United States Virgin Islands

GOLDEN GROVE
ADULT CORRECTIONAL FACILITY

EIGHTH COMPLIANCE MONITORING REPORT

2013 Federal Court Settlement Agreement
In re: United States of America v. The Territory of the Virgin Islands (86/265)
Submitted September 11, 2015

Kenneth A. Ray, M.Ed., Monitor

Kenneth A. Ray
JUSTICE SERVICES
"Assess, Analyze, Actualize"
PO Box 1481 Ashland, KY 41105-1481 Phone: 606-694-3031

"Dripping water hollows out stone, not through force but through persistence." ***- Ovid***

Kenneth A. Ray, MEd, Monitor

TABLE OF CONTENTS

PURPOSE

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

EXECUTIVE SUMMARY & ASSESSMENT OVERVIEW

The eighth onsite compliance monitoring assessment was conducted June 8-11, 2015. A focused and productive Court status conference was held on Thursday, June 11th, 2015. Prior to this site visit, the Monitor coordinated communication between the Parties and monitoring team in preparation for the onsite assessment.

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

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

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

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

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

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

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

This assessment found reasonable cause for the Monitor to reverse one provision from Partial Compliance to Non Compliance. Classification provision IV.F.1.e. is herein reversed due to a continued lack of quality management in various reporting systems necessary for adequately tracking and evaluating performance outcomes. Consequently, overall assessment ratings are slightly lower from the previous assessment. 111 (92.5%) of the 120 Provisions are now rated in Noncompliance; Nine (7.5%), Partial Compliance; and, none are rated in Substantial Compliance. The score card below shows current compliance ratings.

GGACF EIGHTH COMPLIANCE ASSESSMENT SCORE CARD

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

EIGHTH ASSESSMENT FINDINGS OVERVIEW:

This assessment was very well coordinated and attended by GGACF staff and officials. Territory and GGACF participants were prompt, collaborative, and attentive throughout this visit. These participants seemed open and transparent with regard to answering questions posed by the monitoring team and USDOJ attorneys. The participation and contributions of all visit participants exceeded that of previous onsite assessments and deliberately benefited visit outcomes. As noted in the discussion below, however, the Monitor was unable to conduct a complete assessment of several provisions because the Territory did not provide requested documents.

Although overall progress remains at a very slow pace, significant traction has been achieved with regard to establishing new compliance implementation schedules. All health care-related policies and procedures have been approved and training on many of those regulations has commenced. The Territory's adherence to the new security policy development schedule is been unstable and remains not compliant. Under the schedule, the Territory was to have submitted all policies to the Monitor and USDOJ for review and comment by August 21. As of August 26, however, the Territory had submitted 12 of the 18 required policies. The Territory has not submitted any new policies since July 31, when it informed the Monitor and USDOJ that CCA was not able to work on policies at the previously agreed upon schedule. USDOJ has provided comprehensive comments to all policies except one, and the Territory has submitted four revised policies for further review by the Monitor and USDOJ. Full approval and adoption of all security-related policies and procedures is scheduled for October 30, 2015. The schedule for policy training is forthcoming.

IV. SAFETY AND SUPERVISION

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

A. Supervision

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

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: On July 24, 2015, the Territory submitted to the monitoring team and USDOJ draft policies, procedures, and related forms pertaining to housing unit security levels that include stratification for the classification of prisoners. The stratification "matrix" includes all housing units and classification designations. Final approval and implementation of these policies and procedures is pending review.

The Territory's greatest challenge in ensuring prisoner safety and security remains ensuring adequate and consistent housing unit staffing levels, consistent prisoner supervision and monitoring, and staff supervision. The best written policies and procedures are to no avail without sufficient staff and staff supervision to them out. For example, examination of the Incident logs, incident reports, Evidence (Contraband Logs), Daily Staffing Rosters, and interviews with inmates and staff continue to report the active presence of very serious and dangerous safety and security risks and adverse events. Prisoners, and staff for that matter, remain unreasonably expose to actual and potential risk of harm by serious staffing level shortages resulting in inadequate housing unit staffing and prisoner supervision and control.

RECOMMENDATIONS: Previous recommendations remain appropriate.

1. Apply the approved Housing Stratification matrix as designed and with previously recommended revisions. Specifically, previous recommendations involved making physical and

programmatic changes to Kilo (K) unit so as to eliminate insolated conditions of mentally ill inmates.
2. Review current population to verify accurate risk/need classification levels and housing, reclassify and appropriately house as indicated by review process findings.
3. Refer to IV.F. regarding specific classification and housing policy recommendations.

