Golden Grove Adult Corrections & Detention Facility
U.S. Virgin Island Bureau of Corrections
St. Croix, VI

2013 Federal Court Settlement Agreement
In re: United States of America v. The Territory of the Virgin Islands (86/265)
Second Compliance Monitoring Report

Completed by:
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March 17, 2014

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TABLE OF CONTENTS

PURPOSE

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

EXECUTIVE SUMMARY & ASSESSMENT OVERVIEW

This onsite compliance monitoring assessment was conducted by the Monitoring Team December 9-12, 2013. The monitoring team consisted of Mr. Kenneth A. Ray, Monitor and operations expert; Ronald Shansky, MD, correctional medicine expert; and Roberta Stellman, MD, correctional mental health and suicide prevention expert. The selection of Dr. Shansky and Dr. Stellman involved input and concurrence by the Parties as required in Section X subsection C paragraph 3 of the Agreement. Prior to the site visit, the Monitor coordinated communication between the Parties and monitoring team in preparation for the onsite visit.

The site visit included a startup meeting on the first day involving representatives from the United States Department of Justice and the U.S Virgin Islands. The assessment consisted of onsite tours, staff interviews, various inspections, document reviews, meetings, and a culmination meeting during the morning of the last day. Participation and involvement by the Parties was cooperative and active.

Assessment Overview

This Settlement Agreement contains six (6) Sections. Each section contains a number of specific and measureable compliance requirements (Provisions). Combined, these six sections contain 129 provisions; 119 of these represent five (5) primary substantive sections while ten (10) provisions are contained within only one section, Section X. Implementation.

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

> *"In his or her reports, the Monitor will evaluate the status of compliance for each relevant provision of the Agreement using the following standards: (1) Substantial Compliance; (2) Partial Compliance, and (3) Noncompliance, In order to assess compliance, the Monitor will review a sufficient number of pertinent documents to accurately assess current conditions; interview all necessary staff; and interview a sufficient number of prisoners to accurately assess current conditions. The Monitor will be responsible for independently verifying*

representations from Defendants regarding progress toward compliance and for examining supporting documentation, where applicable. Each Monitor's report will describe the steps taken to analyze conditions and assess compliance, including documents reviewed, individuals interviewed, and the factual basis for each of the Monitor's findings."

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

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

Each provision in this report is in bold print and shadowed for clarification purposes. Based on this assessment, there were no changes in compliance rates from the Baseline Report as shown below:

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

Based on this assessment, it is the opinion of the Monitor and monitoring experts that very little has improved at GGACF since the September 2013 Baseline Assessment or Findings of Fact Report (filed on 02/08/13). GGACF continues to be a dangerous and violent environment that is inadequately staffed, equipped, funded, maintained, and operated to provide and consistently sustain environmental and operational conditions of inmate care and confinement that meet constitutional requirements. This will be further demonstrated in the assessment findings of this report.

This assessment finds no basis to significantly re-write the Baseline Report Executive Summary:

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

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

There appears to be no adequate complaint system in place for inmates. Although forms exist that inmates can use to present complaints and grievances, access to and submission of forms is unpredictable. Many of the boxes located in the cells used for inmates to submit complaints and/or sick requests are broken and/or filled with garbage. It seems obvious that no systematic process exists for this requirement.

Environmental conditions remain unsanitary and unhealthy throughout the facility. Housing unit temperatures are too high despite efforts using portable coolers. Cells emit the odor of mold and mildew and many flood during heavy rains. High housing unit temperatures create risks for dehydration and dangerous side effects from psychotropic medications. Mold and mildew remains a serious problem through the housing units, cells, recreation areas, ceilings, and shower areas. Lighting is broken and/or nonfunctional in some areas. Kitchen and food service areas are in serious ill repair and dirty. Cooking equipment is broken, some are dangerously

located, broken floor tiles create serious trip hazards. Insects were found on food and in kitchen areas. Inmates have limited access to drinkable water; there are broken cell sinks, toilets, and showers that must be repaired. Environmental conditions, overall, remain poor and unhealthy.

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

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

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

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

The training program is in a state of significant change according to GGACF officials. It is their intention to rebuild the entire training program and to bring it onsite under direct control of the Warden, which is a positive sign. However, there was no evidence provided to determine the

effectiveness of the existing training program. We were provided an outline of training topics [and training invoices] but the current training curriculum was not available for examination to determine its efficacy relative to pre- and in-service training, or whether any training topics were changed or added to accommodate implementation of the Agreement.

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

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

This assessment found conditions and practices involving healthcare, safety, and security conditions so concerning to the Monitor and monitoring team that the Monitor submitted to Territory officials the following 2nd Monitoring Assessment Emergent Conditions of Confinement letter on January 28, 2014 (see Exhibit 1):

Director Wilson, Mr. Robertson, Mr. Oswald,

This revises the January 6th, 2014 *2nd Monitoring Assessment Emergent Conditions of Confinement* letter following your review and comment period as required under the Agreement and subsequent to your initial response dated January 14, 2014. Revisions include:

1) Removal of the requested sentence regarding environmental conditions
2) Numbers all bullets for better clarity
3) Clarifies the first sentence of section I. Staffing, A. 15, regarding the relationship between staff, inmates, and contraband
4) Removes the unreferenced foot note as indicated

Your January 21, 2014 response is appreciated and evidences commendable and valuable efforts ultimately relevant to prospective compliance and progress. However, and until these and other improvements are fully implemented, I strongly urge and encourage the Territory to timely take any and all appropriate steps to ameliorate and/or mitigate real and potential risks and harm otherwise discussed in the letter. One such step could include issuing directives requiring GGACF officers to maintain locked housing units; to search all inmates before leaving and entering housing units; to ensure all cells are inspected during each shift; and, to require all supervisors to conduct quality assurance inspections of all housing units during their shifts and to take immediate corrective action where non-compliance and/or deficiencies exist.

The second onsite monitoring assessment of GGACF was conducted December 9-12, 2013. The assessment was performed by the monitoring team including, Drs. Shansky and Stellman, and

myself. Representatives from the Virgin Islands and U.S. Department of Justice participating in this assessment.

As stated in our meetings during the course of this assessment, the monitoring team found conditions of confinement at GGACF virtually unchanged from the September 2013 assessment. Additionally, we expressed our serious concern about several specific unchanged conditions that we believe require expedited remedial action to ensure the safety and welfare of inmates and staff.

These risks involve issues related to 1) staffing levels and staff supervision, 2) security practices and systems, 3) life and fire safety conditions, and 4) medical and mental health assessment and care. I encouraged Territory officials during the onsite assessment to take immediate steps to remove and/or reduce these risks and advised you that I would provide you with more specific details about these findings before submission of the second compliance report to assist in developing and prioritizing an emergency action plan for that purpose. That information is provided herein.

In closing, I want to reiterate that the monitoring team will continue to provide requested technical assistance to the Territory in its efforts to comply with the Settlement Agreement.

Respectfully,

Kenneth A. Ray, M.Ed., Monitor
PSCC: Roberta Stellman, MD, Correctional Mental Health Expert
Ronald Shansky, MD, Correctional Medical Expert

The Monitor also included in that letter the following recommendations for correcting the reported deficiencies (see Exhibit 1):

Golden Grove Adult Correctional Facility 2nd Monitoring Assessment
December 9-12, 2013
Urgent Conditions of Confinement Concerns at GGACF
Kenneth A. Ray, Monitor
January 28, 2014

The following articulates certain findings by the monitoring team during the second onsite assessment of GGACF that necessitate emergency action to eliminate and/or reduce safety and welfare risks to inmates and staff. Territory officials are encouraged to take immediate steps to ameliorate these conditions due to their critical nature, real and potential imminent harm these conditions pose to facility security, inmate and staff well-being.

I. <u>Staffing:</u>

A. Correctional Staffing and Inmate Supervision

The serious safety and security risk reported in the Findings of Fact Report and the First Monitoring Report were found to be unchanged. Inadequate staffing levels and staff supervision continue to create dangerous safety and security practices and conditions that expose staff and inmates to actual and potential risk of harm throughout the facility. Some of the most urgent and pervasive examples once again found during the second site assessment include:

1. Chronic staffing shortages resulting in housing units operating with one or no officers.

2. Officers not showing up for work when scheduled and/or refusing to work assigned areas.

3. Officers refusing to work certain housing areas due to fear of inmates and unsafe conditions.

4. Housing unit sally port entrance doors, internal security gates, and control room doors remaining unlocked.

5. Security gates throughout the campus being left unlocked and/or standing open.

6. Officers leaving housing units unattended.

7. Officers being afraid to enter the housing unit alone and/or with no back-up officer to conduct cell inspections and/or security checks; they remain in the unit control room.

8. Officers being required to work extensive overtime that can cause mental fatigue and impair their alertness and awareness to safety and security threats.

9. Access gates leading into housing units are routinely left opened and/or unlocked when officers enter the housing units.

10. Lack of officers contributes to lax security practices and sound inmate supervision as evidenced by inmates being allowed to obstruct visibility into their cells using blankets, towels, cardboard, and/or paper products. Officers cannot see into many prison and detention unit cells due to these obstructions and do not open cell doors for security inspections as a general rule.

11. Inadequate staffing and security practices, for example, impair timely and effective response to security incidents as observed while touring unit 9A, the isolation unit of the detention center. An inmate was able to breach the lock on his cell and access the pod day room. An officer then locked the housing unit gate and the inmate eventually returned to his cell. This inmate could have just as easily bolted out of the building and/or gained access to the officer.

12. Lack of adequate inmate body searches. For example, an inmate was not properly searched before leaving his housing unit or entering the medical facility for services. While receiving medical services from health care staff this inmate produced a shank in the form of a metal coat hanger that he indicated was needed for his protection against other inmates. This device could have easily been used by this inmate to cause serious physical injury to health care staff.

13. In one medical event, a female inmate in X-dorm went into a diabetic coma when no security officers were on the unit. The other female inmates had to scream through the unit windows until another officer who was passing by the building responded and the inmate was subsequently transported to the hospital for care.

14. In another security event in the prison lockdown unit, a handcuffed inmate being escorted by two officers was able to break away from the officers and exit the building before being caught because the pod security gate and housing unit sally port doors were unsecured.

15. Inadequate staffing levels, undertrained and under-supervised staff, under-monitored and under-supervised inmates contribute to the presence of dangerous contraband in housing units. For example, while touring 9B, this Monitor found a 4-inch knife blade openly sitting on the top bunk of an inmate's cell. This clearly suggests this inmate had little or no concern of this weapon being detected by security staff. Upon my notifying security staff of this weapon, the knife was removed and the inmate was locked in his cell before the cell was searched for more contraband or weapons. During the shakedown, other contraband, including screws, frayed bits of cell phone chargers, a cell phone battery, seeds (potentially of marijuana) and "dime bags" (typically used to store drugs) were also recovered. Per the above incident, the presence of contraband in plain view in a cell indicates that the inmates are confident that security staff will never conduct rounds or enter the prisoners' cells to conduct a contraband check. This is a very unsafe security practice because it allows the inmate to obtain other possible weapons in preparation for officers to return and search his cell.

16. During our tour of the juvenile unit, the single unit officer was observed sleeping when we entered the unit. This officer made no attempt to interact with the inmates during our visit, and one juvenile inmate stated that the officers seldom enter the housing area. The two juvenile prisoners were essentially left locked in the housing unit without supervision, having full run of the unit and easy access to broken broom handles. These potential weapons were found covered by a very large mound of trash in one unoccupied cell. This trash pile, which consisted of a large quantity of combustible refuse, appeared to have been there for a long time based on the presence of some decayed food products found.

17. Regarding unlocked security gates and housing units, the Warden stated that many officers do not lock them and/or leave them open for their own safety when entering the units. He stated that officers do not want to be locked in the units with inmates with only one set of keys, especially when there is only one officer on the unit and/or when they do not have radios to summon for assistance if the inmates attempt to take the officer hostage and overrun the unit. This situation is made even more dangerous because the unit officers are not issued weapons they can easily access for self or inmate protection. Officers are, thereby, in extreme danger each time they enter a housing unit.

18. Unit and supervisor log books are filled with examples of the emergency nature of GGACF staffing levels. Unit officers write such entries as "this unit is unmanned," "radios are nonfunctional," "no supervisor came on the unit," "no relief officer," and, "I will not be responsible if anything goes wrong…." Supervisor log books verify that there are times when units are not staffed and inmates are not supervised. The women's unit frequently goes

without any officer on duty, especially during overnight shifts while inmates are locked in their cells.

19. It was also learned that there are times when only one of three security towers are operational due to staffing shortages. This is a serious problem, as it leaves internal and external security perimeters completely unmonitored where unstaffed towers are located. This condition is worsened due to several nonworking perimeter lights.

B. Medical and Mental Health Staffing

Inadequate medical and mental health staffing levels continue to prevent Golden Grove from providing constitutionally adequate care.

1. The logbook entries are replete with examples of medical and mental health care issues being flagged by security staff, along with a note that "no doctor is available" or "no one present in medical." When the woman in the diabetic coma, discussed above, was transported to the hospital, for example, there was no medical staff on duty. As a result, there was no documentation in the prisoner's medical record regarding the prisoner's hospitalization, her return, or any follow-up treatment. But for the log book entries recording this event, it was as if it never happened.

2. The intake health screening requirements of the agreement cannot be met until there is 24-hour medical care available. The monitoring team was advised by Territory officials that the "paperwork had been submitted for night nurses" but nothing was finalized yet. According to the HSA, she had never been shown the resumes submitted for those positions. However, during a meeting with the director, this monitor was shown a resume packet of nursing applicants and was advised that several applicants were approved for hire but no start dates were provided.

3. While on-site, we observed how the lack of coordination between security staff in intake and medical staff leads to a high risk of harm to prisoners. On Monday morning (December 9, 2013), intake forms were obtained by Medical for prisoners who came in at 8:35 pm Friday and 6:09 pm Sunday. Both forms indicated numerous positive responses to questions related to chronic medical needs (diabetes), potential withdrawal (alcohol), and mental health risks ("talks and answers himself, appears to be delusional"). These positive responses should have led to immediate notification to medical/mental health staff, due to the risk the prisoners so obviously faced.

4. In addition to identifying urgent nursing needs, the HSA also requested a medical records assistant and recommended a candidate. However, BOC leadership has not acted on her request and recommendation at this time. The HSA indicated that she does not have time to begin to write the policies required by the Agreement, as she is overburdened with administrative duties that could be handled by an assistant. Even without an assistant, the medical records reviewed were disorganized and missing key information. There were no appointment logs and thus there was no way of knowing whether a prisoner with urgent medical or mental health needs was being seen as needed.

5. The current psychiatrist on-site planned to retire by the end of 2013. Although a replacement, Dr. Sang, was reportedly hired, telephone conversations with Dr. Sang caused concern that she had not been contacted about a start date. Even with the current psychiatrist, there are very few hours of mental health care being provided every week.

6. The one unlicensed mental health counselor on-site tries, but oftentimes prisoners are not transported to their appointments due to a lack of security staff available to transport. As a result of the lack of mental health staff, there are no real suicide prevention or mental health care programs in place. For the second time, we were told that no suicide watches had been initiated in the previous three month period, only to discover through logbook entries that security staff had initiated a watch on their own and had decided when to discontinue the watch, all without notifying mental health staff. Staff are clearly acting without the benefit of clear policies, procedures, supervision, and/or management communication. There was no corresponding documentation of a watch in the medical file. Furthermore, our tour of both detention and prison segregation units found mentally ill inmates, some presenting with paranoid and/or symptom deterioration who stated that they had not seen a mental health staff person in weeks. This is very troubling considering that these inmates were allowed to maintain obstructed view into their cells and/or their cells were so dark that I was unable to see into the living area. These conditions severely impair adequate security supervision of these inmates, and such sensory deprivation can exacerbate psychiatric pathologies causing more severe and prolonged psycho-emotional suffering.

7. With regard to medical staff, while on-site we were informed that the medical director for BOC had only been to the facility six times since our last visit. After bringing this to the attention of BOC leadership, the Director was removed from her position during the week. Another candidate was approached, but given the delays and difficulties getting contracts finalized, it is unclear when and if he will actually start his duties.

8. As noted above, during the week I was told about various medical and mental health hires. However, the HSA and candidates seemed unsure as to whether this staff would ever actually start. At a mid-week meeting, the Director told the HSA that she should begin selecting candidates for the nursing positions, but she was unable to access resumes that had been submitted months ago. When we left, she was still working on gathering this information.

9. With regard to security staff, at the very end of the week a meeting was arranged between the Monitor and the Director of the Bureau of Corrections. At that meeting, the Director indicated that he has approval to hire 30 new corrections officers and that 14 will be entering the academy "sometime before the end of the month." However, as of the end of the visit, no academy start date had been scheduled. It is now the beginning of January 2014, and we have not received any confirmation that these new hires were brought on board and that a new academy class began. It is also unclear why these plans were not revealed to us at the beginning of the visit. One possible explanation was that BOC's human resources director (also training director and director of administration) was on leave during our visit, as she was during our last visit, and other BOC personnel did not have ready access to her files.

II. Inadequate Safety Equipment and Inadequate Training on Use of Equipment

In addition to the staffing shortage, the logbooks also highlighted the lack of working safety equipment in many of the units.

1. Equipment lists on different units often noted that the unit was without a working radio, empty first-aid boxes, and/or no suicide cut down tools. In some instances, particularly in the X-Dorm, the units went without a working radio or phone for weeks at a time. The absence of reliable communication devices presents extreme risk to staff and inmate safety, especially if there is only one officer assigned to each housing unit. If an incident were to occur, the officer would have no way of calling for help. The fact that many of the male units are staffed by one female officer makes this threat even more real and present.

2. We also observed that not every unit had a cut down tool or a working flashlight. And, in at least one instance, the officer on duty did not believe there was a cut down tool available, when in fact one was located at the back of a locked box. It was clear to me that, even where equipment is available, the officers are unaware and therefore unable to use that equipment in an emergency. In one unit where there was a cut down tool, the tool was locked on a wall-mounted cabinet that was too high for the officer to reach.

3. Housing unit equipment logs are not maintained consistently. Logs were found incomplete with some logs missing equipment verification entries for several days at a time. It is clear that these logs are not consistently monitored for quality assurance by supervisor staff.

III. Physical Plant Issues

Numerous environmental hazards were observed during the compliance monitoring tour. Golden Grove's facility is old and in need of much repair.

1. It rained off and on during our visit, creating significant flooding in most of the housing units. Standing water on the floor of the units creates numerous safety risks. Exposed electrical wiring near dripping water was also found.

2. Mold remains prolific throughout the housing units. All of the housing units have a large level of mildew and mold throughout. Some inmates complained that their health is deteriorating as a result of these conditions. One inmate complained that mold in his cell is exacerbating his chronic asthma and he is having difficulty breathing

3. The kitchen remains filthy with rotting food bi-products under sinks, stoves, and between broken floor tiles. Additionally, there appears to be no effective control over cooking instruments such as knives, large metal spoons, etc. During our tour we found the kitchen tool room door unlocked and standing open, the tool cage open and unlocked, several tools, including knives and large metal spoons, missing. No security officers were present on the floor at this time and the two civilian kitchen staff were both sitting in the office socializing with an officer while several inmates cleaned the kitchen area unsupervised.

4. The lack of a working fire safety system is also a very serious concern. The cell fire sprinklers are used by virtually every inmate to anchor homemade clotheslines. It is unclear whether or when the facility plans to fix the sprinkler system so that it is fully operational.

Conclusion and Recommendations:

As previously stated, this is a non-exclusive list of specific serious issues found during the second monitoring site visit that beg for urgent attention and resolution. Considering the potentially life threating nature of many of these findings, Territory officials are encouraged to immediately take the following action:

1. Expedite the hiring and adequate training of all open staff positions – corrections, medical, and mental health. Develop an emergency hire plan that includes deadlines for having all positions trained and working.

2. Stop the practice of allowing inmate housing units to go unstaffed, inmates unsupervised.

3. Stop the practice of leaving housing unit sally port doors, internal security gates, and officer control room doors open and/or unlocked. These doors should remain closed and locked at all times except for authorized movement.

4. Ensure that all housing units are consistently supplied with reliably functioning radios for all officers assigned to the unit, and with all other equipment needed to provide safe and secure supervision of the unit and inmates, i.e. cut down tools, flashlights, etc.

5. Do not allow officers to enter housing units with security keys and without the presence of another officer who can rapidly respond if needed.

6. Ensure adequate, proper, and active management of the juvenile unit and supervision of juvenile inmates.

7. Increase supervisor presence in housing units to perform quality assurance functions and staff supervision.

8. Remove all coverings from cell door windows and cell areas that block clear and complete view inside cells. Also, inmates, especially mentally ill inmates, should not be allowed to live in dark cells as previously discussed.

9. Ensure inmates are properly searched for contraband when leaving and returning to their units, when entering and leaving other facility buildings.

10. Develop a comprehensive plan for repair and/or replacement of all non-functioning security mechanisms, equipment, systems, and lighting. Include a comprehensive plan for repair or replacement of the fire suppression system. These plans should include completion deadlines.

SECOND ASSESSMENT METHODOLOGY

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

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

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

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

   In general, compliance assessment will include the following activities:

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

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

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

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

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

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

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

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

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

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

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

Non-exclusive information required for the baseline visit and monitoring includes the following: many of these documents were not provided as requested but more was provided during the Second visit that for the Baseline visit, and Territory officials stated that they intend to continue

to general 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 limit staff and technical resources, the Monitor intends to assist the Territory in narrowing this list to the most salient items.

A) Corrections Information:

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

25. List and contact information for any and all community vendors who provide services of any kind to GGACF and contracts or professional services agreement authorizing those services.
26. List and contact information for community regulatory agencies who inspect, review, approve, and/or provide consultation to the GGACF i.e., health inspections, fire inspections, etc., and any inter-local agreements involved in these services.

B) 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. Current mental health case list including inmate name, number, diagnosis, date of intake, last psychiatric appointment, next psychiatric

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

C) Suicide Prevention Information:

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

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

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

The monitoring team used four primary reference points from which to assess compliance and progress with Agreement. These included: 1) the agreed 2012 Findings of Fact document, 2) documents, information, and data provided prior to, during, and following the onsite assessment, 3) the onsite visit, which included meetings, discussions, interviews, campus tours and inspections, and 4) the Baseline Assessment Report.

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

IV. SAFETY AND SUPERVISION

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

A. Supervision

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

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: No measurable changes were apparent regarding stratification of inmate housing for institutional classification, housing, policy or procedure. Recommendations provided in the Baseline Report remain appropriate.

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

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

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

One September 4, 2013 an inmate was slashed in a housing unit. The records suggest that no officer was on I Unit when the attack began. One inmate pursued the inmate-victim from one housing unit to another without staff intervention and with the assistance of unlocked housing unit doors. Once the officer arrives to stop the assault, the reports indicate that the victim-inmate spat at the officer. This officer then retreated to the office/control room. The inmate was able to gain access into this office area and a fist fight ensured before backup officers could arrive to stop the violence. The reports also indicate that during this event, many other inmates were trying to get out of the housing unit gate. The existence of, and compliance with, adequate policies and procedures could have easily prevented or mitigated this violence and serious breach in facility security.

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

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

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

RECOMMENDATIONS:

1. Revise/develop housing classification policies based on a current validated intake and review classification instrument. Submit document drafts as indicated in the Agreement before implementation.

2. Timely complete and submit a policy development plan that includes, at a minimum, the following elements:
   A. Policy title with related procedure titles
   B. Primary policy references
   C. Person(s) responsible for document development
   D. Expected dates to be forwarded to the Monitor and USDOJ for review and approval, date(s) of staff training, implementation date
3. Review current population to verify accurate risk/need classification levels and housing, reclassify and appropriately house as indicated by review process findings.
4. Refer to IV.F. Regarding specific classification and housing policy recommendations.

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: No new Post Orders were provided for review during this inspection with regard to Housing Unit Supervision or staffing. Additionally, Housing Unit and Supervisor logs report several instances of staff shortages and absences similar to what was reported in the Baseline Report. These logs indicate that some housing units are left unmanned for long periods of time and inmates are left not supervised. The lack of current post orders and chronic correctional staffing shortages create very unsafe conditions of staff attempting to enter housing units and conduct security / safety checks. Post Orders must clearly and specifically articulate when and how officers are to conduct these checks and include safe options for managing the inmate population while conduction checks. Additionally, lack of adequate levels of correctional officer supervision continues to cause officers to ignore and/or tolerate contraband rule violations. As discussed in Exhibit B, a majority of the occupied cells were either cluttered with various personal items and/or were allowed various items, whether legally considered contraband or not, such as fans with exposed electrical parts and wires, clotheslines tethered to broken fire sprinkler heads, empty food containers that are fire hazards, and other dangerous devices. These findings further emphasis the need for effective Post Orders and staff supervision, and timely completion of the required staffing analysis.

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

Documents titled "Specific" and "General" post orders were provided following the baseline visit. Specific Post Orders comprise 10 pages of specific post directives, General Post Orders comprise in excess of 200 pages of general directives ranging from specific post duties to operational functions. Specific Post Order pages are not numbered, General Post Order pages are numbered but it is difficult to determine between Post Order and regulations, as they appear to be blended. The two sets of documents are formatted quite differently, none are signed by approving authority, none are dated, and none have document review, revision, and/or dates established or issued, nor do any of these documents include professional or regulatory references previously discussed A general examination of both sets of documents suggest that many of these directives are not followed by staff based on observations of

practices, housing and cell conditions. The Orders are not numbered, making it impossible to accurately reference any Order, section or subsection. Some of these directives would be virtually impossible to apply and/or comply with simply due to inadequate security staffing levels, mal-and non-functioning security equipment, and poor cell lighting. I was unable to locate any Post Order (Specific or General) that established minimum staffing levels for any security post. I also found no specific Post Orders specifying supervisor-to-officer ratios.

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

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

It seems more likely than not that these seven log entries reflect a larger, undocumented, problem. All of these reports evidence serious, and likely persistent and pervasive, problems with inadequate staffing levels – though it takes no less than six to seven months to fully train a corrections officer for service – supervision, and inmate and staff safety and security.

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

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

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

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

August 4, 2013(K unit)
The officer reports, "Major repairs are needed within the unit from lighting fixtures, missing ceiling tiles, faulty locks, cells, cracks, mold and mildew…Administration is fully aware of

these safety and health hazard conditions in this facility, also discrepancies in security but blatantly refuses to rectify them!!!"

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

Recommendations provided in the Baseline Report remain appropriate.

RECOMMENDATIONS:

1. Subsequent to policy and procedure development and revisions, conduct a complete review of existing Specific and General Post Order to ensure they are:
   A. post specific;
   B. accurately represent post staffing needs and post resources needed to operate the post safely and consistently;
   C. are numbered, cross-referenced with policies/procedures, and formatted in a manner that makes them easy to interpret and apply;
   D. maintained at each post, kept current, and easily accessible;
   E. regularly reviewed, revised, updated;
   F. consistently enforced;
   G. known to staff through pre-service, in-service, and ongoing training.
2. Develop a plan that provides for regular review of all log books by supervisors to ensure staffing and other unit safety and security issues to be known and resolved in a timely manner.
3. Ensure that all posts are staffed according to post complexity and dynamics, risks and needs.

