training and implementation.

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

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

**MEDICAL FINDINGS:** There is a QI policy that we have now reviewed and approved. We are reemphasizing that by utilizing the logs and improving them as recommended, the HSA can begin to facilitate the monitoring of services such as:

1. Intake processing for completeness and timeliness.
2. Sick call for timeliness as well as for professional performance.
3. Urgent care for completeness and timeliness, including offsite emergency room reports.
4. Scheduled offsite services for completeness and timeliness, including offsite service report.
5. Chronic care visits for timeliness and professional performance.
6. Dental services for timeliness and professional performance.
7. Sick call for timeliness and nursing professional performance.

**RECOMMENDATIONS:**

1. Implement the QI program with respect to the above service areas.

**MENTAL HEALTH FINDINGS:** Until policies are approved, trained to, and implemented this provision cannot be met. In addition, since our last visit there have been no meetings of the Medical Administration Committee or the Quality Improvement Committee. Justification for the cessation of these meetings were reported as due to an absence of a medical director.

**RECOMMENDATIONS:**

Essential monthly or quarterly management meetings should occur regardless of whether a single committee member cannot be present. Although it is useful for the medical director to be present this should not be an essential component blocking communication between medical staff and other department leaders.

**m. Adequate dental care;**

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

**MEDICAL FINDINGS:** There is an oral care policy which we have approved. We were going to discuss the program with the dentist, but he did not show up on the day he was scheduled. Clearly, there needs to be a strategy to improve the consistency with which the dentist is available. We believe there continues to be a problem with access to dental services because of escort issues.

**RECOMMENDATIONS:**

1. The HSA should track both the availability of the dentist as well as the availability of custody escorts under the QI program.
2. The dental program should report to the QI program the number of scheduled patients and the numbers who arrive and the reason for non-arrival of patients.
3. The dental program should track the number of extractions as well as the number of restorations performed each month.
4. Develop adequate dental policies, procedures and protocols.

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

**RECOMMENDATIONS:** defer to Dr. Shansky's report.

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

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

**MEDICAL FINDINGS:** We provided the territory with a policy from another institution. We have not yet seen the mortality review policy. As far as we understand, there have been no deaths since our last visit and we are awaiting completion of the mortality review policy.

**RECOMMENDATIONS:**

1. Draft the mortality review policy.
2. Consider utilizing the services of an offsite service clinician to perform an external death review on all patients who die while incarcerated in Department of Corrections.

**MENTAL HEALTH FINDINGS:** No deaths were reported this quarter. However, as stated in V.1.k, there has been a case of serious morbidity which has generated no comprehensive combined internal investigation or review by security and health services.

**RECOMMENDATIONS**

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

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

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

**MEDICAL FINDINGS:** We do have a draft segregation round policy but our discussions indicate that there are no consistently held segregation rounds either by medical or mental health staff.

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**RECOMMENDATION:**

1. Draft the policy and procedure and begin insuring that rounds are performed weekly by mental health staff and twice a week by nursing staff.

**MENTAL HEALTH FINDINGS**: Since the onset of the monitoring teams work at GGACF, mental health rounds in segregation units has occurred on only one occasion. This provision remains in absolute and complete noncompliance.

**RECOMMENDATIONS:**

1. GGACF will need to hire adequate mental health staff to meet this requirement.

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

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

**MENTAL HEALTH FINDINGS:** As identified at earlier site visits, there is one individual with a chronic and persistent serious mental illness who has been housed in segregation for at least 10 years. His current housing status approximates that of isolation because he has no inmate housed in the cell next to his corner cell. Therefore, he is deprived of even the opportunity of conversing with another individual throughout the course of the day. Inmates in segregation do not have access to radios or televisions either. This monitor also received mixed reports from the inmate population as to the reliability of weekly transportation to the library and their ability to borrow reading materials on a regular basis.

**RECOMMENDATIONS:**

1. As per the provisions of this Memorandum of Agreement, inmates with serious mental illnesses should not be placed in isolation. However, it is also noted that the facility lacks any specialized programming unit to adequately accommodate the treatment needs of the seriously mentally ill population and is unable to currently provide any relief to the mentally ill inmates in segregation who require heightened programming and structure. The latter however does not relieve the Bureau of that obligation to develop, in a timely manner, the necessary treatment programs and housing requirements for these inmates. The lack of programming and appropriate housing has been an issue identified by this monitor for the past year and half. The Bureau of Corrections needs to develop a corrective action plan with specific recommendations for capital improvements and dates to remedy this deficiency.

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

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

**MENTAL HEALTH FINDINGS:** There is observable evidence that without a structured programming area under the supervision of clinical mental health staff, inmates with serious mental illnesses who become symptomatic remain likely subjects of disciplinary charges and sanctions at GGACF.

**RECOMMENDATIONS:**

1. GGACF needs to develop an effective policy and process to provide mental health review and input into the disciplinary process.

2. Mitigating factors discovered by the mental health professional must be considered by the disciplinary committee.
3. Mental health services should track the effectiveness of their input in mitigating sanctions or terminating sanctions as appropriate.
4. Alternative housing and treatment services are an essential component in diverting seriously mentally ill inmates committing infractions due to their impaired judgment and mental processing. Again, it is recommended that GGACF provide appropriate staffing and housing alternatives for this population. (See V.1.p.)

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

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

**MEDICAL FINDINGS:** This area was discussed in letter (c); additionally, it appears that there have been no changes to the proposed infirmary area since our last visit. This includes no additional equipment and no changes to the housing unit examination spaces.