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

ASSESSMENT: NONCOMPLIANCE

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

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

Examination of Shift Supervisor Rounds forms for May 2015 provided by the Territory cannot verify consistent or accurate compliance with the Warden's directive because many of the forms appear to be incomplete and inconsistently completely among supervisors. Many of the daily inspection forms denote " Nothing new report" while other completed forms record numerous problems and issues involving inoperable sally port doors and equipment, specific repairs needed, plumbing leaks, and most troubling, "no officer was present when checked [in detention visiting]."

Shift Supervision Rounds inspections reports can be a valuable tool for monitoring compliance with the Warden's directive, monitoring facility safety and security, and ensuring supervisors monitor the performance and behavior of staff. However, these findings seem to indicate that upper management does not review these forms for quality compliance purposes but should.

Examination of Supervisor Logs and Shift Rosters continue to evidence continued non-compliance with requiring at least one officer is assigned to each occupied housing unit. These records document

supervisors finding housing units without officers for the entire shift, and officers reporting late to housing unit assignments, and "extreme staff shortage". Staff shortages are routinely reported in Shift Rosters as the primary cause for overtime with as many as 75 percent of a shift working overtime.

This Monitor requested all completed Shift Rosters for May 2015. Territory officials provided "what [they] had", which included only 37 reports. However, there should have been 93 reports for May based on 31 days x 3 shifts per day. Unfortunately, assessment of staffing levels was limited to an incomplete set of reports. This assessment was further complicated by GGACF using at least three different shift staffing forms which did not completely match. Nonetheless, this document examination revealed virtually all shifts had staff shortages, officers reporting late to work, and/or housing units not staffed.

Shift staffing levels was analyzed similarly to analyses shown in previous reports. However, actual shift rosters were used rather than abstracting staffing data from supervisor logs. Shift rosters, overall, appear to provide slightly more reliable information but even these documents are very problematic for assessing compliance. Nonetheless, these documents provide sufficient data to calculate reasonably reliable staffing levels.

Shift staffing rosters provided by the Territory for May 2015 were examined and analyzed. Documents were provided to assess 25 of a possible 31 work days and 35 out of a possible 93 work shifts. (31 days x three shifts per day). Shift rosters were not provided for six work days and 58 work shifts. Additionally, two shift roster reports were excluded for the analysis due to documentation errors. Therefore, only 81 percent of possible work days and 38 percent of possible work shifts could be including in this analysis.

As noted in previous reports, this analysis determined that occupied housing units continue to operate either understaffed or without staff. For example, A Dorm operated with one officer for only 25 of the 35 reported shifts. The remaining ten shifts were staffed by .33 or .5 officers. This is because the shift reports indicate that those officers were assigned to other housing units (RSAT and/or Intake) during the reported shifts. No officer was reportedly assigned to A Dorm on the 10p-6a shift for May 15. Concomitantly, RSAT and Intake units appear to have operated without adequate staffing levels for most shifts assessed. This is particularly concerning because Intake has held vulnerable populations such as juveniles. Other housing units reportedly operating with inadequate or no staff include:

G Unit, 5/3, 10p-6a; 5/21, 10p-6a
H Unit, 5/3, 10p-6a;
9A Unit, 5/21, 10p-6a
9C Unit, 5/16, 10p-6a
9D Unit, 5/17, 6a-2p
ACF R/D, 5/3, 10p-6a

Additionally, these records also appear to evidence that staff are frequently late to work and/or depart before the end of shift.

Although these shift document seem to indicate marginal improvement in staffing, this analysis is unable to reliably determine these improvements due to continued documentation problems:

1. At least three (3) different shift roster document forms are used
2. The forms are inconsistently filled out
3. Many are incomplete
4. Many shifts are missing for the month being assessed
5. Legibility problems
6. Not all posts are on the rosters, some rosters use different post terms, some include posts not included in other rosters

RECOMMENDATIONS: Previous recommendations remain appropriate.

1. Immediately correct documentation problems shown above.
2. Rapidly implement the NIC Staffing Analysis recommendations.
3. Complete the draft staffing, as required under the Agreement that reflects the NIC Staffing Analysis and provides concrete steps for hiring sufficient staff.
4. Cease the practice of allowing staff to work high amounts of overtime and ensure that staff working overtime have adequate time away from the facility before returning to work to ensure they are adequately rested.
5. Create a fast-track basic officer training program that ensures recruits are adequately trained on salient correctional topics.
6. Seek Court relief to remove any barriers to rapid remediation of facility safety and security deficiencies that expose people to harm.
7. Subsequent to policy and procedure development and revisions, conduct a complete review of existing specific and general post orders to ensure they are:
   A. post specific;
   B. accurately represent post staffing needs and post resources needed to operate the post safely and consistently;
   C. are numbered, cross-referenced with policies/procedures, and formatted in a manner that makes them easy to interpret and apply;
   D. maintained at each post, kept current, and easily accessible;
   E. regularly reviewed, revised, updated;
   F. consistently enforced;
   G. known to staff through pre-service, in-service, and ongoing training.
8. Develop a plan that provides for regular review of all log books by supervisors to ensure staffing and other unit safety and security issues are detected and resolved in a timely manner.
9. Ensure that all posts are staffed according to post complexity and dynamics, risks and needs.