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: Access to an adequate supply of reliable portable radios for all housing areas remains problematic. A review of housing unit logs and inventory sheets indicate a lack of reliable radios and power charges. In some instances, officers who are managing two housing units must share a single radio. For example, the J unit log reported only one working radio for two housing units, and the X (female Detention and Sentenced unit) log reported not having a functioning radio or telephone for days. The lack of such basic communication equipment makes it virtually impossible for staff to summon help if needed in an emergency. Maintaining radio and telephone communications in housing units at all times is critical to staff and inmate safety and security and must be corrected without delay.

Recommendations provided in the Baseline Report remain appropriate.

RECOMMENDATIONS:

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

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

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

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: As previously described, there has been no detectable improvement since the Baseline Report. Cell conditions indicate that adequate and frequent rounds of cell block are not being conducted by officers or supervisors. As previously stated (refer to Exhibit B) most of the cells were found to be cluttered and inmates were still allowed to keep contraband and/or items that can be used to harm officers and other inmates. Many cells had sheets and/or towels draped across and over cell doors and/or hanging from the previously described clotheslines that fully or partially blocked viewing inside the cell. Many of the occupied cells were very dark making it impossible to perform inmate security / safety checks. The Juvenile unit contained a, unlocked cell that was littered with a large pile of trash, old food items, broken broom handles, etc. and appeared to have been left in this conditions of weeks. It was obvious that staff paid little or no attention to this sanitation problem and that the two juvenile inmates were provide little or no monitoring or supervision.

All cells must be kept reasonably lighted at all times and all visual obstructions into the cells must be removed.

Recommendations provided in the Baseline Report remain appropriate.

RECOMMENDATIONS:

1. Refer to recommendations regarding Post Orders.
2. Revise and/or develop policies and procedures to ensure consistent and reliable monitoring of housing units and cell blocks as stated above.
3. Ensure housing units and cell blocks are consistently staffed at levels required to ensure staff and inmate safety and security, and according to inmate risks and needs.

4. Ensure that special needs inmates (suicide, mentally ill, medical infirm, vulnerable, etc.) are monitored more frequently and by qualified health care staff.
5. Ensure that supervisors routinely inspect general and special housing units to ensure compliance staffing requirements, policy and procedures, and to interview inmates to presenting problem conditions. Supervisors should also ensure that all safety and security equipment is present and functional during these inspections and immediately replace any nonfunctional equipment.
6. Repair all broken lights in housing units and cells, issue flashlights to staff for cell inspections, repair all broken cell doors, keep all housing unit doors locked, repair broken control panels to improve unit security.

B. Contraband

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

a. Clear definitions of what items constitute contraband;

ASSESSMENT: PARTIAL COMPLIANCE

FINDINGS: These policies, as stated in the Baseline Report, remain outdated, under-developed, and incomplete. There was no appreciable improvement determined during this assessment. However, there has been an appreciable increase in contraband recovery as indicated in incident reports and contraband logs. GGACF are commended for this additional attention to controlling contraband but dangerous items, such as the knife blade found on an inmate bunk and the wooden stick found in the juvenile housing area are clear and dangerous indications of chronic inattention to basic security conditions. Another example is an incident involving an inmate who entered the Medical unit with an undetected piece of wire and made a threatening statement to medical staff. The nurse who wrote the incident report referred to the piece of wire as a "shank" but later changed the report stating that it was not a shank. This is a good example how the lack of clear definitions one what constitutes contraband creates security risks for staff.

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

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

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

Recommendations provided in the Baseline Report remain appropriate.

RECOMMENDATIONS:

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

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: As discussed above and previously described, there is no appreciable improvement in the contraband policies or procedures; inmate access to contraband remains dangerously unfettered as evidence below by an examination of contraband seizures reported after the Baseline Assessment for September thru December 2013.

Contraband Seized Sept - Dec 2013	Count
Cell Phone	23
Phone Charger	5
Other Electronic Device	2
Currency	6
Knife	4
Shank	7
Machete	3
Cutting Device	3
Tools	2
Marijuana / Leafy Subs	19
Tobacco / Papers	5
Toxic Chemical	1
Drugs	1
Contraband (as stated in the log)	2
Jewelry	8
Bottles	2
ETC	1
Total Items	**94**
Phones	**23**
Sharp Weapons	**17**
Intoxicants / Drugs	**26**

The Baseline Assessment findings reiterated below for the purposes of showing that the high level of contraband in the facility continues:

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

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

Baseline Assessment Data Previously Reported

Incidents Logged

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

Contraband Found

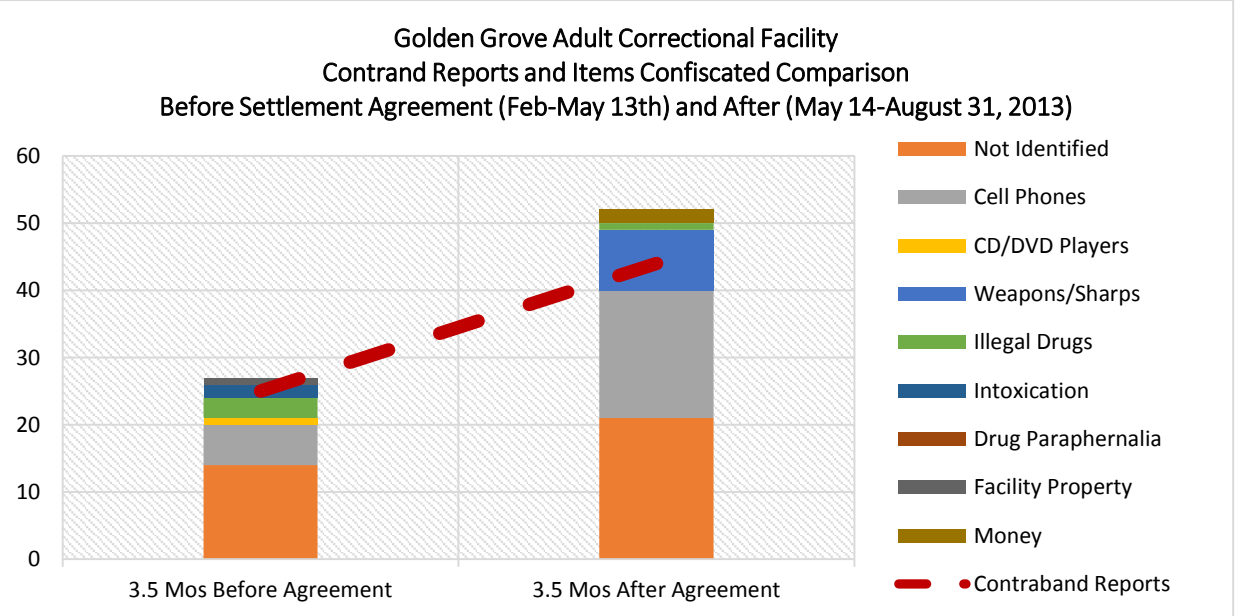
Contraband Found	2012	2013	Total (11mos)
Not Identified	16	38	54
Cell Phones	18	28	46
CD/DVD Players	0	2	2
Weapons/Sharps	2	7	9
Illegal Drugs	4	6	10
Intoxication	0	2	2
Drug Paraphernalia	1	2	3
Money	2	2	4

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

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

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

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



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

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

GGACF officials are encouraged to continue with improvements to policies and procedures. Recommendations provided in the Baseline Report remain appropriate.

RECOMMENDATIONS:

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

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

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

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

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

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

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: Refer to 1B above. Additionally, it is important to note that the Gang Intelligence and Search Team (GIST) has made some progress in seizing contraband but their search activity does not occur with sufficient regularity to effectively control the high levels of contraband. It is very important that the GIST increase frequency and regularity of cell searches.

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

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

ASSESSMENT: PARTIAL COMPLIANCE

FINDINGS: An examination of Evidence Collection Logs indicate that GGACF officials and staff continue to confiscate and preserve contraband and other evidence when found. This log appears to well organized and complete. However, although the evidence collection log is filled out, it does not appear that all contraband collected during cell searches is being properly recorded. For example, after discovering the 3-4 inch blade on and inmate's cell-bunk, a shakedown of the cell was conducted that revealed several other pieces of contraband, including pieces of wire, cell phone battery, and small plastic baggies useful in storing drugs. The Warden completed an incident report for that event but only the blade was reported as "contraband seized." This may have due to the fact that the Warden was not present in the cell when the remaining contraband was confiscated. Regardless, this example demonstrates that a complete log is not necessarily an accurate.

RECOMMENDATIONS:

1. Review, revise, develop, train, and implement, evaluate policies and procedures involving confiscation and preservation of contraband as evidence for administrative and legal enforcement purposes.
2. Ensure staff access to appropriate equipment and supplies needed to safely collect and preserve contraband while maintaining evidentiary integrity.

3. Ensure adequacy of chain-of-custody methods and procedures.
4. Review, revise, develop, implement, train, and evaluate training policies, procedures, methods, and demonstration of staff proficiency in the proper collection/confiscation and disposition of contraband.

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

ASSESSMENT: PARTIAL COMPLIANCE (Based on Baseline Report only)

FINDINGS: Not assessed during this visit. Recommendations provided in the Baseline Report remain appropriate.

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

C. General Security

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

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: As previously described, several inmates continue to wear and possess personal clothing items. This was observed on the yard and in the housing areas. There has been no change since the Baseline assessment. Recommendations provided in the Baseline Report remain appropriate.

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

RECOMMENDATIONS:

1. Review, revise, develop, implement, train, and evaluate policies and procedures requiring all inmates to wear standard-issue correctional uniforms.
2. Consider acquiring correctional apparel that provides obvious recognition of the inmates' classification/status.
3. Ensure there is a consistently sufficient supply of uniforms to regular laundry exchanges and changes in an inmate's classification and/or status.
4. Consider developing a correctional industry for making uniforms onsite.

5. Select/make uniforms specifically designed to reduce/eliminate places to hide contraband and weapons.
6. Mark all uniforms with highly visible letters/numbers.

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: As reported in the Baseline Report, none of the inmates were observed wearing correctional identification that was to be implemented. The inmate identification card provided by the Warden during the Baseline Assessment has not been implemented. Additionally, there were not enough visitor badges available for the monitoring team or DOJ representatives this visit. We were told that badge-clips were misplaced or taken.

However, the Warden reiterated that he has developed an inmate identification card system that should be fully implemented before the next assessment visit. Additionally, and as stated in the Baseline Report, not all non-uniformed staff wore official identification but should. Recommendations provided in the Baseline Report remain appropriate.

RECOMMENDATIONS:

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

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: As previously described, there has been no appreciable improvement in keeping perimeter access gates secured as was found at the facility entrance; GGACF officials reported this was due to a recent lightning strike that disabled locking electronics. Additionally, many internal yard gates were unlocked and open as were many housing unit entrance doors, their internal gates and control room doors. This remains very problematic and dangerous for inmates and staff.

The Warden state that leaving housing unit gates unlock was for officer safety due to staffing shortages. This is a very dangerous situation as leaving housing unit doors and gates unlocked and/or open when officers are in the housing units creates imminent opportunities for escape and violence.

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

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

Recommendations provided in the Baseline Report remain appropriate.

RECOMMENDATIONS:

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

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: There has been no appreciable improvement since the Baseline Report. The facility remains understaffed with maintenance employees. Additionally, a review of housing officer logs indicate continued problems with non-functional cell door locks and emergency exit doors. This issue remains problematic and poses clear and present safety and security risk to inmates and staff. This is evidenced by reports of inmates being able to get out of their locked cell and attacking other prisoners; in some cases, inmates were able to access other housing units because adjacent housing unit gates were unlocked. This condition is exacerbated when only one or no officer is working the housing units, as has also been reported.

Additionally, housing unit emergency exit door locks are often reported as "nonfunctional." This condition creates serious risks to life and safety when inmates must be evacuation in cases of emergencies.

An "all locks" maintenance policy and Plan as previously recommended was not provided during this visit.

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

Recommendations provided in the Baseline Report remain appropriate.

RECOMMENDATIONS:

1. Develop an "all-locks" maintenance plan for review with the Monitor during the December 2013 assessment. The plan should include a complete inventory of all locks, locking mechanisms, date lock found non-functional, date repair/replacement was completed, and a list of all locks and locking systems taken off line.

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: Documents provided during this assessment by Territory officials indicate that the staff recruitment and selection process involves the processes listed above. Documents were provided by the Director that included an Employment Background Screening. However, no documents were provided to verify consistency between policy and practice. The GGACF HR person was not available during this assessment and should be interviewed during the next visit and a sample of personnel files should be reviewed. Recommendations provided in the Baseline Report remain appropriate.

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

RECOMMENDATIONS:

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

D. Security Staffing

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

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: Security staffing levels remain inadequate and dangerously low. Officer and supervisor logs frequently report staff shortages and absences. Housing areas requiring two offices are reported having only one officer working, and there are occasions when housing areas are completely unattended by officers. Despite the fact that VIBOC officials state an additional 14 officers will soon begin the academy, this issue remains very problematic and requires immediate attention to ensure that all posts are consistently staffed with adequate numbers of officers. A comprehensive NIC staffing analysis has not been engaged as of this assessment but is required in the Order.

*A comprehensive staffing analysis has not yet been initiated**,** though the parties and monitor discussed and agreed to delaying the analysis until potential operational efficiencies could be evaluated. Observations during this assessment, staff interviews, and examinations of unit and incident log strongly suggest the facility is significantly understaffed. Only two of three security*

towers are operational due to staffing limitations and there seems to be a chronic shortage of relief staff. Inadequate staffing levels, combined with inadequate physical security controls (e.g. functional locks, control panels, cameras, lighting, etc.), and inconsistent security practices significantly increase safety and security risks to staff, inmates, and visitors.

Recommendations provided in the Baseline Report remain appropriate.

RECOMMENDATIONS:

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

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: An Emergency Staffing Plan was developed by the Director and apparently approved. It was reported that an additional 14 officers have been employed and are attending the training academy. However, this Plan is not based on the results of the required staffing analysis but GGACF officials are commended for these efforts.

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

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

Recommendations provided in the Baseline Report remain appropriate.

RECOMMENDATIONS:

1. Update existing security staffing plans for review with the Monitor during the December site visit.
2. Identify current and anticipated security staffing deficiencies.

3. Be prepared to discuss the staffing and analysis issues in more depth, and Plan provisions during the March 2014 visit.

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: Refer to the above findings. Recommendations provided in the Baseline Report remain appropriate.

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

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

ASSESSMENT: NONCOMPLIANCE

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

RECOMMENDATIONS: Refer to previous recommendations.

E. Sexual Abuse of Prisoners.

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

ASSESSMENT: NONCOMPLIANCE

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

Recommendations provided in the Baseline Report remain appropriate.

RECOMMENDATIONS:

1. GGACF should take advantage of the National PREA Resource Center at http://www.prearesourcecenter.org/, and the National Institute of Corrections at

http://nicic.gov/ for qualified information about PREA compliance, training, and other related resources.

2. Review PREA and develop an action plan for the implementation of PREA requirements.
3. Appoint a PREA Compliance Coordinator as soon as possible.
4. Complete the PREA Self-Audit.
5. Review, revise, develop, train, evaluate policies and procedures that include, at a minimum, the following PREA topics:

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

F. Classification and Housing of Prisoners

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

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: There has been no change since the Baseline Report. No revised policy and procedure drafts have been provided to the Monitor for review as of yet. Compliance with this Provision requires a high level of technical expertise and qualification; it is likely that GGACF officials will required outside technical assistance to comply with this Provision are encouraged to contact the USDOJ NIC for this assistance. Recommendations provided in the Baseline Report remain appropriate.

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

policy Table of Contents shows classification procedures on pp. 47-55; Section 3 is paged 49-50 and appears to be missing several pages.

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

RECOMMENDATIONS:

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

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: As found in the Baseline Report, detainees and convicted offenders are generally held in separate buildings except for sentenced and un-sentenced female inmates who are separated in the same building. Inmates are generally housed according to their security level based on behavioral history and whether their background includes violent criminal acts. Inmates are also housed according to administrative, disciplinary, special needs, and/or work assignments. This is a very basic and unreliable practice for managing inmates and is not based on a reliable classification system. Such a practice is known to facilitate violence against inmates and staff, the introduction of contraband, and can create substantial barriers to inmate health and wellbeing. For example, some inmates with serious mental illness (SMI) are being housed in segregation / lockdown unit for lack of an effective and valid classification system. This practice can exacerbate inmate behavior management problems, their mental illness, and specifically prohibited by the Order per Provision V.1.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;"*

Recommendations provided in the Baseline Report remain appropriate. This issue will remain problematic and contribute to continued introduction of contraband and violence until a valid and reliable classification system is developed, implemented, and evaluated. Refer to previous recommendations.

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

RECOMMENDATIONS:

1. Inmates should be housed and separated according to reliable classification process as previously discussed.
2. Pending completion of a reliable classification process, GGACF officials should use the Incident Log Report to target population cohorts for housing and separation that is more consistent with behavioral risks, and needs.
3. Comply with the Order's prohibition against housing mentally ill inmates in an isolation cell or housing unit.

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: This issue remains problematic and is exacerbated by poor security practices previously described regarding open and unlocked yard gates, housing unit entrance doors and gates, and officer station doors leading between housing units. This issue remains problematic and will continue to pose real and potential risk of harm to staff and inmates. Refer to previous recommendations.

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

RECOMMENDATIONS:

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

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

ASSESSMENT: PARTIAL COMPLIANCE

FINDINGS: As stated in the Baseline Report, there is current practice and general policy for reclassifying inmates following incidents involving violence and disciplinary events. However, this process, as previously stated, should be empirically validated.

Additionally, an examination of Grievance and Discipline Logs show they are incomplete. The Grievance Log is missing several important entries indicating that some important grievances go unanswered. The Discipline Log and disciplinary documents provided evidence that many disciplinary cases are dismissed because timely due process was not provided to the inmate. The accuracy and completeness of these records are very important for making consistent and reliable re-classification decisions. Otherwise, as is indicated in the disciplinary reports, inmates under disciplinary action are given "time served" and release from restrictions without being afforded their right to due process.

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

RECOMMENDATIONS:

1. Refer to previous classification findings and recommendations.
2. Refer to recommends related to grievance and disciplinary policies and procedures.

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

ASSESSMENT: PARTIAL COMPLIANCE

FINDINGS: Implementation of a new Incident Reporting Log was described in the Baseline Report and remains in effect. However, a review of this log shows it is often incomplete and illegible. Additionally, the creation of the Gang Intelligence Search Team (GIST) is a positive improvement to comply with this provision, assist in controlling contraband, and reducing the high incidence of violence. The team's scope of responsibility should be expanded to cover all aspects of this provision and participate in regular meetings review incident reports, data, and outcomes resulting from their efforts. Additionally, specific policies and procedures should be developed to guide in this process. Otherwise, recommendations provided in the Baseline Report remain appropriate.

RECOMMENDATIONS:

1. Develop policies and procedures for the accurate and complete use of the Incident Tracking System.
2. Develop and implement a continuous quality assurance policy and program to ensure that incident reports and logs are consistently accurate and complete.

3. Revise incident report forms to include all essential elements to track incident data in a systematic and unified manner.
4. Establish an incident tracking database to produce and regularly review valid and reliable incident information and data.

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: There continues to be no formal mechanism or process for regularly reviewing status and conditions of inmates housed in segregation. As reported in the Baseline Report, several inmates housed in segregation presented with very poor hygiene and some appeared to be seriously mentally ill. Some inmates interviewed indicated that they did not know how long they were to remain in segregation and several of those with apparent mental illness stated they had not seen a health care professional.

As an example, the mental health case planner described to Dr. Stellman a prisoner who became "increasingly agitated that I had not 'come to see' him during his time in lockdown." (August 14, 2013 Incident Report). The case planner reported that:

> *"I explained most times Case Management Planners are not aware of who is in lockdown . . . I explained with my caseload this is not realistic [to seek the prisoner out while in lockdown]. I requested [help from management] take the responsibility to request help whenever he needs it."*

There remains no formal monitoring process in place. Recommendations provided in the Baseline Report remain appropriate.

RECOMMENDATIONS:

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

G. Incidents and Referrals

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

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: There has been no change since the Baseline visit. Recommendations provided in the Baseline Report remain appropriate.

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

RECOMMENDATIONS:

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

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

ASSESSMENT: PARTIAL COMPLIANCE

FINDINGS: Senior staff now participate in GIST meetings to review incident activity, which is an improvement since the Baseline visit but additional work is needed for compliance.

For example, the lack of administrative staff severely restricts and limits the level of criminal or administrative investigations from taking place, and that incident reports are not consistently reviewed for accuracy or completeness. Participation in GIST meetings, while important, does not necessarily result in meaningful or comprehensive review of incidents. It also does not suggest that staff are identifying trends, and using the information obtained to inform security decisions.

RECOMMENDATIONS:

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

c. Requirements for preservation of evidence; and.

ASSESSMENT: NONCOMPLIANCE

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

RECOMMENDATIONS:

1. Refer to similar recommendations regarding contraband.

d. Central tracking of the above incidents.

ASSESSMENT: NONCOMPLIANCE

FINDINGS: Refer to previous findings regarding incident reporting and tracking. Recommendations provided in the Baseline Report remain appropriate.

RECOMMENDATIONS:

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

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: Refer to previous findings regarding incident reporting and tracking. Recommendations provided in the Baseline Report remain appropriate.

RECOMMENDATIONS:

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

H. Use of Force by Staff on Prisoners

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

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: There has been no change since the Baseline visit. No policy or procedure revisions have been provided to the Monitor for review. A review of reports involving use of force made it virtually impossible to determine whether force and/or the levels of force used were appropriate under the circumstances. Recommendations provided in the Baseline Report remain appropriate.

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

RECOMMENDATIONS:

1. Review, revise, develop, train, evaluate use of force policies as indicated and include, at a minimum the following policy elements:
   A. Mission and purpose statement
   B. Legal authority for use of force
   C. Definitions: of force, conditions, applications, non-physical and physical force, authorized weapons, deadly force, necessary and unnecessary force, etc.;
   D. Pre-service staff proficiency training, qualifications, certification, and regular in-service training;
   E. Use of deadly force;
   F. Use of any weapon authorized for use;
   G. Reporting requirements;
   H. Force event quality control and assurance program and methods;
   I. Self-defense;

J. Impermissible force;
K. Staff noncompliance corrective measures;
L. Medical/mental health involvement in use of force events;
M. Force against special populations, e.g., mentally ill, frail, medically ill, aged;
N. Planned and unplanned force;
O. Special force operations and equipment;
P. Officer safety and protection;
Q. Emergency first aid;
R. Administrative reviews;
S. Use of restraints;
T. Centralized incident, training, and qualification record keeping;
U. Armory operations and instructor training and certification;
V. Photographing, videotaping, recording of planned force events;
W. Other.

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: See above. Recommendations provided in the Baseline Report remain appropriate.

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. No change. Recommendations provided in the Baseline Report remain appropriate.

RECOMMENDATIONS:

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

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: Refer to findings in H.a. above. Recommendations provided in the Baseline Report remain appropriate.

RECOMMENDATIONS:

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

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: No documents were provided to support improvements in this area. As previously stated, the HR/Training person was again not available during this assessment. Recommendations provided in the Baseline Report remain appropriate.

RECOMMENDATIONS:

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

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

ASSESSMENT: PARTIAL COMPLIANCE

FINDINGS: Despite the lack of revised related policies and procedures, incident reports examined during this assessment indicate that force incidents are relatively low and that staff are reporting the incidents. However, GGACF official are encourage to include a use of force review process at the management level to collect relevant data and regularly verify consistent reporting of force events. Otherwise, recommendations provided in the Baseline Report remain appropriate.

RECOMMENDATIONS:

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

g. Supervision and videotaping of planned uses of force;

ASSESSMENT: NONCOMPLIANCE

FINDINGS: No change since the Baseline visit. Recommendations provided in the Baseline Report remain appropriate.

RECOMMENDATIONS:

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

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: No change since Baseline visit. Furthermore, the frequency with which the towers are not operational due to staffing problems renders them a consistently unreliable security control post. Recommendations provided in the Baseline Report remain appropriate.

RECOMMENDATIONS:

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

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: No change since Baseline visit. Recommendations provided in the Baseline Report remain appropriate.

RECOMMENDATIONS:

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

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

ASSESSMENT: PARTIAL COMPLIANCE

FINDINGS: The Warden stated that, although there are few incidents of force being used against inmates, that all incidents and reports are reviewed for accuracy and justification in a timely manner by supervisors and management officials. However, a review of reports indicated that some remain incomplete and/or do effectively articulate what is being reported. No revised policy or procedure has been provided to the Monitor for review as indicated in the Baseline visit. Recommendations provided in the Baseline Report remain appropriate.

RECOMMENDATIONS:

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

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: No change since the Baseline visit. Additionally, the Warden reported that the Investigator position has not yet been filled. Recommendations provided in the Baseline Report remain appropriate.

RECOMMENDATIONS:

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

l. Administrative investigation of uses of force;

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: No change since the Baseline visit. No policy or procedure revision was provided to the Monitor for review. Additionally, a review of the Inmate Grievance and Disciplinary Logs indicates that these documents are often incomplete and do not follow acceptable timeframes for resolution. Additionally, there is no specific mechanism for reviewing grievance or disciplinary events for use of force involvement. Recommendations provided in the Baseline Report remain appropriate.

RECOMMENDATIONS:

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

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: No change from the Baseline visit. No policy or procedure revisions were provided to the Monitor for review. Recommendations provided in the Baseline Report remain appropriate.

RECOMMENDATIONS:

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

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: Training records were not provided to the Monitor at this or the Baseline visit and the Training Director was not available for either assessments. No policies or procedures were provided that articulate such a process.

RECOMMENDATIONS:

1. Refer to previous list of Use of Force policy and procedure topics related to this provision for inclusion in those documents.

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: No records, policies, or procedure were provided to prove compliance with this provision. Additionally, as previously stated, the HR/Training person was not available during this assessment and those records are apparently not kept onsite. Recommendations provided in the Baseline Report remain appropriate.

RECOMMENDATIONS:

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

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: Same findings and recommendation as above. Recommendations provided in the Baseline Report remain appropriate.

RECOMMENDATIONS:

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

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: No change from the Baseline visit. Recommendations provided in the Baseline Report remain appropriate.

RECOMMENDATIONS:

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

d. Required observation of prisoners placed in restraints;

ASSESSMENT: NONCOMPLIANCE

FINDINGS: No change from the Baseline visit. Recommendations provided in the Baseline Report remain appropriate.