**RECOMMENDATIONS:**

1. Complete the infirmary renovations, including the purchase of appropriate equipment and supplies.
2. Appropriately equip the infirmary area, including two dental operatories.
3. Insure that there is at least one more officer available for the clinic/infirmary area.

**MENTAL HEALTH FINDINGS:** The psychiatrist's office is currently being used to house a chronically ill inmate who requires 24 hour nursing care. For the last six months, the psychiatrist has been providing services in a small office behind the nursing station. Clinical services are disrupted due to the comings and goings of other staff who also share this office area. Because of the lack of visibility, the office door must remain open to ensure the safety of the psychiatrist. This is an unacceptable office space and fails to meet the requirements of this provision.

**RECOMMENDATIONS:**

1. Appropriate sound private office space with reasonable visibility by security staff needs to be made available to the psychiatrist and to any mental health professionals that are hired providing services in the medical treatment building.
2. If the infirmary construction resumes then this particular inmate could be housed in a medical observation cell, thereby, allowing the psychiatrist access to her old office space.

Previous Recommendations Remain Appropriate:

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

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

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

**MENTAL HEALTH FINDINGS:**

1. The psychiatrist was absent during this visit due to a conflict with vacation time offered by her other employer, the local hospital. This reviewer did have the opportunity to speak with her by phone and her willingness to do so during her time off was greatly appreciated. She continues to be the only mental health professional on site. In addition to providing services to the inmates Golden Grove Adult Correctional Facility, she continues to volunteer her time to provide forensic evaluations on GGACF inmates to the court. Each of these forensic evaluations is taking approximately 16 hours to complete. This cuts into the time she has available to see patients for direct services.
2. The psychiatrist's office in the medical treatment building has been changed in order to accommodate the housing of a seriously ill inmate. For the last several months she has been seeing inmates in what was formerly the head nurses office. This space is not private and is shared by nursing staff. The doctor noted that nurses walk in and out even during her interviews with inmates.
3. Regarding the timeliness and completeness of the medical encounter, it should be noted that the psychiatrist usually sees all referrals within a very timely period, often within 24 hours of referral. Cases sited in this section are examples of some of the exceptions.
4. Too often the mental status examination was incompletely documented. Even negative findings, such as normal mood and affect, should be noted.
5. Inmates on neuroleptic medication do not consistently have documented AIMS examination at the time neuroleptic medication was initiated, semiannually, or at the time they present with signs of an involuntary movement disorder.
    a. A 37-year-old man was referred after reporting that he was depressed and losing his mind on October 9, 2014. The sick call request was received two days later by medical. On October 16, 2014 there was a very thin response stating that the inmate denied suicidal intent and he was scheduled to be seen by the psychiatrist. He was ultimately seen on October 20, 2014 by the doctor and medication was stopped for torticollis and protrusion of his tongue (likely extra-pyramidal side effects of his medication). No test for extrapyramidal side effects was documented. What should have been triaged as an urgent request took nine days for an assessment to be completed. On his follow-up visit 10 days later no mental status examination was documented in the record.
6. Psychiatric documentation is not always complete with partial details of the examination or history being absent. Every encounter with an inmate by a psychiatrist should have, at a minimum, a brief history of the present illness, a complete mental status examination, a diagnosis and a plan. Deficiencies noted may be due to the lack of efficiencies of the forms being utilized with frequent observations by this reviewer of an absence to record mood, risk assessments, AIMS exams, etc.
7. Delays or failure to provide security for psychiatric visits which could have disastrous consequences.

a. One inmate was reported to have suicidal ideation at the time of intake on 9/26/14. He was referred to the psychiatrist who noted on 9/30/14 that the inmate could not be seen because there was no patrol officer. He was finally seen on 10/30/14 (an excessive delay considering he was referred because of suicidal ideation, an urgent issue) and there is no narrative regarding his suicidal risk factors and the nature of his intake findings. It was noted that the current note only asks for a positive finding of suicidal ideation but it should always include the absence of any suicidal ideation or plan too.

8. Complete an inmate Friday refusal form upon intake stating that the inmates refuses any future treatments with the psychiatrist. Therefore, he was not scared with the doctor for any evaluations despite previous diagnoses consistent with serious mental illness by a different doctor.

**RECOMMENDATIONS:**

1. The psychiatrist and mental health professionals must be provided with sound private interviewing space that minimizes distractions and disruptions in order to allow them to establish adequate rapport with the patient when discussing sensitive issues such as mental health symptomatology and history.
2. As previously discussed with Dr. Sang and Mr. Robertson, the facility psychiatrist should not be performing competency to stand trial evaluations since that could compromise her role as the attending psychiatrist for the prisoners. In addition, these activities reduce the power she has available for direct patient services.
3. This monitor will work with Dr. Sang and Ms. Charles to develop new forms that will hopefully correct some of the documentation deficiencies noted during this visit.
4. Inmates should not be allowed to sign a carte blanche refusal for current and future care. A refusal should only stand for the current service being offered. Otherwise, an inmate may be lost to care, especially if their mental illness interfered with their capacity to appreciate the ramifications of refusing treatment during the initial contact. In addition, a clinician cannot refuse to routinely treat an inmate in a correctional facility unless there are other comparably trained individuals who can accept the transfer of care of the prisoner. In addition, for inmates with a serious mental illness, there should always be documentation that their competence to refuse care has been assessed by the proper clinician (generally an MSW or higher).
5. Again attached please find general documentation guidelines, this are not standards but simply recommendations for standardizing the quantity and quality of records:

**Mental Health Documentation Guidelines**

These guidelines represent minimal requirements for documentation of clinical encounters.