And,

10. GGACF upper management must monitor compliance with any written instructions to subordinate supervisors if compliance with such orders are expected to be followed.
11. Create and implement one, standardized, shift staffing form for supervisors to accurately record shift staffing levels.

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

ASSESSMENT: PARTIAL COMPLIANCE

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

This danger is no better demonstrated than on June 4, 2015 in Unit 9a when an inmate was brutally assaulted and stabbed by two other inmates.[1] In this incident, an inmate physically took the unit cell door keys from one of the two housing unit officers, out-ran both officers to the victim's cell, unlocked the cell and with an inmate, and commenced beating and stabbing the victim. The two unit officers radioed for help but did not physically attempt to stop the assault at the victim's cell and only verbally ordering the two assailants to stop. An examination of the incident video reveals a third officer, who this Monitor was told was a recruit, stood without a radio in the dayroom observing the incident transpire. Ultimately, other officers arrived to stop the assault but not until the victim suffered multiple stab wounds.

This incident could have resulted in even more serious harm or death to this inmate, the two housing unit officers, and possibly the recruit. This recruit was not wearing a radio and was helpless to assist his fellow officers by calling for assistance if needed. Not ensuring that ALL staff assigned to housing units are required to carry function radios is a very dangerous practice.

RECOMMENDATIONS: Previous recommendations remain appropriate...

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

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

[1] GGACF Incident Number 06-0047-15-IR and Housing Unit Video obtained from GGACF Officials.

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

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

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

Current staffing levels make it literally impossible to ensure that officers make all required rounds per shift while also attempting to monitor prisoner flow for contraband and supervise prisoners not locked in their cells. Supervisor Shift Rounds reports examined for May 2015 cannot verify adequate housing unit inspections and staff supervision. However, Shift Rosters report shifts having only one on-duty supervisor at times, making it impossible for a lone supervisor to inspect all housing units and security areas, monitor staff, and respond to various scheduled and unscheduled duties and events.

RECOMMENDATIONS: Previous recommendations remain appropriate.

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

B. Contraband

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: NONCOMPLIANCE

FINDINGS: Contraband detection and prevention efforts are substantively ineffective due to staffing shortages and evidenced by documented constant high levels of dangerous weapons inmates possess and use to violently attack others, drugs and alcohol, and nuisance items found throughout housing units. Interviews with GGACF Gang Intelligence Search Team (GIST) staff during this visit reveal only four to five contraband shakedowns per month due to staffing shortages. Organized and routine contraband searching should occur on a daily basis by each housing unit officer as well as several times per week by the GIST staff. Housing unit officers must thoroughly search all inmates and items entering and leaving their units, routinely inspect all cells in their units, and constantly and vigilantly monitor prisoner behavior for affertive attempts to conceal and/or transfer contraband.

Examination of incident reports and Evidence Collection Logs (April 16-July 5, 2015) again demonstrate that prisoners have relatively unfettered access to contraband. The following contraband was confiscated – sometimes before violence, sometimes following an assault:

GGACF Contraband Seizures	6th Report (10/3-12/3/2014	7th Report 12/25/2014 - 4/15/2015	8th Report (4/16/- 7/15/2015	Combined Total
1. Days Reporting	60	111	80	251
2. Weapons (Knives, Shanks)	21	28	10	59
3. Cell Phones	32	16	21	69
4. Drugs, Alcohol, Paraphernalia	9	11	3	23
5. Handcuff Key	0	1	0	1
6. Money	3	3	0	6
Assessment Period Totals	65	59	34	158
Confiscations Per Day Rate	1.08	0.53	0.43	0.63

Contraband detection and prevention relies primarily on housing unit officers complying with basic security policies and supervisor instruction. However, such compliance does not appear consistent, assuming supervisors are providing consistent supervising and holding staff accountable. For example, the Shift Supervision reporting process mandates supervisors to ensure that officers can "view into cells". This is a basic security procedure that helps to control contraband as well as ensure prisoner safety and security. However, this visit again found cells with blocked cell-door windows and linens being used by prisoners to completely obstruct officer sight into cells. This chronic security neglect can only exist when 1) officers are not

following basic security tenants and/or, 2) officers are not in control of housing units, and/or 3) supervisors are not making rounds and/or 4) supervisors are making rounds but not ensuring compliance with this policy, and 5) chronic staff deficiencies preventing staff from conducting timely and consistent prisoner supervision and control.