RECOMMENDATIONS:

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

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: No change from the Baseline visit. Recommendations provided in the Baseline Report remain appropriate.

RECOMMENDATIONS:

1. Develop, train, implement, and evaluate well-researched, well-written, clear, and complete policies and procedures to managing the use of restraints process.
2. Involve a multidisciplinary process in decision making to use, monitor, and terminate restraint use.
3. Train all staff in this process and the proper use of restraints and less restrictive alternatives.
4. Develop training lesson plans for this process that ensure staff competency in both knowledge and application of the restrain policies and procedures. Always train using the actual restraint devices authorized.

5. Develop and implement a reporting and tracking system for restraint use. Leadership should review all restraint use on a monthly basis to ensure policy compliance and take remedial/corrective actions, whether to policy, procedure, or staff noncompliance, in a timely manner. All remedial/corrective actions should be documented and maintained.

f. Required termination of the use of restraints.

ASSESSMENT: NONCOMPLIANCE

FINDINGS: No change from the Baseline visit. Recommendations provided in the Baseline Report remain appropriate.

RECOMMENDATIONS:

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

J. Prisoner Complaints

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

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: No change from the Baseline visit. Recommendations provided in the Baseline Report remain appropriate.

Additionally, a review of the Inmate/Detainee Grievance Log Sheet indicates that this process is not consistently maintained. Much of the information required by the Log is missing and incomplete. Several dates are missing, which makes it impossible to determine whether responses to inmates were timely. The "Chief's Response" column frequently states "no answer" or is empty. This is problematic as several of the inmates' complaints involved medical issues, officer misconduct, rights violation allegations, request for hygiene products, attorney access, food, assaults by officers, missing eye-wear and personal property, and dietary meals, for example.

There are no clearly written policies and procedures for ensuring confidential access for reporting complaints or that includes assistance to inmates with cognitive and/or communication (verbal/written/auditory) impairments. Although the incident log notes "confidential" in certain cases, this practice is informal and discretionarily determined according to specific circumstances. Discussions with the Warden about this issue revealed that both confidentiality and communication impairment issues are dealt with on a case-by-

case basis, but no formal policies and procedures exists. Those discussions also suggest that management is aware of these needs, takes appropriate steps to meet those needs, but does so in the absence of written guidelines.

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

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

RECOMMENDATIONS:

1. Review, revise, develop, train, and implement inmate complaint policies and procedures.
2. Develop and implement a valid a reliable complaint reporting and tracking system.
3. Conduct monthly administrative reviews of the inmate complaint reporting and tracking process to measure and verify program compliance, take timely and appropriate remedial and correction action.

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: No change from Baseline visit. Recommendations provided in the Baseline Report remain appropriate. Additionally, the development and implementation of a consistent process for timely investigating inmate complaints is thwarted by inmate grievance process discussed above.

RECOMMENDATIONS:

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

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: No change from Baseline visit; there is no formal policy or procedure on this subject matter. Recommendations provided in the Baseline Report remain appropriate.

RECOMMENDATIONS:

1. Complete required policies and procedures.
2. Include specific policy and procedural provisions requiring corrective action for staff noncompliance, and that ensures timely, consistent, and appropriate disciplinary action against staff who violate the policy.
3. Also consider Inmate Grievance Log issues described above in developing these policies and procedures.
4. Develop quality assurance process to ensure the completeness and accuracy of the Grievance Log documents and processes.

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: No change from Baseline visit. Recommendations provided in the Baseline Report remain appropriate. Same issues described above regarding the Grievance Log.

RECOMMENDATIONS:

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

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: No change from Baseline visit. Recommendations provided in the Baseline Report remain appropriate.

Additionally, the Inmate Grievance Log clearly suggest the absence of a systematic and reliable process for reviewing prisoner complaints, trends, or individual and systemic issue.

RECOMMENDATIONS:

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

K. Administrative Investigations

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

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: No change from Baseline visit. Recommendations provided in the Baseline Report remain appropriate. No policy or procedure revisions have been submitted to the Monitor for review.

RECOMMENDATIONS:

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

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: No change from Baseline visit. Recommendations provided in the Baseline Report remain appropriate.

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 change from Baseline visit. Additionally as previously discussed, even if an investigation determines that an inmate deserves some form of punishment for a disciplinary infraction, that punishment is often not determined or enforced because due process proceedings often do not occur. A review of prisoner disciplinary files from the last three months shows that no prisoner had disciplinary action taken against him or her; disciplinary charges were dismissed because there were not enough staff to conduct the due process hearings. Recommendations provided in the Baseline Report remain appropriate.

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: No change from Baseline visit. Recommendations provided in the Baseline Report remain appropriate. As previously stated, the HR/Training person was not available during this visit.

RECOMMENDATIONS:

1. There is no formal pre- or in-service training program to train staff who are involved in initial and/or administrative investigation.
2. Provide adequate training of staff on topics in areas of incident scene investigation and appropriate administrative investigation methods, processes, techniques, legal and ethical issues, etc.
3. Provide training for administrative/leadership in the areas of administrative investigation oversight, coordination, and management.

4. Develop and implement, as an adjunct to these policies and procedures, an "Investigators Manual" that provides guidance to staff responsible for oversight and investigative activities.

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

ASSESSMENT: PARTIAL COMPLIANCE

FINDINGS: No change regarding policy and procedure requirement since the Baseline visit.

RECOMMENDATIONS:

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

V. MEDICAL AND MENTAL HEALTH CARE

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

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

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

ASSESSMENT: NONCOMPLIANCE

MEDICAL FINDINGS: At the time of this second visit, we were provided with a draft of the screening policy which does contain several of the elements that would, if implemented, bring the facility into compliance. We appreciate the work performed by the Golden Grove staff to draft this policy. The draft presumes the ongoing involvement of correctional officers performing the screenings during the off hours. Having reviewed numerous records during this visit, we have concluded that commonly the officer health care screen does not lead to, in most circumstances, appropriate follow-up by health care staff. In fact, the majority of the records we reviewed did not contain appropriate follow-up, which may include contacting the on call physician or at a minimum, an early health assessment by an advanced level clinician. We were also provided with a newly developed screening tool to be used by health care staff which does contain many of the elements which should be present as part of an intake screen. However, the screening tool relies on the use of an acuity scale in order to determine the appropriate disposition, including the urgency with which a physician is called as well as the timing of the health assessment. What is missing is the acuity scale to be developed by the Medical Director. This tool presumes only health care staff are performing the intake screens. We have been told that the budget that took effect October 1, 2013 does contain positions for three additional registered nurses and three additional licensed practical nurses. With these positions in place, the facility should be able to guarantee that only licensed health care staff in fact perform the intake screens 24 hours per day, seven days per week. During our visit, the leadership staff were informed that they should review the applications for nursing staff for these positions. However, they were blocked from doing this when the person in charge of human resources was unavailable and these applications were inaccessible. A responsible leader of human resources would have made arrangements for these applications to be available. It is quite discouraging that the leadership of such an important position within the organization is entrusted to a person who demonstrates such an absence of professionalism. We are quite encouraged by the submission of both the draft policy and the draft intake screen. However, we must also see the draft acuity scale, including the definitions of the type of identified conditions that warrant either an immediate call to the physician or health assessments to be performed on Day 1, Day 2, Day 3, or in some instances based on the need for finger stick or blood pressure monitoring, Day 7. We appreciate that the Health Administrator has

in fact utilized many of the elements that we provided in our initial report. Besides removing the use of correctional officers in the intake health care screening process, the draft policy should specify the tracking of the elements of the intake process, including a completion of the screen, the completion of the TB screen, the completion of the health assessment by dates, and the scheduling of any follow-p, including mental health, dental, chronic care and sick call visits, along with any other required follow-up.

RECOMMENDATIONS:

1. Out of the seven elements listed in the findings, develop a draft policy and procedure along with a new intake screening form for submission to the Monitor.
2. Feel free to solicit input and/or consultation through the Monitor for the development of this policy and procedure.
3. Continue the excellent work on the intake policy, including the provision of an acuity scale and the log tracking system.
4. Solicit input and/or consultation through the monitor for the development of this policy and procedure.
5. Proceed with the hiring process of the RNs and LPNs.
6. The priority policies for development should include: (1) intake screening, (2) health assessment, (3) sick call, (4) chronic care, (5) urgent/emergent services, (6) continuity, (7) discharge planning, (8) intoxication/detoxification, (9) quality improvement, (10) transfer screening, (11) clinical performance enhancement, (12) medication management.

MENTAL HEALTH FINDINGS: The intake process remains flawed with no change in the process or tools. As noted in September 2013 "even when incoming inmates are identified through the screening tool or the officer's observations as having mental health problems, referrals often do not occur, resulting in misidentification and lack of services for those individuals." Medical screenings are frequently delayed significantly and at least in one case, medications have been administered to an inmate for several months with no clinicians order or follow-up visit.

Regarding the development of mental health policies and procedures specific to the facility, no new policies have been developed since the time of our initial visit. Staffing remains unchanged and is still considered inadequate in quantity and composition to meet the needs of those seriously mentally ill and acutely symptomatic inmates housed at GGACF.

RECOMMENDATIONS:

1. A more effective intake process should be developed so that medical staff has access to new detainees and prisoners within 24 hours. The initial security screening tool is not robust enough to provide good identification of medically and psychiatrically ill people. Security staff conducting these interviews will require additional training by health services (medical and mental health) and a quality assurance tool should be developed to monitor the completeness of their documentation and the accuracy of their triage two medical and mental health staff.
2. Medication bridging is problematic with evidence of medications being prescribed and administered but not ordered by a clinician. A review method needs to be developed to oversee the reliability of this process.

3. All of the medical policies need to be reviewed and modified as applicable to this facility.

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

ASSESSMENT: NONCOMPLIANCE

MEDICAL FINDINGS: We have not yet seen the revisions to the health assessment policy that we reviewed after our first visit. In particular, the health assessments policy did not require the development of an initial problem list and plan and should be utilized to insure appropriate continuity of services. Since the acuity scale for performing the health assessments was not available, it is not likely that the timing of the health assessments would always be appropriate. Finally, we are well aware that there have been serious problems with the predictability of the availability of onsite physician or other advanced level practitioner services. Compliance will not be achievable until there is a dependable schedule for onsite advanced level provider services. In particular, there have been serious and prolonged absences with regard to the Medical Director's presence. It is our understanding that efforts are being made to address this problem. Successful implementation of the intake process is dependent on the availability and active participation of the Medical Director. Many of the records we reviewed either lacked a health assessment or contained a health assessment that was greatly delayed. Examples are a patient with a seizure disorder entered in December 2012 who had a screen by an officer but no health assessment or adequate follow-up. In addition, a patient with HIV disease had a physical exam in January 2012 but no listing of HIV on the problem list. This patient, by the way, has not seen an HIV specialist for a year and lacks a recent viral load within the last six months. Our last report contained many of the elements that should be present within the health assessment policy. We look forward to working with the leadership team in the completion of the health assessment policy.

RECOMMENDATIONS:

1. Utilize the elements listed under "Findings" to promulgate a new policy and procedure for the performance of health assessments.
2. Utilize the Monitor and his team for any consultation or technical assistance.

MENTAL HEALTH FINDINGS: Intake medical screenings are often delayed by nearly a week following booking. All too frequently there is evidence of the failure to complete a 14 day history and physical assessment by medical staff. This is an essential process designed to allow the inmate a second opportunity to report signs and symptoms that he/she may have not wish to share with the security officer at the time of intake or he/she may have been impaired at that time and not interested in participating in the process. In addition, failure to complete both of these steps in a timely manner delays or fails completely to provide for mental health referrals. These inmates then become lost to follow-up and current preadmission medications are abruptly discontinued.

Both juvenile males were interviewed on tour and their medical records were then examined which verified their reports.

Findings Case #1	**Deficiencies/ Areas of Potential Harm**
The inmate was recently released from rehabilitation services on Prilosec and Remeron. Intake was performed 8/7/13 and medications were noted. The medical intake was 8/8/13 and a weight but no height was obtained. There has been no 14 day history and physical, has never been seen by a clinician. Inmate is currently on Prilosec without a prescription from an M.D. Psychiatric medication was never administered; inmate has never been referred to mental health, and reports never having been seen. Inmate did not, fortunately, report difficulties off his antidepressant.	1. Failure to refer for psychiatric evaluation 2. Failure to bridge his antidepressant medication 3. Continuation of Prilosec without a clinicians order 4. Failure to perform a 14 day history and physical assessment 5. Incomplete vital signs on intake
An intake was performed on 8/16/13 and the review of systems area on the officers screening is completely blank. A medical screen was performed 8/25/13 with no recorded height. The PPD was placed and read within a reasonable timeframe. Inmate has had no clinical contact since the time of his medical screening.	1. Incomplete intake screening 2. Incomplete vital signs on medical screening 3. Significantly delayed medical screening 4. No 14 day history and physical ever performed

The parties have agreed to amend the definition of a qualified mental health professional to include an unlicensed master level provider. This is in part because the US Virgin Islands does not have a licensure process for social workers or counselors at this time. Instead, the parties have agreed that a qualified professional based on education, training, and experience will satisfy the current settlement agreement. Therefore, the Mental Health Coordinator has sufficient qualifications to perform and complete a comprehensive mental health assessment and deliver psychological services at the facility. The facility is in compliance regarding the qualifications of staff conducting the initial comprehensive mental health/biopsychosocial assessment following referral from the screening staff.

However, there has been no change in the screening tool or process, as well as, 14 day history and physicals. Security intake screening forms are often unsigned and incomplete particularly marked by the failure to document responses to the review of systems questions.

Most significantly, regarding mental health care, is the fact that sentenced inmates do not routinely receive comprehensive mental health assessment unless they are referred to mental health. It is generally a standard throughout the United States that prison inmates all receive an initial evaluation by a qualified mental health professional within the same time frames as the completion of the 14 day history and physical by medical.

RECOMMENDATIONS:

1. Again, GGACF should complete a detailed staffing and programs need analyses to determine the number of qualified mental health professionals required to deliver adequate services to detainees and prisoners.
2. Intake screening tools, as recommended before, should be improved in their comprehensiveness, quality of documentation, legibility, signature, date and time.
3. A quality improvement process should be developed to monitor the quality and timeliness of intake screenings as well as 14 day history and physicals and comprehensive mental health assessments for all prison inmates and the latter for any detainee with a positive mental health screen.

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 not seen the revised policy that addresses sick call or access to primary care health services. We also have not seen a policy that addresses prenatal care for pregnant prisoners. During this visit, we continued to find sick call boxes that were broken and therefore not usable. We were told that in housing units with broken boxes, medication nurses collect the slips. We were also told that the slips are then brought back to the nurse and stamped received and placed in a sick call tray for the head nurse to review. In reviewing the current sick call log, we observed that most patients were seen by a nurse or an advanced level clinician within two days. However, some were not seen for up to a week. We were informed that this was usually due to the absence of an onsite physician. An example is a patient with HIV, diabetes, and hypertension who submitted a slip on November 26 and was not seen until December 2. A second example is a patient who submitted a slip on November 14, complaining of side pain. The inmate was not scheduled for a physician assessment until November 21. When this inmate was seen, labs and x-rays were ordered; however, these were never performed. We were informed that these were not performed because of problems with lack of officers and lack of a transport van to take the patient to the hospital for the tests. Another case was a patient who arrived in March of this year, was screened by an officer but has never had a health assessment. This inmate submitted a slip requesting services for a head infection on November 12, but was not seen until November 27. Finally, there is an example of a middle-aged patient who submitted a slip on 11/13 for knee pain and was not seen until 11/22. An x-ray was ordered but this was never done, we were told, because the transport van to take the patient to the hospital for the x-ray was out of service.

RECOMMENDATIONS:

1. Use the eight elements in our initial report listed under findings of small letter 'c' to develop your sick call policy and procedure.
2. The policy should insure that there is an assessment by either a registered nurse or advanced level clinician within two days of receipt of the request. For referrals to an advanced level provider, there should be a registered nurse assessment within two days

unless there is certainty that the advanced level provider will be onsite within the required two days.
3. The administration must address the escort officer and transport van problems creating delays in access.
4. Utilize the monitor's team for consultation and/or technical assistance.

MENTAL HEALTH FINDINGS: The continued limited and unpredictable hours of psychiatric service are not conducive to the scheduling needs of the service. In addition, the lack of security support hampers the team's ability to deliver timely and predictable services because inmates cannot be brought to the clinic as scheduled. In the past, the facility contracted with a counseling service to provide group and individual counseling (The Village) but that contract ended due to nonpayment and the inability to reach a contract with the facility. There has been no staffing increase to compensate for the loss of that service and no further group therapies provided. As a result, the two staff members are providing less than the minimum service consisting of assessments of referrals, counseling follow-ups for only some of those people assigned to the caseload, and infrequent psychiatric visits. The counselor will expedite visits to the psychiatrist for inmates with acute problems, but the common result is a delay in the management of those inmates on the chronic care caseload because there are insufficient hours of psychiatric time to allow for scheduling of urgent and routine visits in the clinic.

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

The mental health caseload continues to represent a lower than expected percentage of inmates in treatment. The question as to whether there is under-identification of mental illness during the intake process and difficulties with that process needs to be explored through a quality improvement process.

Access to care continues to be significantly restricted due to the lack of security staff available to transport inmates to and from the clinic. We again observed many instances of delayed or untimely follow-up appointments which are at least partially attributable to the lack of escort officers.

Our findings are supported by case reviews as follows:

Case #	Findings Case	Deficiencies/ Areas of Potential Harm
8	Review of this record indicated a psychiatrist order instructing follow-up on the laboratory study the doctor had ordered four months before. There is no mental health initial comprehensive assessment or progress notes from the mental health counselor in this record. The last orders for multiple medications including Haldol and Depakote were written May 7, 2013. This inmate has not been seen by psychiatry since May 2013	1. Delay in carrying out laboratory orders 2. Inadequate psychiatric follow-up 3. Missing mental health documentation from the record
27	The Depakote level was ordered on 10/11/13 and no results are found in the medical record. On 10/31/13 the physician noted that his entry was a second order for valproic acid level. He also noted for the nurses that there was an active order for Cogentin which apparently had not been transcribed and initiated.	1. Nursing transcription omissions for medication and laboratory studies

RECOMMENDATIONS:

1. The elements in the above findings should be used to promulgate a policy and procedure related to access to care and sick call. A system for a confidential retrieval of sick call request by medical staff should be implemented and codified in policy.
2. The Monitor's team should be utilized for consultation and/or technical assistance.
3. The facility needs to define by policy the qualifications required for each clinical process as well as time frames to complete these processes and provide the clinically necessary follow-up.
4. Again, a staffing analysis needs to be completed to determine the required minimum number of psychiatric hours and counseling hours needed.
5. Mental health staff should perform, at a minimum, weekly segregation rounds and monthly well-being checks on all sentenced inmates on the mental health caseload.
6. Nursing transcription omissions should be addressed through education, supervision, and monitored by a Quality Assurance process.

d. Continuity, administration, and management of medications that address:

(i) timely responses to orders for medications and laboratory tests;
(ii) timely and routine physician review of medications and clinical practices;
(iii) review for known side effects of medications; and
(iv) sufficient supplies of medications upon discharge for prisoners with serious medical and mental health needs;

ASSESSMENT: NONCOMPLIANCE

MEDICAL FINDINGS: We still have not been provided with any policy or procedures regarding medication management. We have in our last report provided 18 points which can be utilized with regard to various aspects of the policy as well as the medication program. During this visit, we also observed a medication administration by the nurse who performed this for a morning medication pass. The nurse had excellent rapport with the inmates and interacted with them quite constructively. She also had good rapport with the correctional officers. However, there were basic elements that were either never adhered to or not consistently adhered to. The first element requires that the inmate presenting to the nurse demonstrate, by the presence of an ID card or wristband, that he is who he presents himself to be. This was never done. The second element requires that the inmate present with a container of water with which to ingest the medication. We in fact saw one or two inmates ingest the medication without any water and walk away. This is the perfect strategy if one is going to cheek the medications for use later. Finally, there should be a mouth check conducted by a correctional officer after medication ingestion. This was never done. Finally, the documentation of the administration does not occur until the entire medication process has been completed. Delaying the documentation is known to increase documentation errors. We also reviewed a report prepared by the pharmacist titled, "Assessment of Medication Management Processes," and submitted by the pharmacist in October of 2013. This consultation report documents that the current process is not consistent with Virgin Islands statutes and does not maintain the appropriate controls that would insure protection of the medications. We understand that there is a possibility of a pharmacist being granted a contract to manage the medications. We believe this is an excellent step forward and would strongly endorse it. In order for the medication processes to substantially improve, there has to be education of the patients as well as education of the officers regarding their role as team members in facilitating the provision of medications.

RECOMMENDATIONS:

1. The above elements should be included in a draft policy and procedure dealing with medication management.
2. The Monitor staff should be sought for consultation or technical assistance in the drafting of this policy and procedure.
3. Proceed with the effort to contract with a pharmacist to improve the management of pharmacy services.
4. Modify the post orders of housing unit officers to include their participation in assisting the nurse in the medication process. This assistance should include insuring that the appropriate inmates are made available to the nurse in an orderly fashion and that immediately after ingestion, the officer conducts a visual inspection of the mouth to insure that there is no contraband.
5. When this is in place, the inmates should be informed that in order to receive medications they must present their ID to the nurse as well as bring a container of water to the nurse. Finally, in order for them to receive the medications, they must facilitate a visual inspection of their mouth after ingestion.
6. Continue drafting both medication administration policies and medication management policies, including the 18 elements listed in the findings of our first report.
7. Develop a strategy that allows more timely documentation of the administration in relationship to the actual administration.

8. Develop your policy and procedures regarding making available discharge medications, understanding that the process and procedures are likely to be different for sentenced inmates whose release is planned versus un-sentenced inmates whose release may be unplanned.

MENTAL HEALTH FINDINGS: GGACF has made strides to improve medication management. A consulting pharmacist has been hired and construction to create improved pharmacy facilities and security are underway. The pharmacist is also working with the territories Board of Pharmacy to obtain a facility pharmacy license.

During an interview with a female diabetic inmate (case # 1) we observed two insulin syringes on her person. She reported that the nurse comes once a day with two syringes filled with insulin. These syringes of insulin are left with her for self-administration. She usually keeps her syringes in her cell and the nurse will pick them up the following morning. In reviewing her medical record her medication administration records indicated that in August of 2013 she was dispensed a vial of Novolin. There were no MARs for October or November and her December MARS shows no administration entries. This report raises serious concerns regarding sharps control as well as the dispensing of enough insulin to represent a potential harm to self or others.

Another concern was raised by an interview with a female inmate who reported that she is on to hypertensive medications but half the time she does not receive one or the other medication. She also reported that at one point she had missed almost an entire week of medication. However inspection of the medication administration records demonstrated 100% administration of Procardia, and hydrochlorothiazide. Indeed review of every MAR showed excellent medication administration with sparse refusals.

The psychiatrist reported concerns about the reliability of transcription and implementation of both his medication and laboratory orders and this was substantiated in review of some medical records. Psychiatry does not utilize informed consent forms and there is no routine documentation regarding education about medication side effects and inmate consent. Medication review often is not performed within customary timeframes, with some inmates lost to follow up and psychiatric chronic care review or not seen for 6 months.

See case # 8 cited under 1.c.

RECOMMENDATIONS: defer to Dr. Shansky's report

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

ASSESSMENT: NONCOMPLIANCE

MEDICAL FINDINGS: We have not yet received a medical records policy that deals directly with the procedures required to insure timely accessibility of the medical records to the professional staff. In our first report, we provided some basic elements that should be considered when developing the medical record policies. During this visit, we continued to find records in which documents had not been filed as well as documents filed in the wrong section or not filed chronologically. We also found documents in the records, such as offsite service reports, which had

not been initialed and dated by the responsible clinician. These are all elements that must be addressed in the new policy. It is important that there be a single medical record and that that record contain not only all medical documents but also all dental and mental health documents. This method provides for more timely assessment and care, especially in emergent situations, while also providing for adequate continuity of care. It would be a significant improvement were there to be a dedicated medical record clerk responsible for filing as well as pulling for use the medical records.

RECOMMENDATIONS:

1. The above elements should be utilized to draft a more detailed medical record policy.
2. Consider providing a position for a staff person completely dedicated to the maintenance and timely provision of medical records.
3. Develop policies and procedures requiring the timely review, initialing and dating of all offsite service documents, including procedure reports, consultation reports, emergency room reports and discharge summaries.
4. The Monitor's staff should be utilized as resources to facilitate development of the policy and procedure.

MENTAL HEALTH FINDINGS: Medical records are stored in a separate room. They are alphabetized and do not have a Bureau of Corrections number. Name alerts are utilized when necessary. As noted in the Baseline Report:

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

We again noted that the mental health counseling notes were still being retained in the Mental Health Coordinator's office.

One significant improvement was the development and implementation of the psychiatric progress note. As a result of the use of this form, the psychiatrist's documentation was better, organized, detailed, and easy to read and navigate through.

There continue to be significant problems with documentation in the medication administration record. Our prior notations from September 2013 still hold true:

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

The medical records are not in chronological order and records are not always filed in the correct section of the chart. Chart sections are not labeled. Some charts are combined medical and mental health records while others are separated and the facility should consistently do one or the other.

There is no policy that drives the organization and quality of the medical record. Medication administration records were frequently absent for months at a time. Entries are not routinely timed and often the signature is illegible and lacks credentials.

The only documents that contain a current and past history consistently are the bio psychosocial assessments completed by the Mental Health Coordinator. However, many of the charts reviewed did not contain this document and therefore, more often than not, lack of past and present history.

RECOMMENDATIONS: Unchanged since the baseline visit

1. *There is a need to draft a more detailed medical record policy.*
2. *The Monitor's staff should be utilized as resources to facilitate development of the policy and procedure.*
3. *One chart per inmate, combining medical and mental health documentation for an integrated record.*
4. *It is recommended that the mental health professional immediately file her notes in the medical record so they are available for the psychiatrist to review.*
5. *A policy needs to be developed with documentation guidelines and instructions for organizing and maintaining the medical record.*
6. *Quality improvement effort should be undertaken to track compliance with policy once implemented.*

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

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

ASSESSMENT: NONCOMPLIANCE

MEDICAL FINDINGS: This item was dealt with under letter (c), including recommendations for the policies.

RECOMMENDATIONS: See letter (c) findings and recommendations.

MENTAL HEALTH FINDINGS: Female inmates, by consensus, reported that the most effective system they have been able to develop in order for medical to receive their sick call requests is to hand their requests to male trustees through the gate of their unit. They reported that using sick call boxes or handing their sick call requests to the security officer both failed as reliable methods of communicating with the medical department. They all reported that they were told they were supposed to hand sick call requests to security staff. Even though the nurse is on the unit twice a day that staff member apparently does not request or collect sick call requests.