GUIDELINES APPLICABLE TO ALL MEDICAL RECORD ENTRIES:

1. All entries shall be legible
2. Each entry shall list the inmate's name and MDC number
3. Each entry shall be signed by the clinician and indicate their professional degree
4. All entries shall be dated and timed
5. Current housing location, such as special housing or isolation, should be apparent by reading the chart.
6. 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.

THE INITIAL ASSESSMENTS:

SUBJECTIVE/ OBJECTIVE:

1. 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.
2. 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.
3. Inquiry into previous work history, military history, prior incarceration, and other significant psychosocial information should be provided.
4. Family history should include any history of psychiatric or substance abuse disorders as well as suicidal behavior in close family members.
5. Substance abuse history including current use and previous symptoms when withdrawing should be entered in the chart.
6. Current medications as well as response to prior treatment regimens should be listed.
7. 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.

ASSESSMENT:

8. All assessments completed by psychiatrists, independently licensed mental health professionals, or 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:

9. 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. Medical practitioners will indicate laboratory studies, obtain and file the appropriate consent forms, and perform clinically appropriate tests such as the AIMS and the MMSE.

10. Primary Axis I and Axis II diagnoses should be entered on the master problem list by psychiatrists, psychologists and advance practice nurses. Other disciplines may initially list the symptom deficits such as cognitive deficits and thereafter defer to the diagnosis provided by the above specified disciplines.

THE PSYCHIATRIC PROGRESS NOTE:

SUBJECTIVE/OBJECTIVE:

1. Comments should be entered concerning any reports of side effects or relevant clinical symptoms presented by the patient.
2. 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.
3. The clinician should indicate the clinical response by the patient to the current treatment plan and the presence of medication side effects.
4. Significant additions and deletions in diagnostic categories should be substantiated by DSM (current version) criteria recorded in the subjective portion of the note.
5. The reasons prompting significant changes in medications or the patient's treatment plan should be explained by history or findings

ASSESSMENT:
6. Provide an assessment pertinent to the data documented.

PLAN:
7. The appointment designated as the return to clinic time should be clinically appropriate.
8. Laboratory studies should be ordered as clinically appropriate.
9. Any planned interventions are documented

THE INDIVIDUALIZED TREATMENT PLAN:

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

THE GENERAL POPULATION AND SEGREGATION MENTAL HEALTH PROGRESS NOTE:

SUBJECTIVE/OBJECTIVE:
1. 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.
2. Documentation of any reports of medication issues or side effects
3. A brief mental status examination unless the template does not require that information.

ASSESSMENT:
4. A DSM (current version) diagnostic list as well as an estimate of the current global assessment of function
5. An assessment pertinent to the data documented

PLAN:

6. A clinically appropriate follow-up appointment
7. 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:

1. 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.
2. Only segregation rounds may routinely be conducted at the cell front or in a day room area.
3. Variance may be permissible during extended states of lock down, if the inmate is deemed to lack behavioral control, and other crisis situations.

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

**ASSESSMENT: NONCOMPLIANCE** - No Substantive Improvement from Previous Visit.

**MENTAL HEALTH FINDINGS:** There are no mental health programs currently offered for the inmate population. Since the time of our last site visit, the psychiatrist offered a single group session in addition to the individual visits she provides. The facility has not been able to locate a promising candidate with the proper credentials to hire as a QMHP. In that absence, the psychiatrist has continued to provide psychiatric services consisting of evaluation and the prescription and monitoring of psychiatric medications.

**RECOMMENDATIONS:**

1. QMHPs must be hired in order for GGACF to begin developing and implementing a mental health treatment program.

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

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

**MENTAL HEALTH FINDINGS:** The psychiatrist is doing an excellent job in obtaining vital signs including girth at the time of each visit. However, as mentioned elsewhere the service needs to diligently include a standardized measurement for involuntary movement disorders for the early identification of potentially irreversible extrapyramidal side effects from neuroleptic medication.

It is hoped that at the time of our next visit the medical records will be organized to expedite tracking the ordering of laboratory studies and the location of the results reports in the records. Currently the mental health files have not been collated to reliably support overview in this area.

**RECOMMENDATIONS:**

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

LABORATORY GUIDELINES:

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

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

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

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

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

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

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

Psychostimulants
1. Baseline vital signs
2. Random UDS q 3months

3. Consider TSH whenever clinically appropriate.

Other reference sources on:

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

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

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

**MENTAL HEALTH FINDINGS:** No documents demonstrating that this training has been adequately provided.

**RECOMMENDATIONS**: Correctional officers at GGACF should be commended for continuing to comprehensively complete behavioral checklists to initiate referrals for mental health services.
However, it is greatly concerning that a seriously injured mentally impaired individual mentioned previously was allowed to languish in segregation with no staff detecting serious impairment that in other circumstances would have resulted in a timely behavioral checklist referral being initiated.

**RECOMMENDATIONS:**

1. Continue to utilize the Behavioral Checklist process.
2. Conduct a facility quality improvement morbidity review that can be submitted to the monitoring team for review.
3. A detailed curriculum should be submitted for review to the monitoring team and approval by the Monitor.
4. Once obtained, training should be implemented with pre-and post-testing or other performance measures that have been approved by the Monitor.
5. GGACF should ensure the training officer or her records are available at the time of the next site visit for review by the monitoring team.
6. Develop, implement, and evaluate comprehensive training curricula to comply with Provision.