Deficient contraband control contributes to extant physical prisoner-on-prisoner and prisoner-on-staff assaults. The June 4, 2015 inmate stabbing previously discussed is one serious example but it is not the exception. On May 15, 2015 in Unit 9B at approximately 4:00 pm, a prisoner stabbed another prisoner in the back during a fight. A "weapon was recovered" and the victim was transported to the hospital for care.[2]

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

RECOMMENDATIONS:

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

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: Refer to B.a. above.

RECOMMENDATIONS: Previous recommendations remain appropriate.

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

[2] May 15 2015, 4:29pm Notification of Serious Incident and reports provided by BOC counsel.

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

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: Also refer to above Contraband findings and discussion.

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

RECOMMENDATIONS: Previous recommendations remain appropriate.

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

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

ASSESSMENT: PARTIAL COMPLIANCE

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

RECOMMENDATIONS: Previous recommendations remain appropriate.

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

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

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

ASSESSMENT: PARTIAL COMPLIANCE

FINDINGS: Front desk admission security checks seem improved. Monitoring team briefcases were searched before each daily visit and we were required to empty our pockets. However, monitoring team members were not consistently escorted by security personnel to and from each area inspected. For example, on June 9th when Mr. Romero and a USDOJ attorney were not escorted during a tour of X-Dorm and A-Dorm. Additionally, Dr. Stellman, mental health monitor, reported that she was escorted by a recruit officer. This particularly troubling considering the previous discuss regarding a recruit officer not responding to the inmate assault incident. The primary purpose for these escorts is to ensure the safety of the monitoring team. However, if a recruit officer will not or cannot respond to an inmate assault incident, how will or could a recruit officer provide adequate security to the monitoring team? Additionally, the monitoring team was consistently provided identification for each day of this visit. This practice may not be as consistent as it appeared, however, according to Shift Rosters and the Shift Supervisor Rounds Report.

First, very low staffing levels logically suggest GGACF is forced to prioritize duty assignments to where security protection needs are greatest – the housing units and prisoner locations. Second, none of the different Shift Roster forms show "Visitation" as a post for recording staffing levels. Third, the May 11, 2015 2pm-1-pm Shift Supervisor Rounds Report documents "No officer was present [in Detention Visitation] when checked". Finally, most of these Reports recorded no inspection information for Detention Visitation.

Based on these findings, this Monitor found insufficient evidence demonstrating Partial Compliance with this Provision.

RECOMMENDATIONS: Previous recommendations remain appropriate.

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

C. General Security

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

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: Prisoners continue to be allowed to wear personal "street" clothes in and out of the housing units. Several prisoners were observed wearing non-correctional attire in day rooms, their cells, and in the yard. The Territory's most recent prisoner escape involved the prisoner wearing personal clothing to facilitate the escape. This incident alone seems sufficient to have motivated GGACF to fully comply with this provision.

Some on-duty security staff were observed wearing unmarked clothing and some wore unmarked lightweight jackets that covered their uniforms. Unlike specialized law enforcement staff, there is no value or understandable purpose in allowing uniformed security staff to wear unmarked clothing or to wear personal attire that covers portions of their uniforms. The security officer uniform is specifically marked to provide clear and obvious awareness of the presence of a security officer. As such, a marked security officer uniform should never be obscured.

RECOMMENDATIONS: Previous recommendations remain appropriate.

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

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: Refer to previous findings and discussions pertaining to B.a, C.1.a. In addition, come prisoners were again observed either not wearing identification or not properly displaying their identification if it was being worn.

RECOMMENDATIONS: Previous recommendations remain appropriate.

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

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

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

FINDINGS: Previously requested training documents demonstrating completion of staff training on this subject matter have not been provided to this Monitor. Additionally, some of the Shift Supervisor Rounds reports for May 2015 show several inoperable locking mechanisms throughout the facility stating:

- Detention R&D: "Sally Ports remain inoperable along with Exits and Entrances"
- K Unit: "Sally ports are inoperable"
- 9 D: "Unit entrance gate needs to be repaired"
- X Dorm: "A fence should be put up to separate inmates from detainees"

Inconsistent and incomplete use of these reports makes it very difficult to use these documents as a credible sources to advancing this Provision, and it is logical that compliance with this Provision is frustrated by inadequate maintenance staffing levels.

Doors into housing units were routinely observed to be unlocked and open.

During an interview with the Maintenance Supervisor he reiterated previous concerns and frustrations about locking maintenance. He stated that he makes locking system repairs a top priority but is inadequately staffed to maintain a locking system repair and preventive maintain program that is always timely and consistent.

However, even with an adequate locking system maintenance program, prisoners will continue to gain dangerous access to each other until security staff consistently practice good key control.[3]

RECOMMENDATIONS: Previous recommendations remain appropriate.

[3] The June 4, 2015 stabbing incident previous discussed resulted from the prisoner taking cell keys from the hand of an officer.