The most worrisome finding are the reports, both in September and now, December, of frequent lack of security officers on the units at night when women are locked in their cells. The danger of this practice is highlighted by the following:

Findings Case # 5	**Serious Deficiencies that could result in death**
This woman recently went into a diabetic coma approximately 2 months ago while locked in her cell during the night. Her blood glucose level was critically low. There was no officer on the unit and she reports that an officer was going off duty and had a feeling that she needed to go to the female dormitory. The inmate has been on insulin for 22 years and has never had an insulin induced coma before. As a result of this episode the dose of her insulin was lowered. The medical record validates her reports.	1. It is only by serendipity that an officer decided to check on the unit when going off duty. Had she not this woman would likely have had serious life threatening consequences or died had this officer not performed an unassigned check outside of her post. 2. The other inmates report they were screaming and banging on the walls to attract attention and were frightened by their powerlessness to aid the ill woman.

Additionally, segregation sick call rounds by mental health staff on a weekly basis for both detainees and sentenced inmates is not occurring.

RECOMMENDATIONS: Similar to those of the September 2013 report as follows:

1. A confidential process needs to be established that enables:
    - monitoring of the timeliness of retrieval of sick call requests
    - appropriate triaging by a registered nurse or mental health professional (in the case of mental health requests)
    - timeliness of response by the appropriate qualified health professional
    - appropriateness and effectiveness of the treatment plan generated.

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

ASSESSMENT: NONCOMPLIANCE

MEDICAL FINDINGS: Tracking of care has begun with regard to sick call but has not been fully implemented with regard to intake processing, chronic care, unscheduled offsite services and scheduled offsite services. There are Excel sheets for the unscheduled offsite services but they lack documentation of the presence of the required offsite service report as well as the required follow up visit with the clinician. The same problem is also true for the scheduled offsite services.

RECOMMENDATIONS:

1. Develop tracking logs for the intake process as well as for scheduled and unscheduled offsite services that include the tracking of required follow up services.
2. Utilize the resource of the monitor to assist in developing this process.

MENTAL HEALTH FINDINGS: See above.

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

ASSESSMENT: NONCOMPLIANCE

MEDICAL FINDINGS: We have worked with the GGACF leadership team with regard to a chronic care policy, chronic care clinical guidelines, and forms have been borrowed from materials available through the National Commission on Correctional Health Care. We are also pleased that an internist has been contracted with to provide chronic care services onsite weekly. We believe that the chronic care program structure is near completion. What remains is submission of the policy for final review, along with the disease specific guidelines and any tracking materials. Also, all clinician and nurse staff have to become familiar with both the policy and the guidelines as well as the encounter forms and flow sheets. This particular service could easily move into partial compliance at the next visit. The piece that is missing is the active involvement of the Medical Director in not only helping develop the remaining elements but also in overseeing and performing the training of the staff.

With regard to acute care guidelines, policies and procedures do not exist for assessing and treating acute medical events.

RECOMMENDATIONS: Utilize the above nine elements to expand your chronic disease policy and the guidelines as well as the forms.

1. Continue to develop the structural elements for this program and send out for review any related materials.
2. Continue to contact the monitor and his staff for any technical assistance.

MENTAL HEALTH FINDINGS: unchanged since the baseline assessment as follows:

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

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

It should also be noted that a couple of progress notes by the psychiatrist contain notations that an inmate was unable to be seen due to a lack of an escort officer.

RECOMMENDATIONS: Similar to those of the September 2013 report as follows:

1. *Contact the Monitor and his staff for consultation and/or technical assistance.*
2. *A minor modification to the current case list log as recommended above would improve the tracking capabilities of the facility.*
3. *The list should contain both the BOC number and the inmates' date of birth.*
4. *Any inmate followed by mental health should be captured on a log, perhaps one for psychiatry and one for counseling.*
5. *As mentioned previously, a policy that would dictate required time frames for follow-up of people in the chronic care mental health clinic may improve the timeliness of return visits and allow for tracking when looking for quality outcomes.*
6. *All prison inmates on a mental health caseload should have at a minimum a monthly well-being check by a mental health professional. Minimum frequency of psychiatric visits should be outlined by policy.*
7. *The mental health caseload should be modified to track the date of the follow-up visit for easy identification of overlooked appointments.*

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

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

ASSESSMENT: NONCOMPLIANCE

MEDICAL FINDINGS: We have not yet seen either the policy and procedures or the training material or the record of who has been trained and who remains to be trained. In addition, we continue to be aware of the frustration of staff in accessing the on-call Medical Director. Log books also revealed a consistent frustration among housing unit officers regarding their inability to contact and/or access medical staff when needed. We have heard that there may be some changes made in the near future that will create a dependable and timely availability of clinical resources. We hope that this change is made prior to our next visit. In our first report, we provided elements that should form the basis of the urgent care part of the urgent/emergent policy and procedures. We would encourage either the development of two separate policies, which may in fact be easier to comprehend, or a single policy that has both the urgent and emergency elements included in it.

We reviewed five records specifically with regard to emergency send outs and found the following problems. In none of the records was the emergency room report available. Instead, the only documentation from the hospital was patient discharge instructions. A meeting with emergency room leadership should occur in which it is made clear that your physician needs the emergency room reports in order to insure appropriate continuity. We also did not consistently find a nurse note with vitals upon return and we did not consistently see a timely follow up visit with the onsite clinician which should occur within two to three days after the emergency room trip. The requirement for these elements should be found in the urgent/emergent policies, including the requirement that at the follow up visit onsite, the clinician documents a discussion with the patient of the findings and plan. A review of these required elements should become part of your quality improvement monitoring.

RECOMMENDATIONS:

1. The above elements should be utilized in drafting the urgent/emergent care policy and in constructing the urgent/emergent care log.
2. The Monitor and his team should be contacted for any consultation or technical assistance.
3. Use the elements listed in our first report to develop your urgent care policy along with your emergency care policy.
4. The emergency care policy should include requirements for training and certification in basic life support and first aid as well as the documentation of critiques of quarterly emergency drills.
5. Nurses should be trained that when patients return from unscheduled offsite services they should document a note that describes the patient's condition and a set of vitals, and insure that appropriate paperwork, including the emergency room report, are available and where indicated, a physician contacted for any recommended orders.
6. Your QI program should monitor the presence of the report and the timeliness and appropriateness of the follow up visit by the clinician.
7. Correctional staff, and any staff having contact with inmates should be trained to recognize health care emergencies and qualified health care staff should be consistently available to respond where a qualified medical person can address that emergency.

MENTAL HEALTH FINDINGS: In November 2013 a security log entry notes that an inmate (#9) complained of chest pain and not feeling right. Security notified the treatment building and the nurse responded that there was no doctor present at the time. Examination of the medical record indicated no medical entries for this date and no evaluation by the physician assistant who should have been on site at that time. Such lack of documentation is not only unprofessional but creates and incomplete medical record that exposes the inmate to delay in care and/or incomplete care.

Similar to those of the September 2013 report as follows:

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

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

We have been provided neither training materials nor documentation of staff who have completed the required training as of the training officer has been on vacation during both of the site visits. We were told that no one else has access to her records.

RECOMMENDATIONS: Similar to those of the September 2013 report as follows:

1. The above elements should be utilized in drafting the urgent/emergent care policy and in constructing the urgent/emergent care log.

2. *The sick call request form needs to include triage status.*
3. *Suggest a policy that is highly detailed and provides a well delineated list of staff responsibilities to emergency response.*
4. *Facilitate an emergency transportation system.*
5. *Train staff in CPR and schedule CPR-certified staff during hours when medical staff is unavailable.*
6. *Stock the following essential equipment in a secure location and train staff on use: respiratory barriers, Ambu bags, and defibrillators.*
7. *Schedule accordingly so there is Correctional staff available to provide non-ambulance transportation to an off-site healthcare facility.*
8. *The Monitor and his team should be contacted for any consultation or technical assistance.*

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

ASSESSMENT: NONCOMPLIANCE

MEDICAL FINDINGS: We have not yet reviewed the policy and procedure regarding specialty care or scheduled offsite services, which includes both specialty care and procedures. In our first report, we listed eight elements that should become part of the policy and procedure. These should be utilized in the drafting of the policy and procedure.

During this visit, we found the following problems in records we reviewed. We found some records in which there was no initial progress note describing why the consultation was requested. In addition, we found records in which the consultation report was missing and we also found records in which no follow up visit with a clinician or documented discussion of the findings and plan had occurred.

RECOMMENDATIONS:

1. Use the above elements to construct an offsite service policy and procedure.
2. Contact the Monitor or his team if any technical assistance or consultation is needed.
3. Send us the draft policy and procedure that utilizes the guidance from the first report.
4. Continue to utilize the monitor's team for any technical assistance.

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

MEDICAL FINDINGS: This has been discussed under number v.

RECOMMENDATIONS: See number 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

MEDICAL FINDINGS: We have not yet been provided documents regarding the intoxication and detoxification policies and procedures and/or guidelines. We indicated in the first report that the intake screen is the place where the program makes its initial determination about the liability related to either intoxication or detoxification issues. We saw that the draft intake screen tool does address these issues. We are encouraged by this progress. However, even and effective intake health screening tool is rendered meaningless if it is not being completed by qualified health care staff. We would also like to see protocols developed by the Medical Director for alcohol, benzodiazepine and opiates that include both monitoring performed by nursing staff as well as treatment.

RECOMMENDATIONS:

1. Develop policy and procedure and guidelines beginning with intake screening and leading to protocols for monitoring and treating each of the major common substances.
2. Contact the Monitor or his staff for consultation and/or technical assistance.
3. Develop the policies, procedures and guidelines utilizing information from our first report.

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

RECOMMENDATIONS: defer to Dr. Shansky's report

Mr. Massey, the Substance Abuse counselor reported that GGACF has no detoxification program and that people are detoxifying while housed in a cell in the booking area.

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

ASSESSMENT: NONCOMPLIANCE

MEDICAL FINDINGS: This facility does not yet have an organized infection control program, and requires a nurse, preferably a registered nurse, to assume responsibility on a part-time basis for coordinating the infection control program. The intake screen should contain the TB symptom questions that begin the process of determining risk for tuberculosis. An infection control coordinator coordinates not just the TB control program, which includes the screening on intake and the follow up, in addition to responding to potential new cases, but also the handling of skin infections because of potential MRSA as well as the identification and reporting of sexually transmitted diseases. It would be useful to review an effective jail and/or prison infection control program and obtain policies and procedures and guidelines from existing programs. A place to start would be the Federal Bureau of Prisons policies and guidelines which are available on the

internet. The program should initially focus on the TB control aspects, including the screening on intake.

RECOMMENDATIONS:

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

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

RECOMMENDATIONS: defer to Dr. Shansky's report

i. Adequate suicide prevention, including:

The best way of describing this section's findings is to summarize a case that will highlight all the deficiencies cited below and the assessment for each section:

Findings Case # 9	**Serious Deficiencies that could result in death**
Security log from November 5, 2013 indicated this inmate complained of chest pain and was not feeling right. The treatment building was notified and the nurse stated there was no doctor at that time. Examination of the medical record indicated no entry for this date and no evaluation by the physician's assistant who should have been on site at that time. The second log entry on that day at four o'clock in the afternoon again notes that the inmate was not feeling well. The supervising officer supposedly said the inmate would need to wait until the doctor arrives. At 4:15 PM he was escorted to the treatment building. Later that evening at 10:36 PM it is noted that the inmate is in the multipurpose room trying to commit suicide. He was cutting his wrist. The sergeant was notified and security removed all of his personal possessions. There are two notations the following day shift that a check was made on the detainee. No checks were made on the evening shift. There is one notation at 11:10 PM that the inmate wanted his personal belongings back but the sergeant rejected that privilege. On November 7 at 9:16 AM there is a notation that the inmate was now placed on lockdown per the chief. The next notation that indicates any sort of well-being check appears on November 8 at 8:40 AM and 2:57 PM. The next notation concerning this inmate's status occurs on November 11 when it is noted that he is on lockdown. The next day on November 12 at 2:23 PM the officer notes that per the chief the detainee is no longer on lockdown. The note reads "he checked with the medical staff about said detainee lockdown status and there is nothing to refer to".	1. Failure to provide necessary access to emergency medical evaluation and care 2. The inmate was placed on what appears to be a suicide watch on November 5 in his own cell (not a suicide resistant room) and was not released from lockdown status until November 12. There is a notation that his personal belongings were removed but no mention of whether his linens and uniform (the two most common tools in successful hangings) were removed. It appears that mental health and medical staff were never notified of this lockdown status and never evaluated or followed the inmate. The officers failed to conduct and document, at a minimum per policy, 15 min. checks on the inmate. The inmate was not seen by mental health until 11/15/13 after security had released him from lockdown. This case demonstrates unpredictable and unreliable observation of inmates at imminent or active risk of self-harm and fails to rise to the national minimum guidelines for suicide prevention.

On October 28 a behavioral checklist by security to Health Services was initiated on this inmate stating he had an unusual loss of memory and was depressed. A similar checklist was initiated on November 11 checking radical changes in behavior, expressing a desire to commit suicide, inflicting bodily harm, keep complaining of ailments that are nonexistent, expressing the belief that there are plots are plans against personal safety, and showing poor personal hygiene. The inmate was last seen on August 2, 2013 by mental health counselor and was only seen by the psychiatrist on November 15, 2013 who notes that the inmate was referred by a behavioral checklist. Inmate denied signs or symptoms of the mental illness. He recently met with his attorney said he would be released from prison next week. The detainee appeared happy and denied suicidal ideation. Discharge planning was done.	3. There was no response by Mental Health/Medical to a Behavioral checklist referral from security issued on October 28, 2013 (a Monday). The request on Nov. 11th (a Monday) did not elicit a response from Mental Health services until 11/15/13. <u>There is an undue delay or no response by Health Services to urgent/emergent security referrals.</u> 4. This case demonstrates a complete disconnection between security and health services and also suggests staff has little awareness or no training on the suicide prevention policy.

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

ASSESSMENT: NONCOMPLIANCE

MENTAL HEALTH FINDINGS: Mental Health staff did not report placing anyone on suicide watch this last quarter. However, the security logs demonstrated an inmate placed on observation without his possessions for attempting to cut himself and being suicidal. Mental health was not notified and this was not called a suicide watch.

RECOMMENDATIONS:

1. GGACF needs to develop a communication system that is timely and reliable for notification regarding inmates placed on suicide watch, behavioral referral requests, and intake referrals.
2. Inmates attempting self-harm should be immediately reported to the medical staff on duty that shift or the next business day.

(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: The decision to remove the person from watch in the case discussed was made by security not a psychiatrist or a mental health professional in consultation with a psychiatrist. Grossly inadequate levels of observation are documented in the security logs during the time this person was on lockdown.

Therefore, when medical informs the auditing team that there have been no instances of suicide watch in the facility their data and reports are unintentionally inaccurate.

RECOMMENDATIONS: Until a qualified mental health professional assesses the inmate they should be placed on suicide precaution under direct observation.

1. Therefore, when medical informs the auditing team that there have been no instances of suicide watch in the facility their data and reports are unintentionally inaccurate.

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

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

ASSESSMENT: NONCOMPLIANCE

MENTAL HEALTH FINDINGS: No suicide assessment was performed until after security returned all of the inmate's possessions in the case listed above.

RECOMMENDATIONS: Unchanged from the last report. GGACF needs to implement a policy that requires notification of nursing staff when anyone is placed on observation immediately when staff is on site. An after hour protocol should be considered as well to allow for notification of mental health staff by the next morning

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

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

ASSESSMENT: NONCOMPLIANCE

MENTAL HEALTH FINDINGS: As indicated in the Monitor's previously discussed review, there is a lack of cut-down tools throughout the facility. Additionally, and as reported by the Monitor, some staff are not aware of the location of existing tools, tools are commonly reported as missing on the Officer's Log, and emergency drill training in the use of these tools is not regularly conducted.

RECOMMENDATIONS:

1. 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.
2. 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.
3. Supervisors should regularly inventor and audit tool location and make immediate provisions to replace missing or non-function 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: During both site visits, September and December 2013, the training officer was unavailable and no one had access to her files. No proof of in-service training nor disaster drills have been made available to the monitoring team.

RECOMMENDATIONS: Develop and implement scenario-based suicide prevention, response, and recovery training program that requires application of policy and procedure, and that topic competence is proven by both written test and demonstration by staff. Adequate initial and annual trainings should be documented and maintained.

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

ASSESSMENT: NONCOMPLIANCE

MENTAL HEALTH FINDINGS: During both site visits, September and December 2013, the training officer was unavailable and no one had access to her files. No proof of in-service training has been made available to the monitoring team.

RECOMMENDATIONS: Annual disaster drills should include scenarios with response to a mental health emergency/suicide and be documented in a file maintained by the training supervisor.

(vii) availability of suicide resistant cells;

ASSESSMENT: NONCOMPLIANCE

MENTAL HEALTH FINDINGS: There are no suicide resistant (safety) cells at GGACF. This was further verified in consultation with the Monitor.

RECOMMENDATIONS:

1. Retrofit cells designated suicide precautions to be suicide proof.

2. Renovation of an intake cell may be the only immediate alternative. If this environment is utilized, then the facility needs to carefully monitor how readily medical and mental health staff can maintain daily contact with the inmates.

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

ASSESSMENT: NONCOMPLIANCE

MENTAL HEALTH FINDINGS: The facility needs to develop, train to, and implement a policy for suicide prevention. In addition, there does not appear to be any system by which security implements and maintains an adequate watch.

RECOMMENDATIONS:

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

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

ASSESSMENT: NONCOMPLIANCE

MENTAL HEALTH FINDINGS: There have been no improvements regarding suicide prevention. Security does initiate Behavioral Referrals but these are not always responded to by Health Services/Mental Health Services as promptly as is necessary. It is unclear if the delay is due to delayed arrival of the referral to the clinic, a shortage of security staff to escort the inmate, a shortage of mental health staff, or all of the above plus other obstacles the facility may be aware of.

The provision of adequate suicide prevention and programming remains a grave concern as evidenced by the case reviewed during this visit which fails to meet all nine of the above requirements. Fortunately, no harm befell this individual.

Security places people on lockdown status for self-injurious behavior without notifying mental health services. As a result there is absolutely no mental health review of the inmate. The decision to remove the person from watch is made by security not a psychiatrist or a mental health professional in consultation with a psychiatrist. Grossly inadequate levels of observation are documented in the security logs during the time this person was on lockdown.

Therefore, when medical informs the auditing team that there have been no instances of suicide watch in the facility their data and reports are unintentionally inaccurate.

RECOMMENDATIONS:

1. The facility needs a policy that reflects the current capabilities and provides the greatest amount of supervision required to safely monitor someone on suicide watch.
2. Renovation of an intake cell may be the only immediate alternative.
3. If this environment is utilized then the facility needs to carefully monitor how readily medical and mental health staff can maintain daily contact with the inmates.

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

ASSESSMENT: NONCOMPLIANCE

MEDICAL FINDINGS: We have indicated previously the problem with availability of the Medical Director onsite as well as on-call. In addition, we indicated that the plans to hire three registered nurses and three licensed practical nurses were subverted by a non-cooperative Director of Human Resources. The need for 24/7 nursing coverage remains urgent and requires immediate attention. We have also referred to the need for a clerical person dedicated to the maintenance of the medical records. We believe that addressing these medical staffing needs is likely to suffice for the ability of the program to achieve substantial compliance with regard to medical services.

RECOMMENDATIONS:

1. Provide the staffing document to the Monitor along with the duties assigned to each staff member.
2. Based on the October 2013 budget, provide the staffing positions allocated for Golden Grove for medical services to the monitor.
3. Complete the task of filling the three registered nurse and LPN positions.
4. Identify a Medical Director who will insure both onsite presence as well as on-call timely availability.
5. Address the medical records component.

MENTAL HEALTH FINDINGS: No staffing analysis was presented to the monitor. Mental health staffing levels remain unchanged from the time of our last visit. Delays in follow-up care continue and are frequently related to the lack of escort officers; however, if security staff was increased it is unlikely that the current mental health staff hours would be sufficient to meet the needs of the facility, particularly if sufficient services were provided to the seriously mentally ill inmates. Additionally, the retirement of the psychiatrist is especially troubling as this will increase and prolong gap is care and medication reviews.

1. RECOMMEDATIONS: Refer to the Monitor's assessment, findings and recommendations pertaining to staffing analysis recommendations. Provide the staffing document to the Monitor along with the duties assigned to each staff member.
2. A replacement for the retiring psychiatrist must be employed immediately.

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

ASSESSMENT: NONCOMPLIANCE

MEDICAL FINDINGS: Clearly, the consistent availability of offsite officers as well as a transport van has interfered with the ability to provide follow up ordered lab and x-ray services. In addition, we are aware of access onsite that was either delayed or unavailable due to officer staffing.

RECOMMENDATIONS:

1. Determine the officer staffing needed (a) for offsite services and (b) for onsite services to insure that access is neither delayed nor denied.

MENTAL HEALTH FINDINGS: No change from baseline assessment report as follows:

Correctional staffing documents provided were inadequate to determine existing levels of authorized staff, work shifts, work locations, duty assignments, and shortages.

RECOMMENDATIONS: No change from baseline assessment per port as follows:

1. Develop staffing policies and procedures that reflect facility and population needs.
2. Develop staffing documents that allow for accurate and timely tracking of staffing levels, shift and duty assignments, work locations, and shortages.
3. Prepare for performing a comprehensive staffing analysis to determine require staffing levels using NIC Net Annual Work Hour methodology.
4. Ensure staff members are properly trained in all aspects of their respective duty assignments working with special needs and mentally ill inmates.
5. Provide Monitor with accurate, complete, and up-to-date staffing schedules as described above.

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

ASSESSMENT: NONCOMPLIANCE

MEDICAL FINDINGS: Until the policies and procedures have been implemented, it is difficult for an organized quality improvement program to effectively monitor for either process performance or professional performance. Until an actively involved Medical Director is in place, the professional performance aspects will not be addressed, certainly with regard to the clinicians. There is a chief nurse, but until there is clarity with regard to the expectations of the nursing staff performance, there cannot be accountability expected.

RECOMMENDATIONS:

1. As the policies and procedures are finalized, staff are trained and the policies implemented, begin the monitoring of process performance with regard to intake, health assessments, TB screening, sick call, unscheduled onsite and offsite services, scheduled onsite and offsite services as well as chronic disease management and medication management.
2. Work with the monitor and his staff, who can provide technical assistance.

MENTAL HEALTH FINDINGS: See case #9 cited under section 1. I, adequate suicide prevention.

There is not an operative quality improvement committee and no quality improvement activities at the time of this to work. This element is probably intended to describe a quality improvement program. We are unaware of any policy and/or quality improvement activities. We will work with local staff to develop a policy and program that facilitates improvement and meets NCCHC requirements.

The health services administrator informed us that they are scheduled to begin a quality improvement committee but are having difficulty finding a time when the medical director can attend.

GGACF Mental Health Department, under the supervisions of the Medical Director needs to develop a schedule of quality improvement activities and systems to measure the clinical processes and their outcomes. Currently there is a monthly report, which was not provided for our review, to the Health Services Administrator. From speaking with the Mental Health Coordinator it appears that certain quality assurance activities may be occurring that track some of the statistics monitored through logs and case lists.

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

m. Adequate dental care;

ASSESSMENT: NOT ASSESSED

MEDICAL FINDINGS: The dentist was not available during this trip, which suggests that the dentist's presence may not be predictable and dependable. Insure that there is a predictable and dependable dental presence.

RECOMMENDATIONS:

1. Insure that there is weekly predictable and dependable dentist presence onsite.
2. Begin tracking the weekly frequency of both restorations and extractions.

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

MEDICAL FINDINGS: We still have not seen any policy or procedure with regard to this. Until the Medical Director involvement is improved, we cannot expect any progress on this issue. With each mortality review there must be a medical chronology as well as a mortality review that describes both the things done well as well as opportunities for improvement.

RECOMMENDATIONS:

1. Utilize the above to construct a mortality and morbidity policy.
2. Construct a mortality and morbidity policy with input from the Medical Director.
3. Contact the Monitor and his staff for any consultation or technical assistance.

MENTAL HEALTH FINDINGS: There have been no deaths or significant morbidity reported for the mental health caseload since the time of our last visit.

RECOMMENDATIONS: defer to Dr. Shansky's report

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

ASSESSMENT: NONCOMPLIANCE

MEDICAL FINDINGS: We discussed with the leadership team how this could be accomplished and therefore what the policy should contain. We will await the drafting of such policy.

RECOMMENDATION:

1. Utilize the monitor and his staff for technical assistance.

MENTAL HEALTH FINDINGS: Similar to the baseline assessment as follows:

We saw no policy on this. We would strongly encourage drafting the policy based on NCCHC standards utilizing the compliance indicators and discussion sections. Both the prisoners and mental health staff reported that no mental health isolation/segregation rounds are conducted at the facility.

RECOMMENDATIONS: Similar to the baseline assessment as follows:

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

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

ASSESSMENT: NONCOMPLIANCE

MENTAL HEALTH FINDINGS: Mental health staff provide no structured out of cell therapeutic programming for seriously mentally ill inmates in administrative segregation or the special needs housing unit adjacent to segregation. In general, it is recommended that the former, should they require a residential level of care, receive at least 10 hours per week of unstructured out of cell time and 10 hours of structured out of cell encounters per week (individual or group therapy) driven by their individual treatment needs. Those requiring only outpatient care should have more than five hours per week of unstructured out of cell time and increased private contact with a counselor and a psychiatrist while housed in isolation.

Findings also remain the same as the baseline assessment as follows:

No policy and procedure exists addressing a review process for mental health and medical clearance of inmates with serious mental illness being placed in isolation. There are no policies regulating the amount of out-of-cell time provided to special needs prisoners in segregation. Mental health staff does not perform segregation rounds.

RECOMMENDATIONS: Similar to the baseline assessment as follows:

1. It is recommended that a detailed policy be developed to address this issue that incorporates the requirements of national accrediting bodies such as the NCCHC or the ACA.
2. The facility should develop an outline for therapeutic residential level of treatment on these units, identify the staffing needs and coordinate with security to effectively initiated enhanced treatment designed to stabilize and improve inmate function with the goal of possibly moving some of these men into general population and an outpatient level of care.

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

ASSESSMENT: NONCOMPLIANCE

MENTAL HEALTH FINDINGS: Currently there is no formalized process by which a qualified mental health provider performs a pre-segregation assessment to determine whether the person is at risk of self-injury if placed in isolation and is at risk of an intensification of their mental illness if placed in isolation. Mental health also has no formalized process to determine if there are mitigating factors that would lessen or eliminate the disciplinary sanction.

Similar to the baseline assessment as follows:

There is no policy or procedure requiring participation of mental health staff in the disciplinary process and as a result there currently is no input.