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

**ASSESSMENT: NONCOMPLIANCE - No Substantive Improvement from Previous Visit.**

**MENTAL HEALTH FINDINGS:** There continues to be no improvement in this area. Inmates with serious mental health issues continue to be maintained in segregation and isolation (in the

case of one individual) due to the lack of appropriate housing, programming, and coordination with security and classification. The psychiatrist has continued to encourage the facility to release one individual from isolation into general population without success.

At the time of our initial site assessment visit, we made recommendations to move the mentally ill inmates out of K unit due to the oppressive environmental issues such as elevated heat, humidity and lack of ventilation. Shortly after that visit, the then-Warden and his staff selected individuals, without input from the psychiatrist, who were deemed to be seriously mentally ill and relocated them to A dorm to meet the recommended accommodations.

On the last day of our site visit in December 2014, this reviewer went to the A dorm in an effort to speak with the seriously mentally ill inmates who have been housed in that area. Upon arriving at the unit it was learned that all of these inmates had been moved back to K unit by Acting Warden Prosper, without notice to or input from the Health Services Administrator, and without notice to or input from the monitoring team or U.S. Department of Justice. In fact, the Health Services Administrator was completely unaware that this housing change had occurred.

**RECOMMENDATIONS:**

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

## VI. FIRE AND LIFE SAFETY

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

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

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

**ASSESSMENT: NONCOMPLIANCE** - No substantive improvement from previous assessment. Draft policies and procedures were completed by the monitoring team in the area of Fire and Life Safety by the December 31, 2014 deadline and were provided to both parties.

**FINDINGS:** No substantive improvement from previous assessment. The Territory provided this Monitor draft Fire Safety policies and procedures during the July onsite technical assistance visit. However, during that visit the Fire Safety consultant advised the Monitor that he had revised these policies and would thereafter provide them. The monitor reported in his previous report that he had not yet received revised policy drafts despite making a written request. The revised policies and procedures were not provided to the monitoring team during or after the December 2014 monitoring visit. However, the monitoring team completed a draft version of the GGACF Fire Safety policies and procedures and provided them to both parties by the December 31, 2014 deadline. The staff training and implementation of these policies and procedures remains vital.

Inadequate housing unit staffing levels and contraband control practices continue to enable inmate-caused fires in housing units. For example, according to a November 10, 2014 memorandum from Acting Warden Prosper directed to Director Wilson, Prosper reports that a "Semi Riot and Officer Assault" occurred in 9 Alpha Housing Unit. Although this memorandum does not capture the full extent of the incident in terms of the force used by GGACF staff to quell the disturbance, it does indicate that the majority of the inmates were let out of their cells by another inmate and lit several mattresses on fire, thus creating considerable smoke in the Housing Unit. Video of the incident shows several inmates out of their cells and three separate fires in the unit. Even though the video and photos of the fire damage provided by BOC staff reflect substantial fire and smoke damage, the Fire Safety Consultant was not notified to investigate the incident, from a fire and life safety perspective. This is an unacceptable fire and life safety practice.

Beside the November 10, 2014 memorandum, there were no other documents provided to the Monitor indicating that an investigation of this event took place or whether an adequate post fire-incident review was conducted by GGAF administration or the Fire Safety Consultant. As evidenced above, incident reporting and investigations at GGACF remains woefully inadequate.

This incident alone, clearly continues to demonstrate how dangerous incarceration and employment as a corrections officer at GGACF can be. The automatic fire detection and suppression system remains inoperable, inadequate staffing levels and contraband control leaves housing units deleteriously under controlled and monitored, inmates apparently have undetected and interrupted access to items to ignite fires, and inmates obviously have no inhibition about starting fires.

During this monitoring visit we were also informed about a very serious and potential life threatening electrical explosion that occurred in the Kitchen in the month of October 2014. This incident was investigated by the Fire Safety Consultant and he found that the electrical explosion was caused by a short circuit in an oven. The Kitchen was evacuated and fortunately they found no gas leak. However, it could have been a disastrous situation, but averted by an electrician who promptly found the source of the ignition in an oven where the electrical wires were burning. The near disastrous situation, according to the Fire Safety Inspector, was that the Kitchen could have blown up with gas accelerant that is used to operate the food service stoves, ovens and other equipment. This near disaster was further exacerbated by having an untrained officer assigned to the Kitchen who did not know the location of the valve to shut of the gas feed to the Kitchen. Apparently, this officer was filling in for the regularly assigned Kitchen officer. Certainly, this incident, at a minimum, reflects the need to regularly inspect the food service equipment for functionality and electrical dangers, as well as the overall Kitchen electrical system and the need train all staff regarding fire safety emergencies and the location of electrical, water, and gas shut-off valves.

During our inspection of the Kitchen, we also observed exposed electrical wiring throughout various areas of the Kitchen; boxes stacked in the dry storage area nearly up to the ceiling (should be stacked no higher than 30 inches below the ceiling); and the fire alarm panel box had trouble lights blinking. Also, the Kitchen log book notes that that upon arrival to open the kitchen the stove was found to be on. These findings reveals the urgent need to develop and implement a comprehensive fire safety program at GGACF.

The Fire Safety Inspector reported that the facility has provided copies of the Fire Evacuation Plans to the VI Fire Marshal; however, those evacuation plans only address the housing units. Furthermore, there is no documentation available to demonstrate that even those limited evacuation plans were approved by the VI Fire Marshall. A comprehensive fire evacuation plan that includes all areas and buildings within the confines of GGACF and the contents of the overall fire safety program, such as the fire safety policies and procedures, needs to be developed and provided to the VI Fire Marshal for review.