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

RECOMMENDATIONS: Previous recommendations remain appropriate...

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

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

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: This Monitor examined 15 staff personnel folders during this visit. These documents are maintained in the Administration Building located in a separate building located on the GGACF campus. This document examination found various deficiencies in the personnel folders reviewed:

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

The folders examined were very disorganized and inconsistently maintained. I found no evidence of periodic supervisory review of these records for early staff intervention purposes. Keeping pre-service staff psychological assessment results in the general personal folder is a questionable practice. These records should be considered medical documents pertaining to psychological fitness for service and highly confidential. Additionally, information contained in these documents are is considered "need to know" and should be kept and secured separate from general personnel folders. Psychological findings, however, can be important for assessing recruit performance and understanding staff motivation. This information is also very useful for recognizing working conditions uniquely stressful to an employee so as to provide additional and/or specialized training and/or supervision to that employee.

RECOMMENDATIONS:

1. The employee folder/record system should be standardized and well organized
2. All folders should contain completed Applicant Personal History Statements, criminal history check verification documents
3. Medical records should be kept separately from the general personnel folder
4. Training records should be kept in a staff training folder and separate from the training folder

5. These records should be reviewed periodically for quality assurance purposes and remedial instruction and/or training provide to records staff where indicated.

D. Security Staffing

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

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: As noted in the previous report, the Territory collaborated with the National Institute of Corrections and completed this staffing analysis that incorporated a shift relief factor. This Monitor, in collaboration with the parties, provided a draft staff coverage plan incorporating each security post (i.e. housing units, patrols, supervisors, etc.). Required staffing levels (shift staffing coverage) were determined based on how many staff are required for each post-assignment per shift and multiplied that number by the relief factor of 1.67. This coverage plan establishes the following additional staffing levels:

Security Positions	Coverage Plan 3/2015	2015 Budget Authorized	Total Additional Staff Required
Security Management	6	6	0
TC Command (Lt)	5	4	1
ATC Command (Sgt)	13	7	6
Officer	155	117	38
Total Security Staff	179	134	45

The total additional staffing requirement shown above is in addition to the 2015 budget authorization and does not include currently unfilled positions. As of the previous report, a total of 80 additional security staff were needed (additional and unfilled positions) to comply with staffing requirements of this Agreement. This Monitor is unable to accurately calculate how many total staff are currently required because a current staffing count has not been provided as of the completion of this report.

The Territory has submitted to this Monitor and USDOJ draft policies and procedures required under this Provisions. Those documents are currently in the review process. As discussed in more detail below, the Staffing Plan required under this Agreement remains in draft form and under final revision by the Territory.

RECOMMENDATIONS:

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

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: The Staffing Plan timeline (shown from the previous report below) remains in dispute. USDOJ retains its objection to the seven year time period for filling all positions until the Territory can articulate an acceptable justification or negotiate a shorter timeline, and to the lack of specificity in the Staffing Plan.

VI BOC/ GGACF Hiring Plan			Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Total	
Security Positions	Staffing Plan 3/2015	Staff Needed	2016	2017	2018	2019	2020	2021	2022	2016-2022	Staff Needed
Security Management	6	2	1	1	0	0	0	0	0	2	100%
TC Command (Lt)	5	3	1	1	1	0	0	0	0	3	100%
ATC Command (Sgt)	13	8	2	2	2	2	0	0	0	8	100%
Officer	155	67	10	10	10	10	10	10	7	67	100%
Total Security Staff	179	80	14	14	13	12	10	10	7	80	100%

It is this Monitor's hope that final approval of the required Staffing Plan can be accomplished before or during the September 2015 onsite assessment visit.

RECOMMENDATIONS: Finalize and implement the required Staffing Plan.

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: Draft policies and procedures have been submitted to this Monitor and USDOJ for review and comment.

RECOMMENDATIONS: Finalize and implement required policies and procedures.

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

ASSESSMENT: See above

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

RECOMMENDATIONS: Refer to previous recommendations.

E. Sexual Abuse of Prisoners.

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

ASSESSMENT: NONCOMPLIANCE

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

Also as noted in the previous report, a prisoner's October 20, 2014 complaint of sexual abuse remains not investigated due to the Investigator vacancy according to GGACF officials. **Failure to properly investigate and resolve such compliances violates PREA and federal law**. However, the Territory has informed this Monitor that this position has been filled and the investigator began working on August 24, 2015. The Territory is encouraged to ensure it fully complies with PREA regardless of whether this vacancy is filled.

RECOMMENDATIONS: Previous recommendations remain appropriate.