Regarding placement in segregated environments, it is unclear whether a medical and mental health clearance is done for such a housing assignment. We were also told in a meeting with the Health Services Administrator and Medical Director that medical sees everyone when there has been a use of force, and if severe enough, after hours the inmate will go to the emergency department. The medical department has to rely on the security emergency department log to determine if anyone has been taken to the hospital.

RECOMMENDATIONS: Similar to the baseline assessment as follows:

1. *A policy and procedure should be established to allow for an assessment by mental health of incidents potentially resulting in disciplinary sanctions in those inmates on the mental health caseload.*
2. *Input into the disciplinary process should be written and periodically monitored through a quality improvement process to determine if the disciplinary officer is collaborating with mental health staff in adjusting their sanctions when there are mitigating circumstances secondary to the person's illness.*
3. *Currently, there is no retrospective of use of force as part of the medical quality improvement process but such a process should be put in place.*

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

ASSESSMENT: NONCOMPLIANCE

MEDICAL FINDINGS: No change from previous report.

RECOMMENDATIONS:

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

MENTAL HEALTH FINDINGS: The physical plant regarding the delivery of mental health services has not altered since our last visit. We did observe some confidential log material displayed in a manner that would have been readily visible to inmates being treated within that office space. The staff member was informed that this was a poor practice and immediately removed the materials.

Currently the Mental Health Coordinator is conducting 1 group therapy in an office that would not comfortably hold more than 4 inmates. The physical limitations, in addition to the shortage of escort officers and mental health staff, severely limit any additional programming opportunities at this time. No adequate programming space exists in or near the special needs

unit or segregation for the programming of the seriously mentally ill inmates in these housing units. There is a small satellite medical clinic space that could be used for individual mental health encounters on the segregation pod.

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

RECOMMENDATIONS:

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

ASSESSMENT: NONCOMPLIANCE

MENTAL HEALTH FINDINGS: During this visit we again found examples of inmates with delayed or absent psychiatric follow-up.

Case #	Findings Case	Deficiencies/ Areas of Potential Harm
10	This inmate is still listed on the psychiatric caseload. His intake was done on June 23, 2013 and was positive for thoughts of hurting himself or others, a history of mental health treatment, drug withdrawal, auditory hallucinations, mood changes and medications including Risperdal, Seroquel, and Zoloft. His medical screen occurred two days later and it is noted that psychiatric medications were ordered. He was seen by the psychiatrist for the first time on July 18, 2013 who assigned the diagnosis of psychosis NOS and was referred to the mental health counselor. He was never seen again by the psychiatrist and was noted to have been released from the facility on September 18, 2013	1. Delayed initial psychiatric assessment which should be performed within 10 business days of referral. 2. At least two months between his initial review and any attempt at follow-up, if any may have been in the works prior to his release.
11	The inmate was booked on May 9, 2009. He was originally placed on Haldol in March of 2013. On April 24, 2013 a behavioral referral was sent from security to medical notifying them of a radical change in behavior, and inability to sleep, outbursts and constant hostility. This form was received one day later. He was seen the next day by the mental health social worker who noted that he was taken to a treatment building by four officers and had to be restrained with racing thoughts, pressured speech, and flight of ideas. The psychiatrist was called and ordered intramuscular injections of an antipsychotic agent and that	1. Despite an episode of extreme agitation requiring injectable medication, is inmate was not scheduled for psychiatric reevaluation for more than three months following the episode. 2. Medication noncompliance was repeatedly noted by the mental health counselor with

	he be returned to his cell once stable. His next encounter with the psychiatrist occurred on May 2, 2013 with no further follow-up appointments documented in the record. He was seen again on 5/13/13, 7/30/13, by the mental health counselor who documented medication noncompliance at both visits. On 8/6/13 the counselor noted that the clinic attempted to reevaluate the inmate by the psychiatrist for noncompliance but there was no patrol officer to escort the inmate.	no expedited appointment with the psychiatrist.
12	This gentleman was screened 5/18/12 and noted to have a serious mental illness. He is currently on injectable Haldol and Cogentin but there were no documented psychiatric records for the year 2013 in the chart.	1. At best inadequate documentation or poor medical record management and at worst a complete absence of psychiatric management of this person's medication regimen.
15	The inmate was readmitted to the facility on 5/23/13 and was noted to be incoherent. The psychiatrist was familiar with the inmate and had treated him for schizophrenia in the past. He noted the man was disoriented to time and place, grandiose and had poor hygiene. The inmate needed to be redirected constantly. The psychiatrist started him on injectable Haldol. His next follow-up was not until six months later, 11/26/13. The inmate stated he was doing "very good" but was noted to be grandiose, delusional, inappropriate affect, poor eye contact, poor hygiene, malodorous, and appear to have intellectual disabilities. His medication was continued and he was diagnosed with chronic schizophrenia.	1. Psychiatric follow-up is grossly inadequate. At a minimum this inmate should be followed by the psychiatrist at least monthly given his serious mental illness diagnosis and acute symptomatology. It is also unclear why this man was initially not considered for placement in the acute care unit on St. Thomas. 2. At the time of his follow-up six months later there is little evidence of any significant improvement in his symptomatology which may be related to the sparse services provided to him during that period of time.
18	This inmate is not on the psychiatric case list. On intake he was noted to be depressed and have a history of seizures and high blood pressure. He was observed to have seizure like behavior on the unit in June 2013 and inmate July there is a notation in the record that medical questioned whether his seizures might be psychosomatic. In September 2013 he was seen by a registered nurse complaining of anxiety and frustration. 12/6/13 he removed a sling from his right shoulder and tried to hang himself with it. His affect was noted to be sad and he was presently being interviewed by the mental health social worker. He was seen by the psychiatrist on 12/10/13 who noted that the individual was no longer suicidal and did not have the psychiatric disorder.	1. There appears to be a lack of coordination of care between medical and mental health for inmates with dual diagnoses. In July 2013 when there was a question of psychosomatic etiology for his seizures one would expect an initiation of a referral to psychiatry for evaluation. This did not occur.
19	Seen at intake 4/3/13 and was noted to have auditory hallucinations. Medical screening was delayed and	1. Delayed medical intake

	occurred on day 8 of incarceration. The inmate was not seen by psychiatry until April 23, 2013 when the psychiatrist began him on a low dose of Risperdal. He returned four months later. This second follow-up is documented on an undated note on the newly implemented psychiatric progress note form and there is a medication order on 10/28/13 which appears to be at the same time the note was generated. The plan was for him to return to the clinic in two weeks. This has not occurred.	2. Delayed initial psychiatric evaluation 3. Delayed psychiatric follow-up
22	On 10/8/13 there is a psychiatric note that he allegedly stabbed a detainee. He refused mental health services and his appointment. The plan was to order urine drug screen which he refused on 10/10/13. He has not been seen since. His last mental health counseling note was 8/14/13 with a plan that he attends weekly counseling. He refuses medication and his MAR indicates that he has been 100% noncompliant with Haldol/Cogentin on his December record.	1. Psychiatric medications continued without follow-up and despite repeated documentation of complete noncompliance.
25	A short form intake was done on 5/1/12. A bio psychosocial assessment was performed 3/20/13. He was admitted to this facility on 3/12/13. His first psychiatric assessment was on 3/21/13 were no symptoms were noted and he was to return in one month. Follow-up was on 5/7/13 and he was noted to be slow in his response time. Follow-up was set at 6 months later. On 11/7/13 he was noted to be intellectually deficient with an IQ of 56 and the plan was to continue medications. The day prior he had been seen by the social worker who noted that he was very explosive.	1. Six months return psychiatric appointments exceeds the generally recommended standard of chronic care visits occurring at least every 90 days. 2. No medication administration records were filed in the chart.

Similar to the baseline assessment as follows:

Medical services and mental health services at the current time lack any continuous quality improvement program, which greatly impedes their ability to self-monitor, develop, and implement effective corrective action plans or program development. Treatment plans were only found in a few records. In most circumstances the plans were unrealistic in that they assigned activities such as educational classes and mental health groups which were not provided at the facility. The plans also recommended certain frequency of follow-up by mental health or psychiatry which was not even approximated in the actual practice.

RECOMMENDATIONS: One observation from this audit is that the mental health clinic logs do not show a return to clinic date as well as the last completed visit. Thus, there is no concrete tool to track if someone has actually fallen off the radar and needs to be seen in follow-up. It is recommended that the clinic logs the modified and, perhaps organized on a spreadsheet so that it can be easily sorted for the convenience of the staff to ensure timely follow up appointments based on clinical necessity with an upper limit of time between visits set at 90 days.

Similar to the baseline assessment as follows:

1. Treatment plans should reflect the actual services rendered as opposed to idealistic suggestions.

2. Suggest the following template for crafting the inmate's plan of care:

THE INDIVIDUALIZED TREATMENT PLAN:

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

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

ASSESSMENT: NONCOMPLIANCE

MENTAL HEALTH FINDINGS: Similar to the baseline assessment as follows:

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

As mentioned earlier the Mental Health Coordinator has begun one general population group with four or five inmates. There is no mental health programming for segregated or special needs inmates.

While on site I also had the opportunity to meet with Mr. Massey who educated me regarding the substance abuse programming available at the facility. In the past there had been a residential treatment program but this no longer exists. Currently they have a 90 day outpatient program. He provides programming on a voluntary basis. He has an elders program for inmates over the age of 57 who can act as mentors. There are currently eight men in this category that he supervises and meets with them weekly. Each coordinator receives 160 hours of training from him. Approximately 2 years ago the substance abuse program was dismantled and Mr. Massey was laid off from his full-time position. He was hired back part time. Mr. Massey reported that GGACF has no detoxification program and that people are detoxifying while housed in a cell in the booking area. Recruiting inmates to participate in substance abuse programming has been difficult. He reported the units all have crack cocaine, marijuana, cocaine, and alcohol illicitly available to inmates most of whom are unwilling to consider being substance free. In 2013 he has received a total of 10 referrals of dual diagnosed inmates from the mental health service.

RECOMMENDATIONS: Unchanged from the Baseline Assessment as follows:

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

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

ASSESSMENT: NONCOMPLIANCE

MENTAL HEALTH FINDINGS: Unchanged since the Baseline Assessment based on chart review.

GGACC lacks sufficient psychiatry hours (although we were not provided with the staffing schedule, it appears that GGACC has fewer than eight hours per week of psychiatric time) to perform comprehensive initial psychiatric assessments and chronic care follow-ups at clinically necessary frequencies.

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

A continued finding of dependence on long acting injectable neuroleptics rather than oral agents seems a variance from customary practice. This may be a clinical choice designed to increase medication compliance.

There is no policy that addresses the use of emergency and involuntary medication.

RECOMMENDATIONS:

1. *Improved methods of practice and a staffing and programs analysis needs to be completed.*
2. *GGACC may wish to consider adding telepsychiatry to increase the availability of psychiatric resources by contracting with psychiatrists on the mainland who obtain licenses in the USVI. Of course, the latter would require capital investment in equipment and the development of a policy and procedures that would structure this type of service.*
3. *A reasonable informed consent form should be developed and patient education documented.*
4. *A policy addressing the use of emergency and involuntary medication should be developed.*

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

ASSESSMENT: NONCOMPLIANCE

MENTAL HEALTH FINDINGS: As mentioned previously, the training officer has not been available during our two site visits and no one else has access to her training records. Therefore there is no ability for the monitoring team to make any determinations regarding a level of

compliance with this requirement. In addition case #9, indicates that security staff including supervisory level staff have little awareness and or training in the suicide prevention policy. This is demonstrated by security placing an inmate who was self-injurious on lockdown, failing to notify medical services and mental health services of that status, and failing to implement and document the watch requirements of the policy. In addition, security staff terminated the watch without any review by mental health.

RECOMMENDATIONS: 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.

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

ASSESSMENT: NONCOMPLIANCE

MENTAL HEALTH FINDINGS: Unchanged from the Baseline Assessment as follows:

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

RECOMMENDATIONS: Unchanged from the Baseline Assessment as follows:

1. *GGACC should consider alternative housing and as recommended above, develop a plan to introduce adequate programming for this population.*
2. *Increased out-of-cell-time and life skills activities should be considered.*
3. *It is also recommended that all inmates with a serious mental illness should be seen in a confidential setting at a minimum of at least monthly by a psychiatrist and monthly by a mental health counselor.*
4. *Weekly mental health rounds are also required for this population.*
5. *Suggest the following template for progress monitoring of inmates in segregation (may also be used for general population):*

<u>THE GENERAL POPULATION AND SEGREGATION MENTAL HEALTH PROGRESS NOTE</u>

SUBJECTIVE/OBJECTIVE

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

ASSESSMENT

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

PLAN

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

ENVIRONMENT OF CARE

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

VI. FIRE AND LIFE SAFETY

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

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

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: No change since the Baseline visit, previous recommendations remain appropriate.

RECOMMENDATIONS:

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

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: No change since the Baseline visit, previous recommendations remain appropriate.

RECOMMENDATIONS:

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

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: No change since the Baseline visit, previous recommendations remain appropriate.

RECOMMENDATIONS:

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

d. Regular security inspections of all housing units that includes checking:

(i) that cell locks are functional and are not jammed from the inside or outside of the cell; and

(ii) that all facility remote locking cell mechanisms are functional;

ASSESSMENT: NONCOMPLIANCE

FINDINGS: No change since the Baseline visit, previous recommendations remain appropriate. During this inspection, and as previously described some of the Housing Unit locks are found non-functional.

RECOMMENDATIONS:

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

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: No change since the Baseline visit, previous recommendations remain appropriate.

RECOMMENDATIONS:

1. Refer to previous recommendations for this provision.

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: No change since the Baseline visit, previous recommendations remain appropriate.

RECOMMENDATIONS:

1. Refer to previous recommendations for this provision.

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: No change since the Baseline visit, previous recommendations remain appropriate.

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: No change since the Baseline visit, previous recommendations remain appropriate. There remains no functional fire suppression system in the Housing Units other than fire extinguishers. This system must be made fully operational, regularly tested and maintained.

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.
3. Ensure that the fire suppression system is fully operational, regularly tested, and maintained.

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: No change since the Baseline visit, previous recommendations remain appropriate.

RECOMMENDATIONS:

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

j. Control of highly flammable materials.

ASSESSMENT: NONCOMPLIANCE

FINDINGS: No change since the Baseline visit, previous recommendations remain appropriate. Additionally, and as described throughout Exhibit B, inmates are allowed to keep large amounts of combustible items in their cells. The large amount of combustible trash foundin the juvenile unit evidences a lack of adequate concern for this issue.

RECOMMENDATIONS:

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

VII. ENVIRONMENTAL HEALTH AND SAFETY

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

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

GENERAL COMMENT: The following was provided in the Baseline Report and remains consistent with narrative discussion provided at the beginning of this report.

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

13. Medical and dental exam rooms were filthy with what appeared to be dried bodily fluids on pans that held equipment for procedures. Trash cans were full. Sharps containers were full. This environment, overall, was in serious need of deep cleaning and maintenance.
14. The facility appears inadequately staffed to provide adequate monitoring, oversight, and response to routine or emergency sanitation conditions or maintenance issues.

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: No change since the Baseline visit, previous recommendations remain appropriate. As described in Exhibit B, conditions remain unsanitary throughout the facility i.e. extensive mold, lack of drinking water in cells, dirty showers, etc.

RECOMMENDATIONS:

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

b. Adequate ventilation throughout the facility;

ASSESSMENT: NONCOMPLIANCE

FINDINGS: No change since the Baseline visit, previous recommendations remain appropriate.

RECOMMENDATIONS:

1. Timely complete an air quality assessment performed by a qualified provider. Implement necessary improvements that reduce housing area temperatures and increase air flow.
2. Ensure inmates have constant access to drinkable water.
3. Medical and mental health staff should monitor all inmates for heat and airflow-related health risks. All inmates in segregation or who are locked in their cells should be monitored by medical and mental health staff for signs of health conditions.
4. Train all staff in detecting and responding to health conditions related to heat and air circulation contributors.
5. Install environmental health condition monitoring devices, e.g., temperature, humidity, and air quality readers. Require regular monitoring and recording of readings and take timely action to mitigate environmental conditions that create health risks caused by those conditions.
6. Ensure that adequate amounts of drinkable water is always available to inmates.
7. Medical and mental health professionals should closely monitor inmates being administered medications that are adversely affected by high body temperatures and take appropriate steps to eliminate adverse effects.

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: No change since the Baseline visit, previous recommendations remain appropriate.

RECOMMENDATIONS:

1. Develop a comprehensive campus/facility lighting plan that ensures constant illumination of all required internal and external perimeters, housing areas, support services structures and areas.
2. Maintain an ongoing lighting repair log that evidences repair activities.
3. Ensure rapid repair and replacement of inoperable lighting, add additional external and internal illumination where indicated by a comprehensive security lighting needs assessment.
4. Provide for adequate staffing levels to support lighting plan and maintenance.

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

ASSESSMENT: PARTIAL COMPLIANCE

FINDINGS: No change since the Baseline visit, previous recommendations remain appropriate.

RECOMMENDATIONS:

1. Review, revise, develop, train, implement, evaluate environmental pest control policies and procedures that provide for both incidental and scheduled pest control inspections and mitigation.

2. Ensure that inmates involved in pest control activities are properly trained, equipped, and clothed for requirements of those activities.
3. This provision will be assessed more closely during the December assessment.

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

ASSESSMENT: PARTIAL COMPLIANCE

FINDINGS: No change since the Baseline visit, previous recommendations remain appropriate. However, most of the cells inspected appear to have an adequate supply of personal hygiene products.

RECOMMENDATIONS:

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

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: No change since the Baseline visit, previous recommendations remain appropriate.

RECOMMENDATIONS:

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

2. GGACF officials should consult an environmental specialist to assess these conditions and assist them in developing appropriate mitigation plans and policies.

g. Mattress care and replacement;

ASSESSMENT: NONCOMPLIANCE

FINDINGS: No change since the Baseline visit, previous recommendations remain appropriate.

RECOMMENDATIONS:

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

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

ASSESSMENT: PARTIAL COMPLIANCE

FINDINGS: No change since the Baseline visit, previous recommendations remain appropriate.

RECOMMENDATIONS:

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

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: No change since the Baseline visit, previous recommendations remain appropriate.

RECOMMENDATIONS:

1. Review, revise, develop, train, implement, and evaluate a comprehensive laundry management plan that governs total laundry operations.

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

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: No change since the Baseline visit, previous recommendations remain appropriate. The following observations were found during this inspection of the kitchen:

1. The main kitchen door from the work side has water dripping from the ceiling. There are exposed electrical wires and some standing water. It appears they have been cleaning in in this area but standing water remains on the floor and there are no warning signs or placards. There is a service sink separating the entrance to the male and female bathroom.

2. Entering the women's bathroom, there is full container of hand sanitizer on the sink. The sink is operational but there is no hot water. The bathroom floor is filthy and requires a deep cleaning.

3. The male bathroom is in similar condition as the female bathroom and requires a deep cleaning. There is a dirty wall urinal, the light does not work, and there is cold water but no hot water. The frame separating the toilet areas is rotting at the base. I could find no toilet paper in this bathroom.

4. In the kitchen area, there are large stainless steel sinks back-to-back near the cooking area. The tile under the sinks is damaged and needs to be repaired or replace. The plumbing is exposed. There are rotting food products under the sink. The sinks are both clogged with what appears to be corn or some other food products. There is also a 12 inch knife in the sink attached to a metal cord that is padlocked to the faucets.

5. An inspection of the kitchen tool/utensil found it unlocked and unattended by staff. Light is on and both the tool cage gates are unlocked are wide open. Although a "shadow board" is in place for tool management, there does not appear to be any equipment inventory logs. There does not appear to be a chit system in use for tool tracking and inventor management. It appears that several tools are missing, including knives, ladles, large spoons, etc.

6. The kitchen has two large internal cooler/freezers; one of them is operational and one appears to be broken. The broken cooler has no external temperature gauge and appears to be used for storage.
7. The working cooler has an external temperature gauge showing a temperature of about 47 degrees, and contains various properly stored food products.

8. There is a large iron cook stove here and needs to be replaced. The nearby deep fryer contains used oil. There is also a pan sitting on a cart next to it with some old oil. The second deep fryer appears to be clean and covered by a stainless steel pan.

9. To the opposite side of that group of kitchen equipment is a 12 burner cast iron stove and ovens that are currently being used. This was the oven that was reported in the Baseline Report as positioned too high for safety reasons.

10. There is also a prep area for food distribution. This is the cafeteria are where inmates come here to collect their food. This is a decent size room for distributing food from the kitchen through large food ports. There are additional food service areas nearby, as well as a fairly large stainless steel dish sink. The inmates are busy cleaning this area. There is a single fire extinguisher mounted on the wall as you enter the kitchen area with brief instructions on use that appears recently inspected.

11. In general, the kitchen area remains in the poor condition as it was found at the Baseline visit with broken tiles, leaking ceilings and mold, insects, and equipment that needs to be replaced.

12. Outside of the kitchen building is another freezer with a temperature reading of 21-22 degrees, which is adequate for frozen products. It is locked and we will not enter it.

RECOMMENDATIONS:

1. Review, revise, develop, train, implement, and evaluate food service program policies and procedures.
2. Ensure policies and procedures include, at minimum, the following elements:
   A. Meals that are nutritionally balanced, well-planned, and prepared and served in a manner that meets established health and safety codes;
   B. An adequate number of qualified food service employees and supervisors needed to monitor program quality and inmate worker supervision;
   C. Special menus that comply with various medical and religious needs and requirements;
   D. Maintain accurate accounting records;
   E. That menus are reviewed at least annually by a qualified dietitian to ensure meals comply with nationally recommended allowance for basic nutrition;

F. Prohibitions of using food as a disciplinary measure;
G. Involvement of independent outside sources to verify food service facilities and equipment meet government safety codes;
H. Prescribes regular cleaning schedules including routine deep cleaning;
I. Provide written utensil control methods similar to those used by the tool shop;
J. Accident prevention program;
K. Personal and environmental sanitation requirements;
L. Food temperature monitoring and records keeping;
M. Adequate health protections for all staff and inmates including health screens and prohibitions against working in the kitchen when ill;
N. Requirements for daily monitoring of staff and inmate cleanliness practices, and that all bathrooms and wash basin are consistently supplied with antibacterial soap and hot water;
O. All areas and equipment related to food preparation, distribution, and storage require frequent inspection to ensure they are sanitary, operational, and safe;
P. Water temperature on final dishwasher rinse should be 180 degrees Fahrenheit; between 140 and 160 degrees Fahrenheit is appropriate if a sanitizer is used on the final rinse. The person conducting inspections should be a qualified food service inspector;
Q. Stored shelf goods are maintained at 45 degrees to 80 degrees Fahrenheit, refrigerated foods are 35 to 40 degrees Fahrenheit, and frozen foods at 0 degrees Fahrenheit or below, unless national or state codes specify otherwise;
R. Food temperatures for hot foods should range between 135-140 degrees Fahrenheit and cold foods at approximately 41 degrees Fahrenheit;
S. Supervisory food service staff should monitor food service operations to ensure that that cooking, cooling, and food temperatures and delivery meet established requirements;

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

k. Sanitary and adequate supplies of drinking water.

ASSESSMENT: NONCOMPLIANCE

FINDINGS: No change since the Baseline visit, previous recommendations remain appropriate.

RECOMMENDATIONS:

1. Refer to recommendations regarding sanitation and this provision.
2. Develop and implement a corrective action plan for that ensures inmates have consistent and reliable access to safe drinking water.

3. 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: No change since the Baseline visit, previous recommendations remain appropriate.

Additionally, the Monitor was provided several official documents that listed current training topics, invoices for training, and staff attendance. No curricula documents were provided for review, nor any documents indicating that staff have been trained on policies pursuant to this order. Again, the HR/Training person was not available during this assessment.

RECOMMENDATIONS:

1. Written training policies and procedures should be developed and implemented to govern pre-service, in-service, and ongoing training or corrections and civilian staff. The following are a few recommended elements for training program policies and procedures:

    A. Training program mission statement, goals, objectives, and operating procedures;
    B. Written, understandable, and measurable;
    C. A training program written code of professional standards and ethics;
    D. Employees participate in formulation of policies, procedures, and practices;
    E. The training program is adequately staffed with qualified training and support staff;
    F. There is a written organizational plan that depicts training program structure, lines of communication and authority;
    G. Training records management and control;
    H. Descriptions and roles of agency, public, and private training agencies and/or organizations involved in training development and implementation;
    I. Authorization and description of off-site training facilities;
    J. Regularly scheduled meetings between training leadership and agency leaders for program coordination and management purposes;
    K. A system for monitoring training program methods, content, and outcomes;
    L. Training program funding and space;

M. Training program role in staff recruitment, selection, training, re-training, promotion, dismissal;
N. Prohibitions against and consequences resulting from staff and student misconduct related to training functions and activities;
O. Adequate equipment and supplies are available to develop, prepare, administer, and evaluate training program and services;
P. Appropriate accommodations are available for disabled and/or impaired students;
Q. Training curricula and plans are developed, evaluated, and updated based on a valid assessment of staff performance that identifies current job-related training needs;
R. Ongoing formal evaluation of pre-service, in-service, and specialized training program conducted and/or sanctioned by the agency;
S. Adequate reference materials are available to program staff and learners;
T. All courses provided include attendance records, lesson plans, instructor name, course evaluations, methods for demonstrating topic proficiency and test results; records of certificates or completion verification;
U. Methods that protect the integrity of testing and assessment processes;
V. Courses are based on competency-based curriculum supported by appropriate materials and course resources;
W. All instructors are qualified to teach course topics; instructors teaching uses of force, first aid, weapons use, etc. are currently certified to instruct such courses;
X. Use of force training includes non-physical, physical, and appropriate use of authorized weapons, force levels, justification, etc.;
Y. Training topics, content, proficiency, and hours/weeks of training is established for pre-service, in-service, and specialized training;
Z. Firearms training covers use, safety, and care of firearms and the legal and ethical constraints on their use. Training includes knowledge and performance, and is assignment specific (e.g. use of weapon in various settings, conditions, areas);
AA. Chemical agent training covers the use and handling of chemical agents, as well as the treatment of persons exposed to a chemical agent;
BB. Emergency responders are available to timely respond to training incidents involving injury.

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

b. Pre-service training for all new employees;

ASSESSMENT: NONCOMPLIANCE

FINDINGS: Similar findings as discussed above. No change since the Baseline visit, previous recommendations remain appropriate.

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: Similar findings as discussed above. No change since the Baseline visit, previous recommendations remain appropriate.

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: Similar findings as discussed above. No change since the Baseline visit, previous recommendations remain appropriate.

RECOMMENDATIONS:

1. Provide the Monitor all training program policies and procedures.
2. In the absence of training program policies and procedures, develop such policies and procedures.

IX. IMPLEMENTATION

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

FINDINGS: Territory officials have completed and submitted to the Monitor and DOJ a more detailed plan and schedule for policy development, training, and implementation. However, this draft document omits several important dates, does not prioritize implementation activities according levels of importance, and appears to remain in draft form. The Monitor and DOJ will consult with Territory officials regarding necessary revisions, but Territory officials are to be commended for the effort displayed in working toward accomplishment of this requirement.