Further detracting from the fire safety program at GGACF, we were informed during this monitoring visit that the Fire Safety Consultant's contract was in limbo and his contract with the BOC is on a month to month renewal basis. It is of critical importance that a contract or other method of employment remains in place for a qualified individual to oversee the fire safety program at GGACF. The Fire Safety Consultant also provides fire related services to the St. Thomas facility as well.

**RECOMMENDATIONS:** Previous recommendations remain appropriate. Additionally, the Monitor continues to request the reports for all drills and exercises conducted. It is also that

when the GGACF Fire Safety Program and the Fire Safety Plan are finalized, that they be provided to the Fire Marshal and with a copy to the Monitor.

1. Finalize and implement fire safety policies once approved and according to the Monitor's schedule by 12/31/14.
2. Repair/replace/install fire detection and suppression systems throughout the entire campus and structures.
3. Train all staff on this plan.
4. Install self-contained breath apparatuses (SCBAs) or an appropriate alternative at all locations where staff would need to search for or evacuate people.
5. Conduct and document quarterly fire drills for all shifts and document those activities.
6. Officials must continue to critically review staffing levels to ensure adequate inmate supervision and flammable contraband control in the housing units, fire detection, response, suppression, evacuation, and incident security.
7. Additional part-time fire safety officers should be selected from the officer corps, trained, and participate in the administration of a comprehensive fire safety program. It is unrealistic to expect one expert to develop and oversee such a complex program.
8. Supervisors should conduct routine, scheduled and unscheduled physical inspections of occupied structures, taking particular note of fire risks and hazards, document and report those findings to administration for timely and appropriate corrective action.
9. The fire inspection program is now detailed in the draft fire safety policies and procedures that the monitor provided to the parties, and they should become a fundamental element of pre-and in-service training.

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

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS:** Almost Identical to previous Monitor's reports, we found that the Housing unit fire control panels remain inoperable, the primary fire suppression system remains broken, cell and housing unit sprinklers are non-functional and regularly used by inmates to support personal clotheslines. The primary fire detection and suppression system was designed to automatically detect and extinguish fires within most of the housing areas. However, the older housing units are not equipped with this system. The detection system does not function and the sprinklers are either broken or clogged by inmates.

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

GGACF staff continue to indicate that sprinkler heads may be replaced in the "newer" buildings at some point in 2015. We were provided with a letter, dated November 24, 2014, directed to the Department of Interior from the BOC Director requesting to allocate funding to aid in the replacement of the fire suppression system and for refurbishing the Kitchen at GGACF. However, the scope of work for the fire suppression system seems to only include the purchase and installation of fire sprinkler heads and related parts in areas of the Facility

where there is a fire sprinkler system, but does not seem address to the need to install a fire sprinkler system such as in the old housing units where there is no fire sprinkler system. This needs to be clarified. The estimated cost for the fire sprinkler heads and related parts is approximately $89,700.00. Moreover, GGACF plans to continue to house individuals in the "older" buildings, and has no plans to update or install fire suppression equipment in those buildings. GGACF will never come into compliance with these provisions if that remains the case. GGACF staff provided a verbal estimate of the cost to upgrade the fire/smoke alarm and fire sprinkler system at a cost of approximately $230,000.00; however, all facility upgrade projects are dependent on funding allocation.

**RECOMMENDATIONS:**

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

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

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS:** Documentation demonstrating compliance with this Provision was not provided during this assessment. GGACF staff indicated that fire drills are not conducted on a regular basis and that there were none conducted for the last quarter. As reported in earlier Monitor reports, it is unclear when, if ever, full fire drills are conducted. The failure of GGACF staff to conduct fire drills continues to put inmates at risk of injury or death, should a fire break out that cannot be suppressed by the hand-held fire extinguishers present in the officer control pods of housing units.

During our inspection of the Housing Units, GGACF staff indicated that the emergency set of keys is kept in the office of the Chief of Security. However, this is problematic because when he is not present at the facility, no one has access to his office and the emergency keys. A set of emergency keys need to be made available to all security supervisors in a secure, but accessible location of the facility at all times. At another Housing Unit we were informed by GGACF staff that there is a set of emergency keys located in Master Control. There needs to be a clear and concise understanding by all security staff as to where the facility emergency keys are kept. Some emergency keys for fire exit doors are kept in the housing unit control centers; however, staff took considerable time to locate the proper emergency exit keys in Housing Unit G.

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

**RECOMMENDATIONS:**

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

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

**ASSESSMENT: NONCOMPLIANCE**

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

There is not a written preventative maintenance program or a regular security inspection program in place for checking that cell locks are functional and are not jammed from the inside or outside of the cell nor a system for ensuring that all facility remote locking cell mechanisms are functional. During the monitoring visit we observed evidence of inmates possessing materials such as, small blocks of wood or paper and other materials for jamming the cell locks. We also observed numerous housing unit grills whereby the locking mechanism was inoperable.

There is also no position for a locksmith at the facility; therefore, the Maintenance Supervisor has to assume the duty of working on the locking system as well as supervising the Maintenance Department. We also observed that the R and D entrance doors are still inoperable from previous monitoring visits.

**RECOMMENDATIONS:** Same as above.

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

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

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS:** Although the Fire Safety Inspector reported that he is involved in training staff on fire and life safety procedures, we were unable to ascertain its' validity because as stated in the previous reports and in our current site visit, no records have been provided to verify that all staff have been trained and tested on safety procedures.