1. GGACF should take advantage of the National PREA Resource Center at http://www.prearesourcecenter.org/, and the National Institute of Corrections at http://nicic.gov/ for qualified information about PREA compliance, training, and other related resources.
2. Review PREA and develop an action plan for the implementation of PREA requirements.
3. Appoint a PREA Compliance Coordinator as soon as possible.
4. BOC officials are encouraged to send at least one qualified staff person to USDOJ's PREA auditor certification training. All costs are covered by USDOJ.
5. Complete the PREA Self-Audit.
6. Review, revise, develop, train, evaluate policies and procedures that include, at a minimum, the following PREA topics:
7. Fill the Investigator vacancy immediately.

F. Classification and Housing of Prisoners

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

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: The Territory has yet to provide evidence that the current classification system has been validated. However, draft classification policies and procedures have been submitted to this Monitor and USDOJ for review and comment according to the revised Schedule.

RECOMMENDATIONS: Previous recommendations remain appropriate.

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

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

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

FINDINGS: As stated in F.1.a above.

RECOMMENDATIONS: Previous recommendations remain appropriate.

1. Inmates should be housed and separated according to reliable classification process as previously discussed.

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

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

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

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

RECOMMENDATIONS:

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

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

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

FINDINGS: See previously discussed classification findings.

RECOMMENDATIONS: Previous recommendations remain appropriate.

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

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

ASSESSMENT: NONCOMPLIANCE (Downgraded from Partial Compliance)

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

RECOMMENDATIONS: Previous recommendations remain appropriate.

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

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

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

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

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

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

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

RECOMMENDATIONS: Previous recommendations remain appropriate.

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

G. Incidents and Referrals

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

a. Reporting by staff of serious incidents, including
(i) fights;
(ii) serious rule violations;
(iii) serious injuries to prisoners;

(iv) suicide attempts;
(v) cell extractions;
(vi) medical emergencies;
(vii) contraband;
(viii) serious vandalism;
(ix) fires; and
(x) deaths of prisoners;

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

FINDINGS: Examination of Incident Logs and incident reports provided for March through June 2015 demonstrates continued significant and problematic deficiencies with Provision compliance. This examination again found the following document deficiencies:

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

As stated in previous monitoring reports, the existing incident reporting system must be completely overhauled if it is to provide valid and reliable information from which to evaluate serious events in order to comply with this Provision or any provision requiring accurate and complete incident reporting to assess compliance levels. A simple document quality assurance and compliance accountability process should be implemented and minimally include the following steps:

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

RECOMMENDATIONS: Previous recommendations remain appropriate

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

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: As stated in previous reports, a formal and regular administrative process as indicated remains nonexistent. Effective implementation of this process first requires substantial improvements in the current incident reporting systems and reporting review process. Furthermore, valid and meaningful incident data for tracking and management purposes relies completely on the quality of the incident reporting system, quality compliance monitoring, and timely data management.

RECOMMENDATIONS: Previous recommendations remain appropriate.

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

c. Requirements for preservation of evidence; and.

ASSESSMENT: NONCOMPLIANCE

FINDINGS: As stated in previous monitoring reports, the Evidence Log should include incident report numbers to cross-reference incident reports and evidence (i.e. contraband). This revision to the Evidence Log will help to provide efficient and timely matching of incident reports to evidence, and make the Evidence Log a very useful tool for tracking and managing facility incidents for planning, implementation, and evaluation strategic contraband control policies.

RECOMMENDATIONS: Previous recommendations remain appropriate

1. Refer to similar recommendations regarding contraband.

d. Central tracking of the above incidents.

ASSESSMENT: NONCOMPLIANCE

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

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

RECOMMENDATIONS: Previous recommendations remain appropriate.

1. Refer to previous recommendations regarding incident reporting and tracking.
2. Consider implementation of an electronic jail management system for centralization of incident reporting and data analysis.
3. Implement a quality assurance process that consistently ensures incident log accuracy and completeness.

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: As previously stated, deficiencies in the incident reporting system, lack of reporting quality management, and the vacant Investigator position exacerbate making positive progress with this provision despite the absence of approved policies and procedures.

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

RECOMMENDATIONS: Previous recommendations remain appropriate.

1. Include this element in the required policy and procedure.
2. Establish reasonable timeframes as indicated.
3. Develop and implement corrective action protocols to address staff noncompliance with adopted policies and procedures.
4. Initiate corrective action against supervisors and staff who continually fail to submit and/or approve deficient, late, or no incident reports as required by policy and this Agreement.

H. Use of Force by Staff on Prisoners

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

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

ASSESSMENT: NONCOMPLIANCE

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

RECOMMENDATIONS: Previous recommendations remain appropriate.

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

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: Same as above. No improvement.

RECOMMENDATIONS: Previous recommendations remain appropriate.

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

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: See above findings.

RECOMMENDATIONS: Previous recommendations remain appropriate.