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

FINDINGS: Please refer the findings discussed above. The Monitor has not agreed to the Territory's implementation plan or schedule.

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

FINDINGS: As discussed throughout this assessment report, the Territory provided no evidence that any policies or procedures are in revision. No new policies or procedures or revisions have been provided to the Monitor or DOJ for review and approval as required.

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: This requirement has not been met. The Monitor remains available to assist the Territory as described above.

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

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

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

FINDINGS: Not Assessed.

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: To Be Assessed

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: To Be Assessed

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

FINDINGS: Territory officials provided reasonable access to the facility and staff during the baseline visit. However, it would be helpful and most efficient to the onsite assessment process if requested logs and documents were readily available beginning the first day of each visit.

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

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

EXHIBITS 1 & 2

Criminal Justice
Courts
Law Enforcement
Corrections
Security
Healthcare
Institutional

Federal
State
County
Municipal
Communities

Research
Analysis
Assessment
Development
Implementation
Evaluation

Facilitation
Curricula
Coordination
Collaboration

Systems
Technology
Organizational
Leadership

Recruitment
Selection
Staffing
Training

Policy
Procedure
Risk Management
Legal
Litigation

Fiscal Management
Budget
Grants
Procurement

Options
Alternatives
Strategy
Sustainability

Professional
Competent
Confidential
Ethics
Integrity
Performance

Kenneth A. Ray
JUSTICE SERVICES, LLC
PO Box 1481 Ashland, KY 41105-1481 Phone: 606-694-3031
Email: ken@rjsjusticeservices.com

2nd Monitoring Report
EXHIBIT 1

FEDERAL COURT APPOINTED INDEPENDENT MONITOR

January 28, 2014

Via Electronic Mail

To: ***For the Virgin Islands***

Julius Wilson, Director, Virgin Islands Bureau of Corrections

Kenrick Robertson, Assistant Attorney General, Virgin Islands Department of Justice

Nathen Oswald, Special Assistant Attorney General, Virgin Islands

CC: For the United States

Allyssa Lareau, CRT, Trial Attorney
Special Litigation Section
Civil Rights Division
United States Department of Justice

Sharon Brett, CRT, Trial Attorney
Special Litigation Section
Civil Rights Division
United States Department of Justice

Re: *United States v. Territory of the Virgin Islands*, 86cv265,
2nd Monitoring Assessment Emergent Conditions of Confinement

Director Wilson, Mr. Robertson, Mr. Oswald,

This revises the January 6th, 2014 *2nd Monitoring Assessment Emergent Conditions of Confinement* letter following your review and comment period as required under the Agreement and subsequent to your initial response dated January 14, 2014. Revisions include:

1) Removal of the requested sentence regarding environmental conditions
2) Numbers all bullets for better clarity
3) Clarifies the first sentence of section I. Staffing, A. 15, regarding the relationship between staff, inmates, and contraband
4) Removes the unreferenced foot note as indicated

Your January 21, 2014 response is appreciated and evidences commendable and valuable efforts ultimately relevant to prospective compliance and progress. However, and until these and other improvements are fully implemented, I strongly urge and encourage the Territory to timely take any and all appropriate steps to ameliorate and/or mitigate real and potential risks and harm otherwise discussed in the letter. One such step could include issuing directives requiring GGACF officers to maintain locked housing units; to search all inmates before leaving and entering housing units; to ensure all cells are inspected during each shift; and, to require all supervisors to conduct quality assurance inspections of all housing units during their shifts and to take immediate corrective action involving non-compliance and/or deficiencies exist.

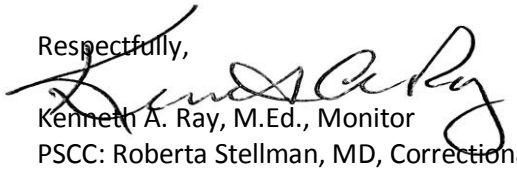
The second onsite monitoring assessment of GGACF was conducted December 9-12, 2013. The assessment was performed by the monitoring team including, Drs. Shansky and Stellman, and myself. Representatives from the Virgin Islands and U.S. Department of Justice participating in this assessment.

As stated in our meetings during the course of this assessment, the monitoring team found conditions of confinement at GGACF virtually unchanged from the September 2013 assessment. Additionally, we expressed our serious concern about several specific unchanged conditions that we believe require expedited remedial action to ensure the safety and welfare of inmates and staff.

These risks involve issues related to 1) staffing levels and staff supervision, 2) security practices and systems, 3) life and fire safety conditions, and 4) medical and mental health assessment and care. I encouraged Territory officials during the onsite assessment to take immediate steps to remove and/or reduce these risks and advised you that I would provide you with more specific details about these findings before submission of the second compliance report to assist in developing and prioritizing an emergency action plan for that purpose. That information is provided herein.

In closing, I want to reiterate that the monitoring team will continue to provide requested technical assistance to the Territory in its efforts to comply with the Settlement Agreement.

Respectfully,



Kenneth A. Ray, M.Ed., Monitor
PSCC: Roberta Stellman, MD, Correctional Mental Health Expert
Ronald Shansky, MD, Correctional Medical Expert

Golden Grove Adult Correctional Facility 2nd Monitoring Assessment
December 9-12, 2013
Urgent Conditions of Confinement Concerns at GGACF
Kenneth A. Ray, Monitor
January 28, 2014

The following articulates certain findings by the monitoring team during the second onsite assessment of GGACF that necessitate emergency action to eliminate and/or reduce safety and welfare risks to inmates and staff. Territory officials are encouraged to take immediate steps to ameliorate these conditions due to their critical nature, real and potential imminent harm these conditions pose to facility security, inmate and staff well-being.

I. Staffing:

A. Correctional Staffing and Inmate Supervision

The serious safety and security risk reported in the Findings of Fact Report and the First Monitoring Report were found to be unchanged. Inadequate staffing levels and staff supervision continue to create dangerous safety and security practices and conditions that expose staff and inmates to actual and potential risk of harm throughout the facility. Some of the most urgent and pervasive examples once again found during the second site assessment include:

1. Chronic staffing shortages resulting in housing units operating with one or no officers.

2. Officers not showing up for work when scheduled and/or refusing to work assigned areas.

3. Officers refusing to work certain housing areas due to fear of inmates and unsafe conditions.

4. Housing unit sally port entrance doors, internal security gates, and control room doors remaining unlocked.

5. Security gates throughout the campus being left unlocked and/or standing open.

6. Officers leaving housing units unattended.

7. Officers being afraid to enter the housing unit alone and/or with no back-up officer to conduct cell inspections and/or security checks; they remain in the unit control room.

8. Officers being required to work extensive overtime that can cause mental fatigue and impair their alertness and awareness to safety and security threats.

9. Access gates leading into housing units are routinely left opened and/or unlocked when officers enter the housing units.

10. Lack of officers contributes to lax security practices and sound inmate supervision as evidenced by inmates being allowed to obstruct visibility into their cells using blankets, towels,

cardboard, and/or paper products. Officers cannot see into many prison and detention unit cells due to these obstructions and do not open cell doors for security inspections as a general rule.

11. Inadequate staffing and security practices, for example, impair timely and effective response to security incidents as observed while touring unit 9A, the isolation unit of the detention center. An inmate was able to breach the lock on his cell and access the pod day room. An officer then locked the housing unit gate and the inmate eventually returned to his cell. This inmate could have just as easily bolted out of the building and/or gained access to the officer.

12. Lack of adequate inmate body searches. For example, an inmate was not properly searched before leaving his housing unit or entering the medical facility for services. While receiving medical services from health care staff this inmate produced a shank in the form of a metal coat hanger that he indicated was needed for his protection against other inmates. This device could have easily been used by this inmate to cause serious physical injury to health care staff.

13. In one medical event, a female inmate in X-dorm went into a diabetic coma when no security officers were on the unit. The other female inmates had to scream through the unit windows until another officer who was passing by the building responded and the inmate was subsequently transported to the hospital for care.

14. In another security event in the prison lockdown unit, a handcuffed inmate being escorted by two officers was able to break away from the officers and exit the building before being caught because the pod security gate and housing unit sally port doors were unsecured.

15. Inadequate staffing levels, undertrained and under-supervised staff, under-monitored and under-supervised inmates contribute to the presence of dangerous contraband in housing units. For example, while touring 9B, this Monitor found a 4-inch knife blade openly sitting on the top bunk of an inmate's cell. This clearly suggests this inmate had little or no concern of this weapon being detected by security staff. Upon my notifying security staff of this weapon, the knife was removed and the inmate was locked in his cell before the cell was searched for more contraband or weapons. During the shakedown, other contraband, including screws, frayed bits of cell phone chargers, a cell phone battery, seeds (potentially of marijuana) and "dime bags" (typically used to store drugs) were also recovered. Per the above incident, the presence of contraband in plain view in a cell indicates that the inmates are confident that security staff will never conduct rounds or enter the prisoners' cells to conduct a contraband check. This is a very unsafe security practice because it allows the inmate to obtain other possible weapons in preparation for officers to return and search his cell.

16. During our tour of the juvenile unit, the single unit officer was observed sleeping when we entered the unit. This officer made no attempt to interact with the inmates during our visit, and one juvenile inmate stated that the officers seldom enter the housing area. The two juvenile prisoners were essentially left locked in the housing unit without supervision, having full run of the unit and easy access to broken broom handles. These potential weapons were found covered by a very large mound of trash in one unoccupied cell. This trash pile, which consisted of a large quantity of combustible refuse, appeared to have been there for a long time based on the presence of some decayed food products found.

17. Regarding unlocked security gates and housing units, the Warden stated that many officers do not lock them and/or leave them open for their own safety when entering the units. He stated that officers do not want to be locked in the units with inmates with only one set of keys, especially when there is only one officer on the unit and/or when they do not have radios to summon for assistance if the inmates attempt to take the officer hostage and overrun the unit. This situation is made even more dangerous because the unit officers are not issued weapons they can easily access for self or inmate protection. Officers are, thereby, in extreme danger each time they enter a housing unit.

18. Unit and supervisor log books are filled with examples of the emergency nature of GGACF staffing levels. Unit officers write such entries as "this unit is unmanned," "radios are nonfunctional," "no supervisor came on the unit," "no relief officer," and, "I will not be responsible if anything goes wrong…." Supervisor log books verify that there are times when units are not staffed and inmates are not supervised. The women's unit frequently goes without any officer on duty, especially during overnight shifts while inmates are locked in their cells.

19. It was also learned that there are times when only one of three security towers are operational due to staffing shortages. This is a serious problem, as it leaves internal and external security perimeters completely unmonitored where unstaffed towers are located. This condition is worsened due to several nonworking perimeter lights.

B. Medical and Mental Health Staffing

Inadequate medical and mental health staffing levels continue to prevent Golden Grove from providing constitutionally adequate care.

1. The logbook entries are replete with examples of medical and mental health care issues being flagged by security staff, along with a note that "no doctor is available" or "no one present in medical." When the woman in the diabetic coma, discussed above, was transported to the hospital, for example, there was no medical staff on duty. As a result, there was no documentation in the prisoner's medical record regarding the prisoner's hospitalization, her return, or any follow-up treatment. But for the log book entries recording this event, it was as if it never happened.

2. The intake health screening requirements of the agreement cannot be met until there is 24-hour medical care available. The monitoring team was advised by Territory officials that the "paperwork had been submitted for night nurses" but nothing was finalized yet. According to the HSA, she had never been shown the resumes submitted for those positions. However, during a meeting with the director, this monitor was shown a resume packet of nursing applicants and was advised that several applicants were approved for hire but no start dates were provided.

3. While on-site, we observed how the lack of coordination between security staff in intake and medical staff leads to a high risk of harm to prisoners. On Monday morning (December 9, 2013), intake forms were obtained by Medical for prisoners who came in at 8:35 pm Friday and 6:09 pm Sunday. Both forms indicated numerous positive responses to questions related

to chronic medical needs (diabetes), potential withdrawal (alcohol), and mental health risks ("talks and answers himself, appears to be delusional"). These positive responses should have led to immediate notification to medical/mental health staff, due to the risk the prisoners so obviously faced.

4. In addition to identifying urgent nursing needs, the HSA also requested a medical records assistant and recommended a candidate. However, BOC leadership has not acted on her request and recommendation at this time. The HSA indicated that she does not have time to begin to write the policies required by the Agreement, as she is overburdened with administrative duties that could be handled by an assistant. Even without an assistant, the medical records reviewed were disorganized and missing key information. There were no appointment logs and thus there was no way of knowing whether a prisoner with urgent medical or mental health needs was being seen as needed.

5. The current psychiatrist on-site planned to retire by the end of 2013. Although a replacement, Dr. Sang, was reportedly hired, telephone conversations with Dr. Sang caused concern that she had not been contacted about a start date. Even with the current psychiatrist, there are very few hours of mental health care being provided every week.

6. The one unlicensed mental health counselor on-site tries, but oftentimes prisoners are not transported to their appointments due to a lack of security staff available to transport. As a result of the lack of mental health staff, there are no real suicide prevention or mental health care programs in place. For the second time, we were told that no suicide watches had been initiated in the previous three month period, only to discover through logbook entries that security staff had initiated a watch on their own and had decided when to discontinue the watch, all without notifying mental health staff. Staff are clearly acting without the benefit of clear policies, procedures, supervision, and/or management communication. There was no corresponding documentation of a watch in the medical file. Furthermore, our tour of both detention and prison segregation units found mentally ill inmates, some presenting with paranoid and/or symptom deterioration who stated that they had not seen a mental health staff person in weeks. This is very troubling considering that these inmates were allowed to maintain obstructed view into their cells and/or their cells were so dark that I was unable to see into the living area. These conditions severely impair adequate security supervision of these inmates, and such sensory deprivation can exacerbate psychiatric pathologies causing more severe and prolonged psycho-emotional suffering.

7. With regard to medical staff, while on-site we were informed that the medical director for BOC had only been to the facility six times since our last visit. After bringing this to the attention of BOC leadership, the Director was removed from her position during the week. Another candidate was approached, but given the delays and difficulties getting contracts finalized, it is unclear when and if he will actually start his duties.

8. As noted above, during the week I was told about various medical and mental health hires. However, the HSA and candidates seemed unsure as to whether this staff would ever actually start. At a mid-week meeting, the Director told the HSA that she should begin selecting

candidates for the nursing positions, but she was unable to access resumes that had been submitted months ago. When we left, she was still working on gathering this information.

9. With regard to security staff, at the very end of the week a meeting was arranged between the Monitor and the Director of the Bureau of Corrections. At that meeting, the Director indicated that he has approval to hire 30 new corrections officers and that 14 will be entering the academy "sometime before the end of the month." However, as of the end of the visit, no academy start date had been scheduled. It is now the beginning of January 2014, and we have not received any confirmation that these new hires were brought on board and that a new academy class began. It is also unclear why these plans were not revealed to us at the beginning of the visit. One possible explanation was that BOC's human resources director (also training director and director of administration) was on leave during our visit, as she was during our last visit, and other BOC personnel did not have ready access to her files.

II. Inadequate Safety Equipment and Inadequate Training on Use of Equipment

In addition to the staffing shortage, the logbooks also highlighted the lack of working safety equipment in many of the units.

1. Equipment lists on different units often noted that the unit was without a working radio, empty first-aid boxes, and/or no suicide cut down tools. In some instances, particularly in the X-Dorm, the units went without a working radio or phone for weeks at a time. The absence of reliable communication devices presents extreme risk to staff and inmate safety, especially if there is only one officer assigned to each housing unit. If an incident were to occur, the officer would have no way of calling for help. The fact that many of the male units are staffed by one female officer makes this threat even more real and present.

2. We also observed that not every unit had a cut down tool or a working flashlight. And, in at least one instance, the officer on duty did not believe there was a cut down tool available, when in fact one was located at the back of a locked box. It was clear to me that, even where equipment is available, the officers are unaware and therefore unable to use that equipment in an emergency. In one unit where there was a cut down tool, the tool was locked on a wall-mounted cabinet that was too high for the officer to reach.

3. Housing unit equipment logs are not maintained consistently. Logs were found incomplete with some logs missing equipment verification entries for several days at a time. It is clear that these logs are not consistently monitored for quality assurance by supervisor staff.

III. Physical Plant Issues

Numerous environmental hazards were observed during the compliance monitoring tour. Golden Grove's facility is old and in need of much repair.

1. It rained off and on during our visit, creating significant flooding in most of the housing units. Standing water on the floor of the units creates numerous safety risks. Exposed electrical wiring near dripping water was also found.

2. Mold remains prolific throughout the housing units. All of the housing units have a large level of mildew and mold throughout. Some inmates complained that their health is deteriorating as a result of these conditions. One inmate complained that mold in his cell is exacerbating his chronic asthma and he is having difficulty breathing

3. The kitchen remains filthy with rotting food bi-products under sinks, stoves, and between broken floor tiles. Additionally, there appears to be no effective control over cooking instruments such as knives, large metal spoons, etc. During our tour we found the kitchen tool room door unlocked and standing open, the tool cage open and unlocked, several tools, including knives and large metal spoons, missing. No security officers were present on the floor at this time and the two civilian kitchen staff were both sitting in the office socializing with an officer while several inmates cleaned the kitchen area unsupervised.

4. The lack of a working fire safety system is also a very serious concern. The cell fire sprinklers are used by virtually every inmate to anchor homemade clotheslines. It is unclear whether or when the facility plans to fix the sprinkler system so that it is fully operational.

Conclusion and Recommendations:

As previously stated, this is a non-exclusive list of specific serious issues found during the second monitoring site visit that beg for urgent attention and resolution. Considering the potentially life threating nature of many of these findings, Territory officials are encouraged to immediately take the following action:

1. Expedite the hiring and adequate training of all open staff positions – corrections, medical, and mental health. Develop an emergency hire plan that includes deadlines for having all positions trained and working.

2. Stop the practice of allowing inmate housing units to go unstaffed, inmates unsupervised.

3. Stop the practice of leaving housing unit sally port doors, internal security gates, and officer control room doors open and/or unlocked. These doors should remain closed and locked at all times except for authorized movement.

4. Ensure that all housing units are consistently supplied with reliably functioning radios for all officers assigned to the unit, and with all other equipment needed to provide safe and secure supervision of the unit and inmates, i.e. cut down tools, flashlights, etc.

5. Do not allow officers to enter housing units with security keys and without the presence of another officer who can rapidly respond if needed.

6. Ensure adequate, proper, and active management of the juvenile unit and supervision of juvenile inmates.

7. Increase supervisor presence in housing units to perform quality assurance functions and staff supervision.

8. Remove all coverings from cell door windows and cell areas that block clear and complete view inside cells. Also, inmates, especially mentally ill inmates, should not be allowed to live in dark cells as previously discussed.

9. Ensure inmates are properly searched for contraband when leaving and returning to their units, when entering and leaving other facility buildings.

10. Develop a comprehensive plan for repair and/or replacement of all non-functioning security mechanisms, equipment, systems, and lighting. Include a comprehensive plan for repair or replacement of the fire suppression system. These plans should include completion deadlines.

END REPORT

Golden Grove Adult Correctional Facility 2nd Monitoring Assessment
December 9-12, 2013
Urgent Conditions of Confinement Concerns at GGACF
Kenneth A. Ray, Monitor
January 28, 2014

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cardboard, and/or paper products. Officers cannot see into many prison and detention unit cells due to these obstructions and do not open cell doors for security inspections as a general rule.

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15. Inadequate staffing levels, undertrained and under-supervised staff, under-monitored and under-supervised inmates contribute to the presence of dangerous contraband in housing units. For example, while touring 9B, this Monitor found a 4-inch knife blade openly sitting on the top bunk of an inmate's cell. This clearly suggests this inmate had little or no concern of this weapon being detected by security staff. Upon my notifying security staff of this weapon, the knife was removed and the inmate was locked in his cell before the cell was searched for more contraband or weapons. During the shakedown, other contraband, including screws, frayed bits of cell phone chargers, a cell phone battery, seeds (potentially of marijuana) and "dime bags" (typically used to store drugs) were also recovered. Per the above incident, the presence of contraband in plain view in a cell indicates that the inmates are confident that security staff will never conduct rounds or enter the prisoners' cells to conduct a contraband check. This is a very unsafe security practice because it allows the inmate to obtain other possible weapons in preparation for officers to return and search his cell.

16. During our tour of the juvenile unit, the single unit officer was observed sleeping when we entered the unit. This officer made no attempt to interact with the inmates during our visit, and one juvenile inmate stated that the officers seldom enter the housing area. The two juvenile prisoners were essentially left locked in the housing unit without supervision, having full run of the unit and easy access to broken broom handles. These potential weapons were found covered by a very large mound of trash in one unoccupied cell. This trash pile, which consisted of a large quantity of combustible refuse, appeared to have been there for a long time based on the presence of some decayed food products found.

17. Regarding unlocked security gates and housing units, the Warden stated that many officers do not lock them and/or leave them open for their own safety when entering the units. He stated that officers do not want to be locked in the units with inmates with only one set of keys, especially when there is only one officer on the unit and/or when they do not have radios to summon for assistance if the inmates attempt to take the officer hostage and overrun the unit. This situation is made even more dangerous because the unit officers are not issued weapons they can easily access for self or inmate protection. Officers are, thereby, in extreme danger each time they enter a housing unit.

18. Unit and supervisor log books are filled with examples of the emergency nature of GGACF staffing levels. Unit officers write such entries as "this unit is unmanned," "radios are nonfunctional," "no supervisor came on the unit," "no relief officer," and, "I will not be responsible if anything goes wrong…." Supervisor log books verify that there are times when units are not staffed and inmates are not supervised. The women's unit frequently goes without any officer on duty, especially during overnight shifts while inmates are locked in their cells.

19. It was also learned that there are times when only one of three security towers are operational due to staffing shortages. This is a serious problem, as it leaves internal and external security perimeters completely unmonitored where unstaffed towers are located. This condition is worsened due to several nonworking perimeter lights.

B. Medical and Mental Health Staffing

Inadequate medical and mental health staffing levels continue to prevent Golden Grove from providing constitutionally adequate care.

1. The logbook entries are replete with examples of medical and mental health care issues being flagged by security staff, along with a note that "no doctor is available" or "no one present in medical." When the woman in the diabetic coma, discussed above, was transported to the hospital, for example, there was no medical staff on duty. As a result, there was no documentation in the prisoner's medical record regarding the prisoner's hospitalization, her return, or any follow-up treatment. But for the log book entries recording this event, it was as if it never happened.

2. The intake health screening requirements of the agreement cannot be met until there is 24-hour medical care available. The monitoring team was advised by Territory officials that the "paperwork had been submitted for night nurses" but nothing was finalized yet. According to the HSA, she had never been shown the resumes submitted for those positions. However, during a meeting with the director, this monitor was shown a resume packet of nursing applicants and was advised that several applicants were approved for hire but no start dates were provided.

3. While on-site, we observed how the lack of coordination between security staff in intake and medical staff leads to a high risk of harm to prisoners. On Monday morning (December 9, 2013), intake forms were obtained by Medical for prisoners who came in at 8:35 pm Friday and 6:09 pm Sunday. Both forms indicated numerous positive responses to questions related

to chronic medical needs (diabetes), potential withdrawal (alcohol), and mental health risks ("talks and answers himself, appears to be delusional"). These positive responses should have led to immediate notification to medical/mental health staff, due to the risk the prisoners so obviously faced.

4. In addition to identifying urgent nursing needs, the HSA also requested a medical records assistant and recommended a candidate. However, BOC leadership has not acted on her request and recommendation at this time. The HSA indicated that she does not have time to begin to write the policies required by the Agreement, as she is overburdened with administrative duties that could be handled by an assistant. Even without an assistant, the medical records reviewed were disorganized and missing key information. There were no appointment logs and thus there was no way of knowing whether a prisoner with urgent medical or mental health needs was being seen as needed.

5. The current psychiatrist on-site planned to retire by the end of 2013. Although a replacement, Dr. Sang, was reportedly hired, telephone conversations with Dr. Sang caused concern that she had not been contacted about a start date. Even with the current psychiatrist, there are very few hours of mental health care being provided every week.

6. The one unlicensed mental health counselor on-site tries, but oftentimes prisoners are not transported to their appointments due to a lack of security staff available to transport. As a result of the lack of mental health staff, there are no real suicide prevention or mental health care programs in place. For the second time, we were told that no suicide watches had been initiated in the previous three month period, only to discover through logbook entries that security staff had initiated a watch on their own and had decided when to discontinue the watch, all without notifying mental health staff. Staff are clearly acting without the benefit of clear policies, procedures, supervision, and/or management communication. There was no corresponding documentation of a watch in the medical file. Furthermore, our tour of both detention and prison segregation units found mentally ill inmates, some presenting with paranoid and/or symptom deterioration who stated that they had not seen a mental health staff person in weeks. This is very troubling considering that these inmates were allowed to maintain obstructed view into their cells and/or their cells were so dark that I was unable to see into the living area. These conditions severely impair adequate security supervision of these inmates, and such sensory deprivation can exacerbate psychiatric pathologies causing more severe and prolonged psycho-emotional suffering.

7. With regard to medical staff, while on-site we were informed that the medical director for BOC had only been to the facility six times since our last visit. After bringing this to the attention of BOC leadership, the Director was removed from her position during the week. Another candidate was approached, but given the delays and difficulties getting contracts finalized, it is unclear when and if he will actually start his duties.

8. As noted above, during the week I was told about various medical and mental health hires. However, the HSA and candidates seemed unsure as to whether this staff would ever actually start. At a mid-week meeting, the Director told the HSA that she should begin selecting

candidates for the nursing positions, but she was unable to access resumes that had been submitted months ago. When we left, she was still working on gathering this information.

9. With regard to security staff, at the very end of the week a meeting was arranged between the Monitor and the Director of the Bureau of Corrections. At that meeting, the Director indicated that he has approval to hire 30 new corrections officers and that 14 will be entering the academy "sometime before the end of the month." However, as of the end of the visit, no academy start date had been scheduled. It is now the beginning of January 2014, and we have not received any confirmation that these new hires were brought on board and that a new academy class began. It is also unclear why these plans were not revealed to us at the beginning of the visit. One possible explanation was that BOC's human resources director (also training director and director of administration) was on leave during our visit, as she was during our last visit, and other BOC personnel did not have ready access to her files.

II. Inadequate Safety Equipment and Inadequate Training on Use of Equipment

In addition to the staffing shortage, the logbooks also highlighted the lack of working safety equipment in many of the units.

1. Equipment lists on different units often noted that the unit was without a working radio, empty first-aid boxes, and/or no suicide cut down tools. In some instances, particularly in the X-Dorm, the units went without a working radio or phone for weeks at a time. The absence of reliable communication devices presents extreme risk to staff and inmate safety, especially if there is only one officer assigned to each housing unit. If an incident were to occur, the officer would have no way of calling for help. The fact that many of the male units are staffed by one female officer makes this threat even more real and present.