**RECOMMENDATIONS:**

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

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

**ASSESSMENT: NONCOMPLIANCE**

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

During this monitoring visit we observed that GGACF has had the necessary equipment for installing a manual fire alert notification system stored in an office for about two (2) years. It appears that in order to install this system, the facility needs to provide the necessary electrical components. It is mind boggling that management staff have not intervened in ensuring that, at a minimum, the manual fire alert notification system was given priority and installed promptly instead of being stored in an office for two (2) years.

**RECOMMENDATIONS:**

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

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

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS:** As previously stated, the fire evacuation policies have not been approved and no evacuation drills were conducted during the preceding quarter.

**RECOMMENDATIONS:**

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

**h. Fire suppression;**

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS:** Same as previously stated. There is no functional fire suppression system. Additionally, and as stated in the previous report, officers do not follow basic fire safety practices when suppression fires. This was demonstrated when an officer use a water bottle to extinguish an inmate-made fire using an unknown flammable liquid. The officer used water from a water bottle rather than the readily available and functional fire extinguisher. Using water on an unknown flammable liquid could have triggered an explosion in the housing unit and exposed all persons present to very serious harm.

**RECOMMENDATIONS:**

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

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

**ASSESSMENT: NONCOMPLIANCE**

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

**RECOMMENDATIONS:**

1. 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.
2. 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.
3. Policy components involving medical and mental health staff should provide for their safety and security when involved in fire incident responses.
4. Qualified medical staff should participate in the development of fire program training topic that involves burns and smoke inhalation concerns. Qualified mental health staff should participate in the development of training related to critical incident recovery and emotional injury and recovery.

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

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS:** There seems to have been slippage from the previous inspection because we found that many inmate cells contain considerable personal property, thus creating a fire and safety risk. The Monitor provided a draft policy and procedure dealing with the Control of Chemicals, Flammables, Toxic and Caustic Materials to the parties which substantially addresses this provision.

**RECOMMENDATIONS:** Same as above.

## VII. ENVIRONMENTAL HEALTH AND SAFETY

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

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

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

**ASSESSMENT: PARTIAL COMPLIANCE**

**FINDINGS:** Documentation was provided during the previous monitoring visit that demonstrated ongoing efforts of GGACF officials, maintenance supervisors, and the Fire Safety Consultant to assess, improve, and monitor facility sanitation and hygiene. Draft policies were provided to this Monitor for review prior to the Court ordering the monitoring team to write draft operational policies. The Monitoring team reviewed and further revised these policies and procedures and provided them to both parties in December 2014.

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

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

**RECOMMENDATIONS**: Previous recommendations remain appropriate.

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

7. Improve practices involving mattress cleaning and ensure inmates and staff involved in this program are trained in proper cleaning methods and use of materials and chemicals. Ensure mattress storage areas are sanitary at all times.
8. Repair all housing/cell windows to prevent penetration by insects.

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

**ASSESSMENT: NONCOMPLIANCE**

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

The Maintenance Supervisor indicated that the housing unit exhaust system was not properly designed to operate effectively, compounded by the severe problem that most of the exhaust fans are not even operable.

The Monitoring team was provided with a draft proposal regarding a Detailed Energy Audit conducted by Energy Systems Group, dated November 10, 2014. This proposal includes measures to retrofit the lighting system, the air conditioning system, the PV Panels and for conducting plumbing upgrades at the Facility at an estimated cost of approximately $8,425,106.69. Certainly these upgrades are necessary for the continued operation of GGACF. However, we also caution that concomitant with physical plant repairs, the facility needs to ensure that there are adequate preventative maintenance systems in place, the availability of spare parts for conducting repairs and adequate maintenance staffing levels to maintain the systems. Furthermore, the Facility needs to ensure that there are adequate levels of trained correctional officers and supervisors available in order to properly supervise the inmate/detainee population and especially within the housing units, in order to prevent vandalism and costly repairs of these systems.

**RECOMMENDATIONS:**

1. Timely complete an air quality assessment performed by a qualified provider.
2. Implement necessary improvements that reduce housing area and cell temperatures and increase air flow.
3. Medical and mental health staff should monitor all inmates for heat and airflow-related health risks. All inmates in segregation or who are locked in their cells should be monitored by medical and mental health staff for signs of health conditions.
4. Train all staff in detecting and responding to health conditions related to heat and air circulation contributors.
5. Install environmental health condition monitoring devices, e.g., temperature, humidity, and air quality readers. Require regular monitoring and recording of readings and take timely action to mitigate environmental conditions that create health risks caused by those conditions.

6. Medical and mental health professionals should closely monitor inmates being administered medications that are adversely affected by high body temperatures and take appropriate steps to eliminate adverse effects.

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

**ASSESSMENT: PARTIAL COMPLIANCE**

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

**RECOMMENDATIONS**:

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

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

**ASSESSMENT:** PARTIAL COMPLIANCE

**FINDINGS:** Very little change since previous inspections. This provision remains in Partial Compliance but no decline in performance was found. In the Kitchen we found flies as well as insects in the inoperable refrigerator. Inmate accounts and at least one logbook entry indicate the presence of insects in food. We also noted that the overhead door to the storage area of the Kitchen is not properly sealed and rodents and vermin can easily infiltrate the Kitchen. Inmates in the housing units complained of mosquitos. Some inmates have lit "wicks" made, apparently, of toilet paper on their cell windows, hoping that the smoke will deter mosquitoes. We also observed missing or broken screens on many facility windows.

GGACF staff reported that they have a contract for pest control services; however, we were not provided with a copy of such contract.

The Monitoring Team developed a draft Vermin and Pest Control Policy and Procedure that was provided to both parties in December 2014.

**RECOMMENDATIONS**: Previous recommendations remain appropriate

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

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

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

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

The Monitor provided the parties with draft policies and procedures for this area of Environmental Health and Safety.