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

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS:

RECOMMENDATIONS:

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

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

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

FINDINGS: Same as above. No change.

RECOMMENDATIONS:

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

2. Refer to Training Provision **RECOMMENDATIONS** and apply to this requirement.

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

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

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

RECOMMENDATIONS: Previous recommendations remain appropriate.

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

g. Supervision and videotaping of planned uses of force;

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

FINDINGS: No planned uses of force were reported during this assessment period. However, the Territory did not provide proof that GGACF staff had access to video equipment if needed.

RECOMMENDATIONS:

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

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: No change.

RECOMMENDATIONS: Previous recommendations remain appropriate.

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

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: No change.

RECOMMENDATIONS:

1. Provide Monitor documentation of Compliance with this Provision.

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

ASSESSMENT: NON COMPLIANCE

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

RECOMMENDATIONS: Previous recommendations remain appropriate.

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

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

ASSESSMENT: NONCOMPLIANCE

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

RECOMMENDATIONS: Same as above

l. Administrative investigation of uses of force;

ASSESSMENT: NONCOMPLIANCE

FINDINGS: Same as above.

RECOMMENDATIONS: Same as above

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: Same as above. The Territory did not provide requested documentation necessary for the Monitor to assess compliance with this Provision.

RECOMMENDATIONS:

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

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: Same as above.

RECOMMENDATIONS: Previous recommendations remain appropriate.

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

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

ASSESSMENT: NONCOMPLIANCE

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

.

RECOMMENDATIONS:

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

I. Use of Physical Restraints on Prisoners

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

a. Permissible and unauthorized types of use of restraints;

ASSESSMENT: NONCOMPLIANCE

FINDINGS: Same as above.

RECOMMENDATIONS: Previous recommendations remain appropriate.

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

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: Same as above

RECOMMENDATIONS:

1. Same as above.

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: Same as above.

RECOMMENDATIONS: Same as above.

d. Required observation of prisoners placed in restraints;

ASSESSMENT: NONCOMPLIANCE

FINDINGS: Same as above.
RECOMMENDATIONS: Same as above.

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: Same as above.

RECOMMENDATIONS: Same as above.

f. Required termination of the use of restraints .

ASSESSMENT: NONCOMPLIANCE

FINDINGS: Same as above.

RECOMMENDATIONS: Same as above

J. Prisoner Complaints

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

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

ASSESSMENT: NONCOMPLIANCE

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

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

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

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

RECOMMENDATIONS: Previous recommendations remain appropriate.

1. Conduct monthly administrative reviews of the inmate complaint reporting and tracking process to measure and verify program compliance, take timely and appropriate remedial and correction action.
2. Ensure tracking log is consistently completed and accurate.
3. Assign reliable and timely oversight of the inmate complaint process and logs to a staff person who will provide the process consistent, dedicated, and comprehensive attention.
4. Develop a valid and reliable tracking a quality management statistical report for monitoring inmate and facility needs and problems.
5. Ensure staff are available during onsite visits to allow this Monitor to adequately assess this Provision.

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

ASSESSMENT: NONCOMPLIANCE

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

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

RECOMMENDATIONS: Same as above

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: Same finding related to administrative and use force investigations and reviews.

RECOMMENDATIONS: Refer to administrative and use of force investigation review

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

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

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

FINDINGS: Same as above.

RECOMMENDATIONS: Same as above, and:

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

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: Similar to administrative investigations, use of force and incident reviews, this process remains essentially nonexistent.

RECOMMENDATIONS: Same as above.

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

K. Administrative Investigations

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

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

ASSESSMENT: NONCOMPLIANCE

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

RECOMMENDATIONS: Same as previous report

1. Fill the vacant investigator position.
2. Supervisory/management staff must be consistently held appropriately accountable for adherence to agency rules, regulations, policies, and procedures.
3. The November 2014 housing unit riot must be thoroughly investigated and reviewed to prevent similar future events and to improve organizational planning, response, and management of these types of major incidents.

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: Same as above.

RECOMMENDATIONS:

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

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: No substantive change since previous visit.

RECOMMENDATIONS:

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

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

ASSESSMENT: NONCOMPLIANCE

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

RECOMMENDATIONS: Fill the currently vacant Chief Investigator position immediately.

1. Finalize, approve, and implement relevant policies and procedures.
2. Create a formal pre- and in-service training program to train staff who are involved in initial and/or administrative investigation.
3. Provide adequate training of investigative staff on topics in areas of incident scene investigation and appropriate administrative investigation methods, processes, techniques, legal and ethical issues, etc.
4. Provide training for administrative/leadership in the areas of administrative investigation oversight, coordination, and management.
5. Develop and implement, as an adjunct to these policies and procedures, an "Investigators Manual" that provides guidance to staff responsible for oversight and investigative activities.
6. Provide the Monitor qualification documents for the newly appointed Chief Investigator for review upon his/her appointment**.**

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: No change from previous Report.