2. We also observed that not every unit had a cut down tool or a working flashlight. And, in at least one instance, the officer on duty did not believe there was a cut down tool available, when in fact one was located at the back of a locked box. It was clear to me that, even where equipment is available, the officers are unaware and therefore unable to use that equipment in an emergency. In one unit where there was a cut down tool, the tool was locked on a wall-mounted cabinet that was too high for the officer to reach.

3. Housing unit equipment logs are not maintained consistently. Logs were found incomplete with some logs missing equipment verification entries for several days at a time. It is clear that these logs are not consistently monitored for quality assurance by supervisor staff.

III. Physical Plant Issues

Numerous environmental hazards were observed during the compliance monitoring tour. Golden Grove's facility is old and in need of much repair.

1. It rained off and on during our visit, creating significant flooding in most of the housing units. Standing water on the floor of the units creates numerous safety risks. Exposed electrical wiring near dripping water was also found.

2. Mold remains prolific throughout the housing units. All of the housing units have a large level of mildew and mold throughout. Some inmates complained that their health is deteriorating as a result of these conditions. One inmate complained that mold in his cell is exacerbating his chronic asthma and he is having difficulty breathing

3. The kitchen remains filthy with rotting food bi-products under sinks, stoves, and between broken floor tiles. Additionally, there appears to be no effective control over cooking instruments such as knives, large metal spoons, etc. During our tour we found the kitchen tool room door unlocked and standing open, the tool cage open and unlocked, several tools, including knives and large metal spoons, missing. No security officers were present on the floor at this time and the two civilian kitchen staff were both sitting in the office socializing with an officer while several inmates cleaned the kitchen area unsupervised.

4. The lack of a working fire safety system is also a very serious concern. The cell fire sprinklers are used by virtually every inmate to anchor homemade clotheslines. It is unclear whether or when the facility plans to fix the sprinkler system so that it is fully operational.

Conclusion and Recommendations:

As previously stated, this is a non-exclusive list of specific serious issues found during the second monitoring site visit that beg for urgent attention and resolution. Considering the potentially life threating nature of many of these findings, Territory officials are encouraged to immediately take the following action:

1. Expedite the hiring and adequate training of all open staff positions – corrections, medical, and mental health. Develop an emergency hire plan that includes deadlines for having all positions trained and working.

2. Stop the practice of allowing inmate housing units to go unstaffed, inmates unsupervised.

3. Stop the practice of leaving housing unit sally port doors, internal security gates, and officer control room doors open and/or unlocked. These doors should remain closed and locked at all times except for authorized movement.

4. Ensure that all housing units are consistently supplied with reliably functioning radios for all officers assigned to the unit, and with all other equipment needed to provide safe and secure supervision of the unit and inmates, i.e. cut down tools, flashlights, etc.

5. Do not allow officers to enter housing units with security keys and without the presence of another officer who can rapidly respond if needed.

6. Ensure adequate, proper, and active management of the juvenile unit and supervision of juvenile inmates.

7. Increase supervisor presence in housing units to perform quality assurance functions and staff supervision.

8. Remove all coverings from cell door windows and cell areas that block clear and complete view inside cells. Also, inmates, especially mentally ill inmates, should not be allowed to live in dark cells as previously discussed.

9. Ensure inmates are properly searched for contraband when leaving and returning to their units, when entering and leaving other facility buildings.

10. Develop a comprehensive plan for repair and/or replacement of all non-functioning security mechanisms, equipment, systems, and lighting. Include a comprehensive plan for repair or replacement of the fire suppression system. These plans should include completion deadlines.

END REPORT

EXHIBIT 2

2nd Compliance Monitoring Report
DESCRIPTIVE NARRATIVE OF FACILITY ASSESSMENT FINDINGS

This descriptive narrative intends to provide a detailed overview of findings during this assessment, and to serve as a foundation for Compliance Ratings.

Conditions of Confinement, Safety and Security Overview

Upon entry to the facility, the entrance gate leading to the main electronic security gate was unsecured. A cursory inspection of the security mechanism indicates that the gate is out of alignment with the electronic latch, causing intermittent latch failure. This security problem was also found and discussed in the Baseline Report.

A reasonable search of persons and possessions was conducted by the entrance security officer but there were not enough visitor badges for the monitoring team and USDOJ officials. It was reported that all badges were currently in use.

The facility yard appeared recently mowed and clean with a few inmate workers tending to their work responsibilities under the general supervision of one officer. Two un-cuffed female inmates were being escorted toward us by an officer; one of these inmate wore proper inmate clothing, the other was out of uniform and wearing a New York Giants uniform jacket.

The yard security gates leading to building 9 were unlocked and the electronics appeared to be broken and inoperable. All three security gates on secured walkway to building 9 were unlocked and standing open.

Building 9 (Bravo): The security gate to 9-Bravo is secured, requiring key lock. However, the door to the officer's station is unlocked. The housing unit Activity Room/Day Room ceiling is covered with mold. Eating tables on two surfaces are broken and need to be repaired. There is minor rubbish on the ground and standing water near the window. There are several exposed wires hanging from the ceiling and from electrical areas that power the TV. The ceiling going into this multi-purpose room is damaged. Due to recent heavy rain fall and roof problems, water is leaking from a corner down the wall onto the floor and into a bucket.

The swamp cooler is functioning and the air temperature feels reasonably comfortable. The medical exam room has been partially retiled. The sink is working because the water has been left running. There are broken and missing ceiling tiles. A plastic fork is jammed into the exam room entrance door preventing it from locking. The janitor's closet door is open and propped open. There appears to be a cable wire loose and unconnected atop of a stainless steel shelf that is long enough to be used potential weapon, ligature, or whip. There are hoses connected the faucets, the sink appears reasonably clean, and the water is working.

9 Bravo has four showers on the lower tier and upper tiers. The first lower tier shower floor has mold and broken concrete with exposed rocks. The plaster ceiling paint is peeling, there are soap stains and soap pieces lying on the ground, which are slip hazards. The second shower is similar to the first. It also appears to have a broken faucet. The water is running freely and the air vents appear to be somewhat plugged up. The third shower appears to be a bit cleaner; however, this shower is inoperable. The faucets are missing and the hot and cold water pipes are exposed. The fourth shower appears to be inoperable. The ceiling and paint are peeling, and the floor appears reasonably clean.

An inspection of ground level (lower tier) inmate cells found safety, security, and sanitation problems.

Cell 1-B was locked and unoccupied. However, the door window screen mesh is covered with a substance blocking the view.

Cell 2-B is unlocked. The steel window grate looks fairly new. There is one inmate lying down, apparently asleep. The room is reasonably clean but dark. The lights are off. There is a homemade clothesline tied from the sprinkler head over to the window. There is a plug-in fan. The sink does not work. The toilet is running. This is a 2-person cell with one person in it. The top bunk is being used for personal possessions, books, etc. An adequate supply of personal hygiene products appears to be present.

Cell 3-B is locked. It is a 2-person cell and appears unoccupied and appears clean; however, dark.

Cell 4-B is locked. This cell is unoccupied. The screen window mesh appears intact. It is dark, and I don't know if the water is running or not because I was unable to enter the cell.

Cell 5-B has a towel hanging over the screen; however, it is open. This is an occupied cell, one person in this cell. It appears that this person has their own supply of ice in an ice cooler. The toilet flushes. The sink works. It appears reasonably clean and organized. There are two homemade ashtrays from a metal can that can also serve as a puncture weapon. The room appears organized with appropriate personal hygiene supplies. This cell has a homemade clothesline attached to the sprinkler head and the window.

Cell 6-B has a cover over the door window screen about halfway up from the inside. It is unlocked and occupied. There is a little bit of standing water on the floor. The toilet and sink are functional. There is an array of disorganized personal possessions on the top bunk as well as food products, empty water bottles, mail, clothing, and marked and unmarked medication bottles; the unmarked bottle is empty. The electrical power socket has a power surge protector; however, it is uncapped. There is a substantial amount of water running under the bottom bunk due to leaking from the rain.

Cell 7-B is a handicapped cell that appears unoccupied and is locked. The door window screen mesh has been pushed in and is rusted and dirty.

Cell 8-B is occupied and unlocked. The door window screen mesh is dirty with a dime-sized hole in the mesh. The cell is dark. The sink works but the toilet does not flush. The floor appears dry;

however, there is an unplugged electric fan with a damaged cord. The fan's motor assembly is uncovered and exposed, which exposes its electrical functioning making it a safety hazard. There is also some sort of power plug plugged into the receptacle with the surge protector. The power plug is running under the bunk and connected to a DVD player. The top bunk is cluttered with an assortment of personal possessions, i.e., movies, clothing. There appears to be an adequate supply of personal hygiene products.

B-56 is a locked pass-through door to the adjacent Unit. The vestibule area floor has dirt, old batteries, old plastic sporks (plastic combination of spoon and fork), waste and some sort of electrical wire laying on it. These items should be completely removed to provide unobstructed movement of staff and inmates in the case of an emergency.

Cell 9-B is another handicapped cell. Again, I cannot see through, it is dark. The mesh is filthy with dust and something else.

Cell 10-B was closed but unlocked. This cell appears to be unoccupied. There is no bed in here. The sink is operable but the toilet is not operable. There appears to be waste in the toilet, i.e., a fork, some paper and some sort of powder substance covering the lip of the toilet. There also appears to be some sort of insulation stuffing, maybe out of a mattress that has been torn up. This cell is filthy, unoccupied, but accessible to inmates and it should not be accessible to inmates if it is unoccupied. Just about everything in here is combustible and a fire hazard, especially considering the fact that inmates are allow the use of tobacco and lighters.

Cell 11-B is a handicap cell that is locked, unoccupied, and reasonably clean.

Cell 12-B is locked, unoccupied, and appears to be clean.

Cell 13-B is occupied and locked. The cell appears to be clean and somewhat organized. The bed is made. There are personal belongings as well as empty paper cups and commissary product packages on the top bunk. There appears to be an adequate supply of personal hygiene. There is a fan, similar to the previous fan, plugged in and not running but the motor assembly is exposed, exposing the electrical components of the fan.

Cell 14-B is occupied and open. The toilet flushes and the sink works; however, the sink appears to have a homemade rubber faucet to direct the water. The cell is reasonably clean. There are several empty plastic bottles, i.e., juice bottles, personal hygiene bottles. The top bunk has personal clothing and personal possessions that look well organized and clothing folded. There is a homemade clothesline attached from the sprinkler head to the window as noted before. There is an unplugged electric fan with exposed electrical components and motor assembly. There is a red line tied to the inside of the door to allow the inmate to close the door at will. A wet towel is rolled up at the inside base of the door that inmate stated "is needed to keep the large centipedes out…"

Cell 15-B is a handicapped cell that has a fairly new metal mesh. It appears empty but I cannot see inside because it is dark.

Cell 16-B is unlocked and occupied. The cell floor appears to be clean. There are wet T-shirts or some clothing at the cracks of the wall base to prevent water from coming in. Top bunk is cluttered with personal possessions, covered food products, water products, plastic forks, combustible products, personal hygiene products. The bed has no blanket.

An inspection of the upper tier of 9 Bravo found conditions similar to its lower tier. This tier also has four showers. Shower one is apparently broken and the floor area reasonably clean. The shower head is covered with plastic. Shower two has stains around the shower head but it is functional. The floor is reasonably clean. Shower three is functional with peeling paint. Floor appears to be reasonably clean. Shower four appears to be functional but the paint is peeling and there is a considerable amount of mold present.

An inspection of upper-tier inmate cells found similar safety, security, and sanitation problems.

Cell 17-B is locked, appears to be unoccupied, and the door window grate appears new.

Cell 18-B is locked, apparently occupied, and the screen mesh is torn at the base offering loose small wire shards that can be used for a weapon. It was difficult to see inside due to the damaged window mesh but the cell looks reasonable clean. There is a homemade clothesline attached to the sprinkler head running to the window. There appears to be an adequate supply of personal hygiene products.

Cell 19-B is locked and occupied; however, the fairly new door screen grate is covered by paper, preventing visibility to the inside. An internal inspection found two homemade clotheslines as previously described. The cell seems reasonably clean and organized. There appears to be a homemade ashtray on the top bunk, a bottle of "White Out" correction fluid, and a knife blade that is approximately four inches in length that will need to be removed immediately and conducted a contraband search. There is an electrical fan with frayed wires. There appears to be an adequate supply personal hygiene products. The presence the openly exposed knife blade in this unit is indicative of a lack of cell searches or attention to detail by operation staff running this unit.

Cell 20-B is locked with a fairly new door window metal grate; however, this window is covered by a cardboard that obscures internal visibility. Water appears to be working in this cell. As with other cells, this cell has makeshift clotheslines attached from the sprinkler head to the window and the sprinkler head to the upper bunk area. The table is reasonably organized with personal possessions and clothing. There appears to be an adequate hygiene products on the table. The top bunk is holding mostly books and papers. There is a small fan plugged in and attached to the top bunk. Motor assembly appears to be covered as manufactured.

Cell 21-B is locked and not occupied. It has rubbish, trash bags in it. It does not appear to have been cleaned in quite some time. The walls are covered with peeling paint. The locking mechanism appears to be broken with cellophane commissary product bags stuck in the locking mechanism.

Cell 22-B is locked with a fairly new metal grate on the door window that is unobstructed. There is a clothesline attached from the sprinkler head to the window. The mattress consists of what

appears to be stacked shards of torn insulation from a mattress that present a significant fire hazard. There does not appear to be a standard mattress in this cell. There are also trash bags and other personal effects lying about.

Cell 23-B is locked and appears occupied, the door window mesh is somewhat covered and damaged, and the room is dark with a homemade clothesline as previously described.

Cell 24-B is locked and appears occupied. The door window mesh is dirty but does not obstruct internal visibility. There is a plastic bag at the bottom, either to keep out the centipedes or water. The room's floor appears to be clean. Bed is made and there appears to be and adequate supply of personal hygiene products.

Cell 25-B is locked and appears occupied. The door window mesh appears intact and does not obstruct internal visibility. There is a towel hanging over the top bunk that prevents viewing to the bottom bunk. There is also a smell of marijuana emitting from this cell. There is a plugged in DVD player, a fan, and an adequate supply of personal hygiene products.

Cell 26-B is locked and occupied with what appears to be a fairly new door grate that is unobstructed. It appears to be reasonably kept and what appears to be an adequate supply of personal hygiene products.

Cell 27-B is locked and appears to be unoccupied; however, it has not been cleaned out. There are old cellophane food wrappers scattered on the floor. There is a homemade rope tied to the bottom of the bench.

Cell 28-B is locked and occupied by an inmate who states he is in "lock-down for security reasons." A towel is mounted to the top bunk that covers visibility into the bottom bunk. The cell, though dark, appears to have an adequate supply of personal hygiene products and is reasonably well kept.

Cell 29-B is occupied and locked. It is fairly sparse with personal belongings; however, this cell has a homemade curtain using a sheet that is anchored to the ceiling. This should be removed. Looks like a fairly new mattress but no bedding on the mattress. There appears to be an adequate supply of personal hygiene products.

Cell 30-B is locked and occupied. The door window mesh is in fair condition. There is a large fan inside. Again, there is a homemade clothesline attached to the sprinkler head to the window. This is fairly well kept and does not appear cluttered. The inmate appears to keep it fairly clean and organized. There appears to be an adequate supply of personal hygiene supplies.

Cell 31-B is locked and occupied. Screen mesh is hard to see through but I can see because of the natural light. It has a clothesline anchored from the sprinkler head to the window. It has full trash bags on the upper bunk. There is also a foot locker near the bottom bunk where the inmate sleeps, between the bed and table that has a DVD player on it. There appears to be a large can being used for an ashtray; there is a faint odor of burnt tobacco.

Cell 32-B is unlocked and occupied. There is a towel draped over the top of the door that covers the inside of the metal grate. Again, the security visibility practices here reflect lack of attention to standard security policies and practices that are very dangerous for inmates and staff.

The Day Room environment of 9 Bravo is reasonably clean. Inmates are socializing and playing cards. Some of the inmates are wearing prison uniforms, others are wearing personal clothing such as personal shorts, personal T-shirts, personal tennis shoes, flip flops. The television appears to be gone. The swamp cooler is working and blowing air. The Grievance Form and Inmate Request Forms box, which would be for medical and inmate grievances, has a missing top and provides no protection for these documents.

The corrections officer came from the 9 Bravo control room into the housing unit, leaving the gate unlocked, which is a condition of the lack of staffing that requires them to carry security keys into it and leave the gate unlocked. Leaving the gate unlocked from the inside gives inmates access to the outside and to the control room. The control room for 9-Bravo is unlocked. The gate is unlocked and an inmate could easily enter this control room. Entering the control room, they would have direct access to the fire extinguisher that could be used as a weapon. There are chemicals setting on desks. This security deficiency gives inmates easy access to the lighting system, fire alarm systems. They would have access to coat hangers and areas in this control room. 9 Bravo control room does not have any security control systems in it. Ceiling panels are missing, exposing electrical wires that would be too high to reach without a ladder. Between the two control rooms (Alpha and Bravo) is the bathroom, which appears to be fairly clean with running water and a toilet. I see hand sanitizer and toilet paper and a can of comet or powdered detergent.

Building 9 (Alpha). Upon entering the Control Room there are no security control panels or any electrical security control systems. The red fire control system box does not appear operational. All of the ceiling panels are gone except those at the lights. There are electrical cords and what appears to be a computer cable running to the PC. This room contains a fire extinguisher with an updated pressure inspection. The officer in this control room states that there are no suicide cut-down tools in this control room or this unit. (The fact is there was a cut-down tool in there in a box locked but the officer was not aware of that fact). The Control Room door to the secured vestibule is unlocked. The security gate into the housing is unlocked – I just let myself in. It is unlocked on both sides allowing inmates direct access from the housing unit to this Control Room to Control Room B into housing 9 Bravo.

9 Alpha Multipurpose Room has standing water, apparently from the storms. The television has been taken out. The ceiling appears to have mold. There is a towel draped across one of the horizontal fire plumbing pipes.

Alpha recreation yard has a plastic baggie and small homemade twine tied to the steel grate. The door is unlocked allowing access to that rec area. The rec area appears to have been flooded during the storms this week but is drying. It appears the drain system is working fine.

The inmates in 9 Alpha are locked in their cells (security lock-down). The Grievance Box is locked with a padlock securing confidentiality of documents. The swamp cooler is working. Some of the lights are not working, either burned out or shut off. All lights should be on in this environment

for security visibility purposes. The exam room door is standing open. The exam room sink plumbing drain pipe is disconnected. The janitor's closet floor appears clean. The drain sink has mold, rust, macaroni, a plastic fork, and several washcloths hanging from the hanger. The sink itself is plastic and looks fairly clean. There is running water and bars of soap. There also appears to be plastic Tupperware and a plastic spoon in the sink. The floor is wet from recent cleaning.

9 Alpha has four shower stalls on the ground level (lower tier) and four on the top tier. The first shower stall on the lower tier is a handicapped shower with what appears to be appropriately positioned rails and seating. The floor is filthy and the shower appears functional. Shower two uses a large piece of plastic for privacy. This shower appears functional. The floor is much cleaner than the previous shower; however, there are soap stains and melted soap as well as old bars of soap that are laying on the ground presenting slip hazards. Lower tier shower three has the same plastic burlap mesh in front of the gate. There is an empty soap box and soap pieces that present slip hazard and needs to be cleaned. This shower does not appear to be functional. The shower head is missing but there is a cleaning product bottle on the floor.

An inspection of ground level (lower tier) inmate cells found safety, security, and sanitation problems. This is a high security housing unit so we will not enter any of the cells at this time.

Cell 1-A is padlocked and appears occupied, and it is very difficult to see inside. The officers do not regularly carry flashlights for visibility. This cell door window mesh has food products that need to be removed for sanitation and security reasons.

Cell 2-A is padlocked and appears occupied. Visibility is extremely low. The steel mesh has a cigarette in it.

Cell 3- is padlocked and appears occupied. The door window mesh is somewhat obstructed. It appears the inmate was able to slide paper between the wire mesh and metal grate to reduce visibility. Looking inside this cell, this inmate has homemade clotheslines that have towels, clothing and sheets draped over them preventing full visibility into the cell.

Cell 4-A: Cannot see inside.

Cell 5-A: Cannot see inside.

Cell 6-A is padlocked and cannot see inside. The inmate can control the hatch with a rope tied to it and has a towel draped over to prevent visibility from the inside.

Cell 7-A is padlocked. I cannot see inside. Lights are out and it is dark.

Cell 8-A is not padlocked but there is no visibility.

A-56 is an exit door leading to the outside. The outside door is open. The internal door is locked and vestibule area appears to be a staging area for some current electrical. This area contains electrical transformers and other metal products.

Cell 9-A is dark, torn mesh, new grate and a homemade device to control the food-hatch.

Cell 10-A is padlocked. There is absolutely no visibility. This cell needs to be cleaned.

Cell 11-A has absolutely no visibility. The inmate has placed newspapers inside the door window to prevent internal visibility. This condition creates an extremely dangerous situation by forcing an officer to lean down to speak with the inmate and no visibility through this door.

Cell 12-A is padlocked with obscured visibility through the mesh. The mesh is covered and the inmate appears to be sitting on his bunk. There is a clothesline with a sheet draped over preventing full visibility into the cell.

Cell 13-A is padlocked with low visibility.

Cell 14-A is padlocked with no visibility.

Cell 15-A is padlocked with no visibility.

Cell 16-A appears unoccupied with very little visibility into the cell.

Inspecting the upper tier, there are four shower stalls as previously stated. Shower #1 appears functional and cleaner than the others. There is standing soap on the floor creating slip hazard. Shower #2 appears to be in the same condition as shower one. Shower #3, same condition as showers #1 and #2 but there is a lot of rust running down from the shower head cover plates. There also appears to be spider webs near the ceiling. Shower #4 appears to be operational; however, it is absolutely filthy.

Door A-62 is a pass-through door leading to door B-62 (9 Bravo housing). The vestibule space between doors A-62 to B-62 is absolutely filthy. The floor is covered with dirt, food products, plastic utensils and food bags. This are must be kept cleaned for inmate movement in case of emergencies.

Cell 17-A is unoccupied and locked. This cell appears to be reasonably clean.

Cell 18-A reveals the food hatch is closed and controlled by the inmate. There is absolutely no visibility through the door grate. There is a towel draped over it with newspapers stuffed in the grate.

Cell 19-A is the same condition as the previous cell. The food port is open, no padlock. It is occupied and fairly organized.

Cell 20-A has some visibility through the mesh, but very low. It is unoccupied.

Cell 21-A is unoccupied and needs to be cleaned

Cell 22-A is appears to be occupied but there is no internal visibility. The food hatch is controlled by the inmate. There is a towel draped over the door from the inside preventing full visibility into the cell.

Cell 23-A is occupied is fairly organized and kept. There is standing water coming from cracks in the floor. There is also a towel draped over the door preventing full visibility.

Cell 24-A is unoccupied and locked.

Door A-61 is a service door that is closed and locked.

Cell 25-A is unoccupied. The cell appears reasonably clean.

Cell 26-A is unoccupied. The cell appears reasonably clean.

Cell 27-A is occupied but I cannot see inside because it is dark and the door window is cluttered.

Cell 28-A is unoccupied with paper between the door grate and the door mesh. The door mesh is torn.

Cell 29-A is unoccupied and appears reasonably clean.

Cell 30-A is occupied but visibility completely obscured by a towel of sheet.

Cell 31-A is occupied but visibility is completely obscured similar to the previous cell.

Cell 32-A has the same condition as the previous two.

The inmates in this unit are high security disciplinary inmates. Many complain of lack of hygiene products, lack of clothing products, and complain about commissary prices, lack of access to water in their cells.

Building 9 (Charlie). The rolling security door entering the building were unsecured. The door to the officer's station was unsecured; however, the gate into the housing unit was secure. The Day Room is similar to those previously described and there is standing water on the floor due to the heavy rains. The Rec Yard appears to have flooded, but it is mostly clear of standing water. There is water dripping from the ceiling at the yard entrance door. There is standing water throughout the housing unit.

In general, this housing unit, similar to the previous housing units, has mold on the ceilings. There are leaks in the ceiling at the top tier and the bottom tier. The floor drains are not completely open and need to be cleaned. It is a brand new swamp cooler that is not operating. I am told by an officer that the cooler it is brand new. The date of issue shows 12/05/13.

The Control Room door in 9 Charlie is unlocked and the door from the housing unit and the gate to the housing unit leading to this Control Room is unlocked.

My review of the equipment log indicates there is no suicide prevention cut-down tool located in this unit. The officer stated that a tool was not provided to this Control Room.

The Control Room requires accounting for the following equipment, which also shows no cut-down tool listed.

- A/C unit
- Air Horn
- Baton
- Cable Box
- Cut Down Tool
- Log Book
- Microwave
- Phone
- Handcuff
- First Aid Kit
- Keys
- Fire Extinguisher
- Hand Radio
- Garbage Bin
- Water Cooler
- Chairs
- TV
- DVD Player
- Washer/Dryer
- Standing Fan
- Wall Fan
- Computer
- Caliper

This equipment inventory log shows no equipment entry verifications for December 1, 2, 6, 7, 8, 9, 10 and 11. This log appears to be incomplete and not regularly maintained.

An inspection of upper level inmate cells found safety, security, and sanitation problems similar to those previously described.

Cell 32-C appears to be occupied but visibility in the room is obscured through the door grate. There is a sheet blocking visibility in the room.

Cell 31-C appears to be occupied by two inmates with fair visibility. The cell is reasonably clean with an adequate supply of personal hygiene products.

Cell 30-C appears to be occupied. Several personal belongings and an adequate supply of personal hygiene products. The room needs to be cleaned.

Cell 29-C appears similar to previous cells. There are three clotheslines hanging as previously described. There is no visibility of the bottom bunk due to a towel blocking draped over the top bunk. There appears to be an adequate supply personal hygiene products.

Cell 28-C is occupied. This cell has several towels, apparently serving as a carpet. There are homemade clotheslines as previously described, several personal belonging, several books, writing materials. There appears to be an adequate supply of personal hygiene products.

Cell 27-C: Similar to the previous cell described.

Cell 26-C is occupied with visibility mostly obscured by hanging sheets being used as room separators.

Cell 25-C is occupied with a towel blocking the view to the bottom bunk. There are numerous personal possessions and food products. It is reasonably organized and clean. There appears to be an adequate supply of personal hygiene products.

Cell 24-C is occupied with full view inside. There are clotheslines as previously described and what appears to be an adequate supply of personal hygiene products.

Cell 23-C appears to be occupied but visibility into the cell is completely obscured by towels hanging from a clothesline as previously described.