**RECOMMENDATIONS:**

1. Ensure that all inmates have access to hygiene products upon admission to the facility.
2. Continue to provide adequate supply of these personal care items in control pods or housing units to ensure timely exchange of use-for-new products.
3. Prohibit inmates from bartering these supplies and from hoarding empty containers in their cells and living areas.

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

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

**ASSESSMENT: PARTIAL COMPLIANCE**

**FINDINGS:** No substantive change from previous assessment.

There is no formal sanitation plan or protocols covering compliance with this Provision nor a form training program for staff or inmates on this topic. Staff and inmates must be trained and demonstrate competence in handling bio-hazardous materials, provided and instructed on the proper use of bio-protective clothing and supplies, and supervisors must closely monitor bi-hazard clean-ups. Remaining in Partial Compliance with this Provision can jeopardize the health of staff and inmates.

During the inspection of the medical department we asked the assigned officer where the bio-hazard spill clean-up kits were maintained; however, the assigned officer could not locate them. After some time, the Health Services Administrator showed us where they are maintained in the medical area. Even though it appears that the medical department is the central storage area for bio-hazard clean-up kits, the Health Services Administrator does not recall the last time anyone asked for such a kit.

**RECOMMENDATIONS:**

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

**g. Mattress care and replacement;**

**ASSESSMENT: NONCOMPLIANCE**

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

**RECOMMENDATIONS:**

1. Refer to previously discussed sanitation recommendations.
2. Issue clean and usable mattresses to all inmates.
3. Complete a full inventory of non-usable mattresses and remove them from the supply.
4. Do not issue mattresses to inmates until after properly inspected for damage and contraband, cleaned and sanitized.

5. Maintain reliable records that verify mattress inventories, cleaning and maintenance requirements.

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

**ASSESSMENT: PARTIAL COMPLIANCE**

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

The Monitor provided the parties with a draft Control of Chemicals, Flammables, Toxic and Caustic Materials policy and procedure which incorporates this Provision.

**RECOMMENDATIONS:**

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

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

**ASSESSMENT: NONCOMPLIANCE**

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

The Monitor provided a draft Inmate/Detainee Clothing, Bedding, and Linen Supplies policy and procedure to both parties in December 2014 that addresses the requirements of this Provision.

**RECOMMENDATIONS:**

1. Cease the practice of allowing inmates to wash personal and issued clothing in toilets and sinks.

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

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

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS:** Territory officials report the initiation of a major project to repair and clean-up the kitchen area. A scope of work for the project was submitted to the BOC Director on July 11, 2014. However, it is not clear if funding has been approved for this project.

The physical plant of the Kitchen has substantial deterioration as does the food service equipment. We found the flooring to be substandard with numerous broken tiles resulting in standing water and unable to properly clean and sanitize it. The dishwasher has not being working properly for a lengthy period of time. We observed numerous plumbing leaks throughout the Kitchen. We observed inoperable ovens. There is an inoperable walk-in refrigerator that is unsanitary and had insect infestation, along with a foul smell. There is no hot water in the inmate bathroom to properly clean their hands, nor was there soap readily available. It was not possible to check food temperatures because there was no food thermometer in the Kitchen. We observed the presence of flies and other insects in the Kitchen. The kitchen doors are not rodent proof. We observed an inmate putting food in the trays who had a beard but was not wearing a beard guard. Inmates in the housing units complained of seeing hair and insects in their food trays. We found that there is no master inventory of the utensils and dangerous implements. The Territory still has not implemented a utensil check-in/out system to monitor tool/utensil inventory.

The Monitor provided the parties with draft Food Service Sanitation and Hygiene policies and procedures that can serve as the foundation for the food service program once they are approved and implemented and staff are trained on them.

**RECOMMENDATIONS:**

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

3. GGACF officials should review food service requirements promulgated by the National Correctional Association and National Commission on Correctional Health Care.
4. Develop a food service training program that includes inmate and staff training records and ensure that all training is well-documented.

5. Policies and procedures developed should include controls for the use of caustic, toxic, and hazardous materials used in the kitchen. Material Safety Data Sheets should be posted conspicuously.

**k. Sanitary and adequate supplies of drinking water.**

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS:** No improvement was again observed in the housing units during this assessment.

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

This problem was again particularly acute in X dorm, per interviews with X Dorm prisoners, officers and our observations. There is no sink or fountain available for providing drinking water, and the women reported that in lieu of drinking water, correctional staff deliver large buckets of ice from which the women chip chunks into individual cups and allow to melt overnight to provide water the next day. This practice is unsafe and falls far below constitutional standards.

Further exacerbating the problem is the lack of cooling and ventilation in theses housing units. We found these Housing Units to be unbearably hot, both for the inmates and the staff.

**RECOMMENDATIONS:**

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

## VIII. TRAINING

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

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

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

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS:** This Monitor has repeatedly requested, over a period of months, all pre-service and in-service training curricula and related documents. The Territory has not provided any such material.

**RECOMMENDATIONS:**

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

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

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS:** Same as above.

**RECOMMENDATIONS:**

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

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

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS:** Same as above.

**RECOMMENDATIONS:**

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

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

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS:** Same as above.

**RECOMMENDATIONS:**

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

## IX. IMPLEMENTATION

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

**FINDINGS:** This Monitor completed and issued a revised Schedule as directed by the Court. Policy and procedure drafts were provide to the Territory on 12/31/14 as directed by the Court.