Cell 22-C is occupied. Towels are being using towels as a carpet, possibly to deal with rainwater entering the cell. There appears to be an adequate supply of personal hygiene products. There also appears to be a blunt force weapon that has been crafted out of tightly rolled newspaper, probably for exercise. Although this device appears to be used for exercise, it could easily be used to seriously assault other inmates and/or staff and should be removed.

Cell 21-C is occupied with a sparse amount of personal possessions but an adequate supply of personal hygiene products. This inmate reports health concerns about the mold and dust throughout his cell and housing unit.

Cell 20-C is occupied with clear visibility into the cell. The cell appears to be reasonably clean and organized with an adequate supply of personal hygiene products.

Cell 19-C is occupied but very dark inside. The view into the cell is partial obscured by sheets or towels hanging from a clothesline as previously described. The cell is disorganized and emits the order of smoke.

Cell 18-C is occupied but full view into the cell is obscured by a towel draped over the top bunk. There appears to be an adequate supply of personal hygiene products.

Cell 17-C appears to be occupied but the door grate is completely blocked by cardboard with a small viewing port cut from inside. The cell is dark and disorganized.

Door C-62 is a pass-through door to D-62 similar to those previously described. The vestibule area needs to be cleaned, also as previously described and for the same emergency life-safety reasons.

Building 9 (Delta). The Control Room door is secured as is the gate to the housing unit. An inspection of the Officer Equipment log also shows no entries for December 1 or 2. Similar to the previous equipment log, this log is incomplete.

An inspection upper-tier inmate cells found similar safety, security, and sanitation problems as previously discussed.

Cell 17-D is an occupied cell. There is standing water in the floor. The inmate states he has been mopping. There appears to be an adequate supply of personal hygiene products.

Cell 18-D is occupied but door window is almost completely covered by a cardboard commissary product.

Cell 19-D is occupied with good visibility that appears clean and organized. There is a clothesline anchored to the sprinkler head and window as previously discussed. There appears to be an adequate supply of personal hygiene products.

Cell 20-D is occupied and somewhat disheveled. The window and lighting above is covered by newspaper. The door window is covered by a black towel. There are clotheslines hanging from the door hinges to the bunks and from the sprinkler heads to the window and from the door hinges to the sprinkler head, all holding towels and clothing. Personal belongs and food products clutter the floor. This cell needs to be organized and cleaned. There appears to be an adequate supply of personal hygiene products. There are also several small trash bags that appear to be filled with garbage and need to be removed. Several paper items, torn cardboard lying around on the ground. This needs to be cleaned up. Plastic bottles. Toilet needs to be flushed. There are several boxes in here. This is a fire hazard.

Cell 21-D appears to be unoccupied and metal grate on the door window is blocked by paper. The cell needs to be cleaned.

Cell 22-D appears to be unoccupied. It needs to be cleaned as well as the clotheslines need to be removed from their anchors.

Cell 23-D appears to be occupied; however, there is a towel draped over preventing visibility into it from the door and (open the door).

Building K & L. The sliding security door into this Unit is unlocked and open. The security gate to L is open and the control room door is unlocked.

L Control Room does have a functional security control panel. I am advised by officers that the control panel remains non-operational. These all need to be repaired and functional.

The Multi-Purpose Room is locked and appears to be nonfunctional. This room is filled with garbage bags and boxes, indicating that it is not being used by inmates. Again, as previously discussed, the unit has standing water on some areas of the floor. The Examination Room is locked and does not appear to be used. The Janitor's Closet is locked.

Similar to those previously described, there are shower stalls located on the upper and lower levels. The doors to the lower tier showers are made of metal framed screening with locking mechanisms. Shower #1 is a handicap shower with what appears to be appropriately placed hand rails and seating, and appears to be in better condition than those previously described. This shower appears to be functional and reasonably clean. Shower #2 appears to be functional and reasonably clean. Showers #3 and #4 are similar to #2.

An inspection lower-tier inmate cells found similar safety, security, and sanitation problems as previously discussed.

Door L-55 door is a pass-through door to Housing Unit K-55. The pass-through vestibule area has standing water and exposed electrical wires with the electrical connections taped with electrical tape. The wires need to be secured. The floor needs to be kept dry. This area should be well maintained for emergency movement of inmates as previously described.

Cell L-1 appears to be empty. The cell needs a deep cleaning.

The plumbing chaise door adjacent to this cell is unlocked and poorly lighted. This, and all similar doors should remain locked at all times.

Cell 2-L is unoccupied. Screen is torn but has a secured grate over it. It needs to be cleaned.

Cell 3-L has an intact screen and grate and is unoccupied.

Cell 4-L hatch is open. The room is dark and appears occupied and cannot see inside.

Cell 5-L appears to be occupied and is similar to the above.

Cell 6-L appears to be unoccupied and very dark inside.

Cell 7-L appears in the same condition as 6-L.

Cell 8-L appears in the same condition as 7-L.

Door L-56 door is a pass-through door to L-57. The floor appears to have been flooded, at least in the corners at the external walls. This room needs to be cleaned for emergency movement reasons previously discussed.

Cell 9-L is unoccupied but needs to be cleaned. Mattresses and pillows need to be removed and sanitized.

Cell 10-L is occupied and the inmate is covered by a sheet. There appears to be standing water that needs to be removed. There appears to be an adequate supply of personal hygiene products. Visibility is fair.

Cell 11-L is occupied with the inmate standing at the door preventing my view into the cell area. This inmate does not respond to my questions.

Cell 12-L is unoccupied with standing water that needs to be completely cleaned.

Cell 13-L is unoccupied and in similar condition as 12-L.

Cell 14-L is occupied with fair visibility. However, the inmate has a plastic bag draped over his lighting preventing visibility at night except by a flashlight.

Cell 15-L is too dark to see inside. The door window screen is torn but the grate is intact.

Cell 16-L appears to be unoccupied, the door window screen is torn but the window grate is intact. There is standing water and rust on the metal bunk. This cell to be cleaned and dried.

An inspection upper-tier inmate cells found similar safety, security, and sanitation problems as previously discussed.

Cell 32-L is occupied and there is standing water in front cell door. The door window grate is intact and there appears to be an adequate supply of personal hygiene products.

Cell 31-L is pitch black. The screen is torn but grate intact.

Cell 30-L is in similar condition as 31-L.

Cell 29-L is in similar condition as 32-L.

Cell 28-L is unoccupied and needs to be cleaned.

Cell 27-L is unoccupied, needs to be clean, and standing water removed.

Cell 26-L is in similar condition as 27-L.

Cell 25-L is too dark to inspect.

Cell 24-L is unoccupied and needs to be cleaned.

Cell 23-L is unoccupied and needs to be cleaned.

Cell 22-L is unoccupied and needs to be cleaned.

Cell 21-L is too dark to inspect, the door window screen is dirty and obscures visibility.

Cell 20-L appears to be occupied but is too dark to inspect.

Cell 19-L appears to be occupied but is too dark to inspect.

Cell 18-L is occupied and the room is filthy.

Cell 17-L is occupied and the room is filthy.

Door L-62 leads K-62 pass through and is completely under standing water.

Top tier showers are in similar condition to the bottom tier showers. I do not see anything remarkably different from the bottom showers.

In general, the cell environments are in poor condition. The Day Room is clear of any tables or out time seating areas. The ceiling appears to have mold. There is standing water.

The K-side of the Control Room also has no functioning security control panel.

An Officer here showed me the cut-down tool and stated she received initial training on its use but there are no emergency drills using the cut-down tool. There should be tools on both sides that are easily accessible by officers.

Officers here appeared attentive to their work. They showed me a disorganized filing system for documenting cell checks on the lockdown side. I recommend they use a 3-ring binder with dividers for each inmate.

The K Multi-Purpose room door is empty and locked. Overall, this Unit is much cleaner and better kept than those previously inspected. The Janitor Closet appears clean with adequate supplies for cleaning that would be left available. The swamp cooler is not operating.

There are no doors on lower level showers in Unit K. Three of the showers stalls have transparent plastic strung-across drape about five feet high. Shower #1 is handicapped accessible and appears functional. Showers #2, #3, and #4 appear in fair condition and functional.

An inspection lower-tier inmate cells found similar safety, security, and sanitation problems as previously discussed.

Cell 1-K is occupied and open. This cell appears clean, and well-kept. There is a clothesline as previously described. There appears to be an adequate supply of personal hygiene products.

Cell 2-K is locked and too dark to inspect.

Cell 3-K is occupied and open. There is standing water on the floor. There appears to be an adequate supply of personal hygiene products. This cell is reasonably clean and organized.

Cell 4-K is similar to 3-K but there is no tooth paste.

Cell 5-K is similar to 3-K.

Cell 6-K is similar to 3-K.

Cell 7-K is similar to 3-K.

Cell 8-K is similar to 3-K.

Door K-56 is a pass-through door either to the outside, probably an outside door. However, it is too dark to inspect the vestibule area.

Cell 9-K is similar to 3-K but dark inside.

Cell 10-K is similar to 9-K.

Cell 11-K is occupied and open. The cell is sparse of personal belongings. The mattress is heavily damaged and without linens. The pillow is made of a foam product, is not covered, and is damaged. There appears to be an adequate supply of personal hygiene products.

Cell 12-K is unoccupied and needs to be cleaned.

Cell 13-K is occupied, clean and organized with a clothesline as previously described. There appears to be an adequate supply of personal hygiene products.

Cell 14-K is occupied, clean and organized with an adequate supply of personal hygiene products.

Cell 15-K is occupied and emits the odor of smoke. This call has no mattress or pillow, but there is a sheet blanketing the metal bunk. There appears to be an adequate personal hygiene products.

Cell 16-K appears to be unoccupied but is too dark inside to inspect.

There are four upper showers in this unit; three of them are functional but all appear to be reasonably clean and need of minor tile maintenance.

An inspection upper-tier inmate cells found similar safety, security, and sanitation problems as previously discussed.

Cell 17-K is occupied and good visibility into the cell. The cell emits a pungent odor. There are no bed linens on the mattress or pillow. There is an adequate supply of personal hygiene products. The cell, overall, is reasonable clean and organized.

Cell 18-K is occupied and disorganized. There appears to be an adequate supply of personal hygiene products.

Cell 19-K is occupied, clean, and organized.

Cell 20-K is occupied, very dark, and disorganized. There is a clothesline as previously discussed but no personal hygiene products are found.

Cell 21-K is occupied, clean, and organized. There appears to be an adequate supply of personal hygiene products.

Cell 22-K appears to be occupied, is disorganized but there appears to be an adequate supply of personal hygiene products.

Cell 23-K is occupied and reasonably kept. Adequate personal hygiene products.

Cell 24-K appears to be unoccupied but is locked and very dark inside. There is a clothesline as previously described but no personal items.

Cell 25-K: It is occupied but empty. There is a fan running and there appears to be an adequate personal hygiene products. The inmate appears to take good care of his environment.

Cell 26-K is occupied and open with few personal possessions. There appears to be an adequate personal hygiene products. The mattress and bed linens are present and appear to be reasonably clean. Clothing items are stuffed in the external window, probably to stop wind and rain. The cell is organized but should be cleaned.

Cell 27-K: is occupied and open. There appears to be an adequate personal hygiene products. The cell is reasonably clean and organized.

Cell 28-K: is similar to 27-K

Cell 29-K is occupied and probably the best kept cell in this entire facility. Well-organized, looks very clean. The inmate appears to take great pride in maintaining his cell. There appears to be an adequate supply of personal hygiene products.

Cell 30-K is similar in condition to 29-K.

Cell 31-K: Occupied and somewhat disorganized. There is a towel at the base of the cell door to control water, according to the inmate. There appears to be an adequate personal hygiene products.

Cell 32-K is occupied, reasonably clean and organized. There appears to be an adequate supply of personal hygiene products.

K Unit is specialty housing unit for protective custody, mentally ill, medically infirm and other inmates requiring special housing separation. Inmates here, compared to other Units inspected, are very quiet, playing games, watching TV and appear to be socializing well.

The ceiling is similar to the previous housing units. There are large areas of mold on the ceilings and standing water near outer walls in some areas.

J-Unit the entrance door and locked and open upon entry. The vestibule doors to the security gates leading to the housing unit was standing wide open. Additionally, the door into the officer's station is unlocked and open. The officers are both in the housing unit with the security keys.

The Equipment Log is incomplete. The log reports that there is no cut-down tool, although the officer says there is one "somewhere on the unit." A closer review of the log indicates that there are consistently no cut-down tools, no microwave, no handcuffs, no water cooler, no TV, no DVD player, no washer/dryer, no standing fan, no wall fan, and no computer. Additionally, and similar to other logs, there is no column to verify the presence of a flashlight(s).

The December log also reports that there is only one radio for the two units. This is an extremely unsafe practice as it would only require an inmate to grab the radio, rendering staff unable to call for assistance in an emergency.

The Multi-Purpose Room appears clean and reasonably organized. There is no standing water and the floor looks clean. However, the rec yard appears to have flood as previously described in other housing areas and there are sandbags being used to stop water from entering the unit. The swamp cooler is operational.

Exam Room is open but it does not appear operational. There is no sink and the room needs to be clean and repaired. The janitor's closet has a broken tile at the base, the water is running and the room needs to be cleaned.

There are four showers on the lower level, similar to those previously discussed. All shower stalls have operating doors. Shower #1 is a handicap shower with appropriately placed rails and seating. The shower head is leaking but the shower is in fair condition and reasonably clean. Shower stalls #2, #3, and #4 four are in similar condition as #1 but #4 has no running water.

An inspection of lower-tier inmate cells found similar safety, security, and sanitation problems as previously discussed.

Cell 1-J has its window covered preventing inspection.

The adjacent plumbing chaise door is unsecured, exposing electrical cable and plumbing systems. This door should remain secured at all times as previously discussed.

Cell 2-J is occupied but too dark to inspect.

Cell 3-J is too dark to inspect.

Cell 4-J visibility is obstructed.

Cell 5-J is similar to 4-J.

The next plumbing chaise door is secured.

Cell 6-J window are covered.

Cell 7-J appears occupied, is locked but dark.

Cell 8-J is similar to 7-J.

Cell 9-J is occupied but door is locked. There are some plastic products on the window grate that obscure visibility into the cell.

Cell 10-J is similar to 7-J.

Cell 11-J has the door window grate completely blocked; there is no visibility into the cell.

The plumbing chaise door adjacent to 11-J is open and unlocked. Same concern and recommendation as previously discussed.

Cell 12-J is occupied, clean and reasonably organized. There appears to be an adequate supply of personal hygiene products.

Cell 13-J is similar to 11-J.

The plumbing chaise door adjacent to 13-J is unlocked. Same concern and recommendation as previously discussed.

Cell 14-J is occupied and locked. The internal view is blocked by a towel draped inside covering the door window.

Cell 15-J is occupied, reasonably clean and organized with an adequate supply of personal hygiene products.

The plumbing chaise door next to 15-J is unlocked. Same concern and recommendation as previously discussed.

Cell J-16 is occupied, reasonably clean and organized with an adequate supply of personal hygiene products.

The upper tier showers are currently being used by inmates and will not be inspected. They are apparently functional.

An inspection of upper-tier inmate cells found similar safety, security, and sanitation problems as previously discussed.

Cell 17-J is too dark inside to inspect.

Cell 18-J is occupied and unlocked. This inmate reports being the victim of the machete attack in September. His wounds appear to be healing. He states he is being provided adequate medical care; however, his jaw appears to be wired shut. The cell is reasonably clean and organized. There appears to be an adequate supply of personal hygiene items.

Cell 19-J is occupied, locked, clean, and reasonably organized. There appears to be an adequate supply of personal hygiene items.

Cell 20-J is occupied, appears clean but dark. The inmate is not very responsive, somewhat paranoid.

Cell 21-J is occupied, appears clean and dark inside.

The plumbing chaise adjacent to Cell 21-J is unlocked and open. Same concern and recommendation as previously discussed.

Cell 22-J appears to be occupied. A towel draped over the top bunk prevents visibility to the bottom bunk. Room reasonably kept using a large towel or something as a carpet.

Cell 23-J is similar to 21-J.

The plumbing chaise door adjacent to 23-J is unlocked. Same concern and recommendation as previously discussed.

Cell 24-J is occupied. The inmate is standing in the door blocking intentionally blocking my view into the cell.

Cell 25-J is occupied but is a curtain blocking visibility to the bunks; however, it is fairly clean and organized.

Cell 26-J is similar to 25-J.

Cell 27-J is similar to 25-J.

Cell 28-J is similar to 25-J.

Cell 29-J is similar to 25-J.

Cell 30-J is similar to 25-J.

Cell 31-J is too dark to inspect.

Cell 32-J is similar to 31-J.

A cursory inspection of I Unit found it to be in much the same condition as the J Unit with no remarkable distinctions.

Medical Building. The entrance gate and sliding glass doors into this Unit were unlocked, allowing easy access into these areas. The doors leading into the reception area and rear areas were also unlocked; there was no staff at the reception desk but charts were left sitting on the reception desk.

An inspection of the exam rooms found the cabinets unlocked but no scalpels were found in any cabinet as in the Baseline visit. However, there were several medical instruments setting about that could be used as a weapon or blunt instruments. The stainless steel instrument pans do not appear to have been cleaned since my last visit in September. There is a small bio hazard container with a foot pedal containing what appears to be bio-waste; however, it contains no liner. These garbage receptacles should contain red biohazard bags, regularly emptied and sanitized. Administrative offices seem to be clean and reasonably organized.

The medication room security gate and access door were unlocked, allowing direct access to medications. The padlock to the medications and narcotics is unlocked and the room was unattended by staff. The security gate, so to speak, to a small medications cabinet is unlocked and open. None of the cabinets or drawers have locks on them. This entire environment should be kept secured at all times and there should be no access into this environment without proper authority. There is no record system maintained to log staff access to this room.

X Dorm (Female Convicted Offenders Side). Access to X-Dorm is gained through a secured gate. The padlock and chain found during the previous inspection has been removed and replaced with a security padlock.

The Officer's Station door is open to the inmate Day Room. The fire panel remains dysfunctional. There is an unlocked cabinet in this office that contains latex gloves, a small hand-held air horn, a large supply of feminine hygiene products, and a semi-stocked first-aid kit possessing a cut-down too. There is a fire extinguisher in this room that shows a maintenance inspection of June 13, 2013.

The sentenced side and detention side are separated by a shared dayroom. Currently, the sentenced inmates are out of their cells, most of whom are in the dayroom.

There are two shower stalls at the far end of the housing corridor. Shower #1 has a shower door frame but no door panel for privacy. The door panel was laying against the wall next to the shower stall. The door to shower stall #2 was intact. Both showers need to be cleaned and repainted. The faucets were dripping and appeared to be in need of minor repair.

Cell 1 is occupied. The cell appears to be reasonably tidy, clean and organized. A clothesline is attached to the wall. There appeared to be an adequate supply of personal hygiene products.

Cell 2 is a storage room that is padlocked containing assorted supply items.

Cell 3 is occupied and is reasonably well-kept and tidy with an adequate supply of personal hygiene products.

Cell 4 appears to be occupied but the door window grate is covered from the inside.

Cell 5 is occupied, reasonably tidy and clean.

Cell 6 appears to be occupied but the door window grate is covered from the inside.

Cell 7 is occupied, clean and very organized.

X Dorm (Female Detention Side). The general Day Room has an open door to the secured rec yard. There are a few seating areas, picnic benches, a cat wandering about. There is also a direct open area through the chain link fence into the visitation walkway. Additionally, the gate to that walkway is open, leaving direct visibility from this rec yard for these detention inmates to the outside visitation area as well as through the chain link fences into the public parking areas. This is a serious contraband risk. Undergarments are being dried in the sun on a clothesline stretched across vertical pipes.

The Day Room inside has an exercise bike, a large picnic bench, and bookshelf with books.
There is a secured metal screen door between the Officer's Station and this Day Room. The hot water closet was unlocked. Inside this closet was a hot water heater, several plastic bags, several sandbags, and a couple of mop-handles. The proximity of the plastic bags to the water heater electrical component present a potential fire hazard, and the unsecured mop-handles present an assault risk. All combustible items should be removed from this closet; it should be kept locked and not accessible to inmates.

These showers are similar to the sentenced side; however, both shower doors are intact. Showers appear to be fairly clean with some paint decay over the showerheads.

Cell 15 is occupied and has a concrete bunk and a small mattress. There is a bucket of food stuff on the floor. The cell is reasonably clean and organized. There appears to be an adequate supply of personal hygiene products. However, the door screen is damaged and needs to be replaced.

Cell 14 is occupied, the door view port is somewhat covered from the inside. The room appears reasonably clean and organized. This the inmate states she prefers to remain locked in her cell and to no socialize with other inmates. She seems lucid and communicative. There appears to be an adequate supply of personal hygiene products.

Cell 11 is not occupied and appears to be clean.

Cell 12 is occupied, is clean and organized with several personal hygiene products.

Cell 10 is occupied, reasonably clean and organized.

Juvenile Housing Unit. The entrance door is unlocked and open. The officer, upon entering this housing area, appeared to be sleeping at the duty station. There are no video monitors to monitor the juveniles who are locked in the housing unit some distance from the duty station. There is a fire extinguisher mounted behind the Officer's Station with a current inspection sticker and positive pressure. Officer assigned to this post states he has no cut-down tool.

Entering the living areas, there is a gang bathroom off the side with two showers; many of tiles are broken and in a state of disrepair. The showers apparently work but do not appear to provide adequate privacy required by PREA. An adjacent water closet floor is damaged and dirty but the cold water seems to be working.

The Unit currently housing two juvenile inmates. Both of them appear to have their door grates partially covered with cardboard.

Cell 20 is occupied and reasonably clean and organized. It has a bathroom, however the toilet is not flushed and there is a large plastic liquid dispenser sitting atop the sink. There appears to be adequate personal hygiene products.

Cell 21 is occupied and in similar condition as Cell 20.

Cell 19 is unoccupied and it is absolutely filthy with large pile of garbage, bags, rotting and old food containers, and other discarded items. A wooden stick, approximately three feet in length, is laying on the ground under some of the trash. This stick is a clear and present risk to the inmates and/or staff it used as a weapon. This cell must me completely cleaned, sanitized, and searched for all potential weapons and those items removed.

At the end of the hall is a large Multi-Purpose recreation area. It needs to be cleaned. There is a ping pong table, two (2) small picnic tables and a correctional grade chess table in here. There is also cat food, indicating that there is a cat in this area.

It seems clear that the juvenile inmates are simply placed in this living environment and fed. Both inmates report that they are not provided educational or counseling services. Both inmates state that they have not seen healthcare staff following the intake process, although neither report any medical problems.

Adult Male Special Housing. We will now enter a special detention unit near the administration access area from the yard. Access gate is locked. This is called the Intake Unit; however, it is the former booking area that has been converted into an 8-cell housing unit. There are three (3) inmates in there. None report on medications. It is calm and reasonably well-kept.

Kitchen Building. The yard gate leading to the kitchen is locked from the inside and requires staff to unlock to gain entry.

Entering the kitchen, the main kitchen door from the work side has water dripping from the ceiling. There are exposed electrical wires and some standing water. It appears they have been cleaning in this area but standing water remains on the floor and there are no warning signs or placards. There is a service sink separating the entrance to the male and female bathroom.

Entering the women's bathroom, there is full container of hand sanitizer on the sink. The sink is operational but there is no hot water. The bathroom floor is filthy and requires a deep cleaning.

The male bathroom is in similar condition as the female bathroom and requires a deep cleaning. There is a dirty wall urinal, the light does not work, and there is cold water but no hot water. The frame separating the toilet areas is rotting at the base. I could find no toilet paper in this bathroom.

In the kitchen area, there are large stainless steel sinks back-to-back near the cooking area. The tile under the sinks is damaged and needs to be repaired or replace. The plumbing is exposed. There are rotting food products under the sink. The sinks are both clogged with what appears to be corn or some other food products. There is also a 12 inch knife in the sink attached to a metal cord that is padlocked to the faucets.

An inspection of the kitchen tool/utensil found it unlocked and unattended by staff. Light is on and both the tool cage gates are unlocked and are wide open. Although a "shadow board" is in place for tool management, there does not appear to be any equipment inventory logs. There does not appear to be a chit system in use for tool tracking and inventor management. It appears that several tools are missing, including knives, ladles, large spoons, etc.

The kitchen has two large internal cooler/freezers; one of them is operational and one appears to be broken. The broken cooler has no external temperature gauge and appears to be used for storage. The working cooler has an external temperature gauge showing a temperature of about 47 degrees, and contains various properly stored food products.

There is a large iron cook stove here that needs to be replaced. The nearby deep fryer contains used oil. There is also a pan sitting on a cart next to it with some old oil. The second deep fryer appears to be cleaned and covered by a stainless steel pan.

To the opposite side of that group of kitchen equipment is a 12 burner cast iron stove and ovens that are currently being used. This was the oven that was reported in the Baseline Report as positioned too high for safety reasons.

There is also a prep area for food distribution. This is the cafeteria are where inmates come here to collect their food. This is a decent sized room for distributing food from the kitchen through large food ports. There are additional food service areas nearby, as well as a fairly large stainless steel dish sink. The inmates are busy cleaning this area. There is a single fire extinguisher mounted on the wall as you enter the kitchen area with brief instructions on use that appears recently inspected.

In general, the kitchen area remains in the poor condition as it was found at the Baseline visit with broken tiles, leaking ceilings and mold, insects, and equipment that needs to be replaced.

Outside of the kitchen building is another freezer with a temperature reading of 21-22 degrees, which is adequate for frozen products. It is locked and we will not enter it.

Carpentry Shop Building. The shop consists of various wood-working equipment and supplies including planers, saws, lathes, presses, etc. There is a fire extinguisher in a cabinet accessible with an inspection date of June 13, 2013. The pressure, like the others, appears to be positive. I see no MSDS signs. I see no work safety signs other than "Noisy Area Wear Protection" and "No Smoking" signs. This area should have work safety signs posted throughout. The room is otherwise reasonably kept and well-organized for the work performed.

An adjacent inmate break area contains wood rubbish, is very un-kept and filthy. There appears to be a partially functional refrigerator containing ice. This room, if used for breaks, food preparation, and/or eating should be kept well cleaned and sanitized.

Classroom Area. Now entering the classroom area (as it is called). It has a work room with a couple of absolutely beautiful table tops under construction by inmates. There is an inmate bathroom in this area with only cold sink water. The floor, walls, and toilets are filthy. This area requires a deep cleaning. Adjacent to this area is an unlocked storage room cluttered with cardboard and wood bi-products. These items present a fire hazard.

Car Repair Shop. The car repair shop appears to be reasonably clean and organized. The tool room is open. The tool supervisor is putting away the tools and appears that all the tools are accounted for, and as reported in the Baseline assessment. This tool area remains well managed and secured. An inspection of all tool rooms indicates an appropriate level of security in these areas.

Upholstery Shop. This area appears to be reasonably organized and relatively clean. Several inmates are busy working on projects. An inspection of cabinets finds no dangerous tools.