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

**FINDINGS:** Same as above.

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

**FINDINGS:** This Monitor issued policy and procedures drafts as on 12/31/14 as directed by the Court. The Monitor's Schedule includes deadlines for all document reviews and implementation in accordance with this Agreement.

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

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

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

**FINDINGS:** The Territory will propose modifications to the Monitor's draft policies and procedures by 1/30/2015. The Monitor and DOJ shall thereafter provide written objections, if any, as needed. This Monitor will assist the parties resolve and related disputes.

**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 December 5, 2014 Status Report largely provides inadequate information to reliably assess or evaluate progress toward compliance. The information provided does not link progress to compliance.

**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:** Documents provided were inadequate to assess compliance with this requirement. However, a review of the incident log, medical records, and incident reports indicate that the Territory has failed to notify this Monitor and DOJ of all incidents requirement emergency medical attention for inmate injuries. This issue will be further assessed during the upcoming site assessment.

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

**FINDINGS:** The Territory failed to provide all documents requested prior to this assessment visit. Documents requested to adequately conduct this assessment are similar to those requested for all previous assessments. Significant delays in submission of requested documents and information disabled a complete and thorough site assessment. It is hope that the Territory will furnish the monitoring team and DOJ all requested documents in a timely manner going forward. This Monitor intends to seek Court intervention, if required, to obtain all requested documents authorized under 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:** This assessment experience numerous unnecessary delays and disruptions due to management interference with DOJ obtaining access to the facility. The Acting Warden ordered one DOJ attorney to exit the premises due to their apparel – a business suit. This event caused an unnecessary delay and disruption to the monitoring process. Upon being advised of the reason for this delay, this Monitor asked the Acting Warden to contact BOC Director Wilson to verify her order to remove the DOJ attorney from the premises. The Acting Warden refused to contact the Director and refused to provide this Monitor the Director's telephone number stating, "I don't need to call him, I made this decision." This Monitor respectfully reiterated that request but was denied the information; the Acting Warden stormed out of the meeting room, reportedly grabbed her purse and left the facility, and did not involve herself in much of the assessment process thereafter. This Monitor was eventually provided the Director's telephone and called the Director. The Director quickly returned to GGACF and advised the Acting Warden and other staff to allow facility access to DOJ attorney. He then departed from the facility. Around noon (same day), the DOJ attorney was again prohibited access to the facility for the same reason. This Monitor again contacted the Director who returned to the facility and resolved the matter.

The event seemed to demonstrate disparate enforcement of facility access policies and vivid insubordination to the Director's orders by certain GGACF staff. The event caused a troubling and absolutely unnecessary disruption to the assessment process and waste of limited onsite assessment time. Going forward, this Monitor prays that GGACF staff and management officials will afford the monitoring team more respect and consideration for the assessment process and work we are obligated to complete while onsite.

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

**FINDINGS:** This Monitor believes that DOJ continues to experience considerable delays in Territory responses to written questions/requests for information concerning compliance with the requirements of this Agreement. This Monitor defers to DOJ for more specific information concerning compliance with this requirement.

The Monitor requests court intervention to remediate this ongoing problem for the monitoring process.

## X. Monitoring

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

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

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

**FINDINGS:** The Monitor has consistently provided reasonable advanced requests for documents and information that are essential for carrying out his duties required and authorized within this Agreement. As previously discussed in this and previous reports, the Monitor (an USDOJ for that matter) continues to experience significant delays in receiving requested documents and information and not received some requested documents at all.

The Monitor, hereby, respectfully requests intervention from the Court that will permanently remedy this ongoing problem.

## APPENDIX A
## ASSESSMENT METHODOLOGY

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

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

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

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

   In general, compliance assessment will include the following activities:

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

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

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

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

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

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

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

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

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

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

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

Non-exclusive information required for the Baseline and subsequent visits and monitoring includes the following. Many of these documents were not provided at the Baseline and second visit as requested but more were provided during the second and third visits. Territory officials

stated that they intend to continue to generate and provide the requested documents. It is important to reiterate the need for the documents listed below. Considering the size of this list, and GGACF's limited staff and technical resources, the Monitor intends to assist the Territory in narrowing this list to the most salient items. Documents in bold below have either not been provided or have not been updated but are necessary for effective monitoring.

**A) Corrections Information:**

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

**23.** Records and/or lists of physical improvements, repairs, and renovation completed to correct security problems and deficiencies over the past 36 months.
**24. Past 36 months of agency budgets.**
**25. List and contact information for any and all community vendors who provide services of any kind to GGACF and contracts or professional services agreement authorizing those services.**
**26. List and contact information for community regulatory agencies who inspect, review, approve, and/or provide consultation to the GGACF i.e., health inspections, fire inspections, etc., and any inter-local agreements involved in these services.**

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

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

**46.** A list of all the inmates housed at the facility by birthdate, entry date, and cell location.
**47.** To the extent not provided above, external and internal reviews or studies of medical or mental health services including needs assessments and any American Correctional Association and National Commission on Correctional Healthcare reports.
**48.** **List of all inmates placed in restraints, and all inmates receiving mental health treatments, under suicide watch, or taking psychotropic drugs.**
**49.** Current mental health case list including inmate name, number, diagnosis, date of intake, last psychiatric appointment, next psychiatric appointment, and any case lists of inmates followed only by counseling staff with last appointment date and follow-up appointment.
**50.** **Documentation reflecting any training that facility staff have received on suicide prevention, including certificates and training materials.**
**51.** All documents related to the any suicide occurring within the past year.
**52.** List of all persons on warfarin, Plavix, digoxin.

**C) Suicide Prevention Information:**

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

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