RECOMMENDATIONS: Previous recommendations remain appropriate...

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

V. MEDICAL AND MENTAL HEALTH CARE

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

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

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

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

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

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

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

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

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

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

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

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

RECOMMENDATIONS:

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

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

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

RECOMMENDATIONS:

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

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

ASSESSMENT: NONCOMPLIANCE

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

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

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

RECOMMENDATIONS:

1. The Medical Director position was filled in August.

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

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

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

RECOMMENDATIONS:

1. This monitor remains available to assist GGACF in developing standardized mental health intake screening, initial behavioral health evaluation, and progress note forms for implementation in the coming months.
2. Technical assistance is also always available and encouraged regarding development of treatment programs at the facility.
3. Continue to track inmates entering the facility and monitor time from admission, screening, and initial psychosocial assessment. In addition, referrals to the psychiatrist should be monitored for time to completion.

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

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

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

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

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

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

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

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

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

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

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

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

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

RECOMMENDATIONS:

1. Moving forward, a variety of quality indicators regarding services should be developed and maintained to aid the staff in ongoing quality improvement reviews as well as provide proof of practice for the monitoring team and any other Bureau, independent agency or accrediting reviews.

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

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

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

ASSESSMENT: NONCOMPLIANCE. No substantive improvement from previous assessment.

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

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

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

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

RECOMMENDATIONS:

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

3. Provide either a card or a wristband that allows correct official identification for the inmates.
4. Continue to improve the pharmacy arrangements so that it is possible to comply with the Pharmacy Practice Act.
5. The Director of Nursing should monitor the performance of the medication administration process as part of the quality improvement program.

MENTAL HEALTH FINDINGS: 100% of all MARS for the current month were inspected on June 9, 2015, for completeness. Eighteen (18) inmates currently receiving psychiatric medications demonstrated issues that were of significant concern. Rather than list each chart separately, a general summary will be given. On June 2 and June 3, multiple patients did not receive Cogentin, a medication frequently utilized to treat the common neuromuscular side effects of antipsychotic medications.

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

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

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

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

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

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

RECOMMENDATIONS:

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

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

ASSESSMENT: NONCOMPLIANCE.

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

RECOMMENDATIONS:

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

ASSESSMENT: NONCOMPLIANCE

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

RECOMMENDATIONS:
1. Once all records are appropriately organized and filed, a quality improvement tool needs to be developed to track compliance with this provision.
2. The mental health records should be scrutinized in organizing chronological fashion.

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

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

ASSESSMENT: NONCOMPLIANCE

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

RECOMMENDATIONS: See letter (c) findings and recommendations.

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

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

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

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

RECOMMENDATIONS:

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

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

ASSESSMENT: NONCOMPLIANCE.

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

Patient #1

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

Patient #2

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

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

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

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

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

MENTAL HEALTH FINDINGS: The mental health clinic continues to maintain a tracking log for all patients followed by Dr. Sang that appears to be up-to-date during this review. The current log tracks all items critical for ensuring predictable and reliable patient follow up.

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

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

ASSESSMENT: NONCOMPLIANCE.

MEDICAL FINDINGS: See f (ii).

RECOMMENDATIONS: See f (ii).

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

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

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

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

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

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

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

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

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

RECOMMENDATIONS:

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

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

RECOMMENDATIONS: None

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

ASSESSMENT: NONCOMPLIANCE. No substantive improvement from previous assessment.

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

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

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

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

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

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

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

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

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

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

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

RECOMMENDATIONS: None

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

ASSESSMENT: NONCOMPLIANCE. No substantive improvement from previous assessment.

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

RECOMMENDATIONS:

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

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

RECOMMENDATIONS: None

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

ASSESSMENT: NONCOMPLIANCE. No substantive improvement from previous assessment.

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

RECOMMENDATIONS:

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

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

RECOMMENDATIONS: None

i. Adequate suicide prevention, including:

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

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

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

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

RECOMMENDATIONS:

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

(ii) a protocol for constant observation of suicidal prisoners until supervision needs are assessed by a qualified mental health professional;

ASSESSMENT: NONCOMPLIANCE

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

RECOMMENDATIONS:

1. The facility will need to develop a means of documenting whether or not an inmate is maintained on constant observation until the time of the evaluation in order to demonstrate compliance with this provision.
2. Currently, documentation is scattered between an observation form and hit-or-miss notations in the officers' unit log. Implement approved Log of Suicide Watch (PCO) Rounds.
3. Once implemented, these should be reviewed by mental health staff regularly to ensure security's compliance with the policy.

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

ASSESSMENT: NONCOMPLIANCE

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

RECOMMENDATIONS:

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

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

ASSESSMENT: NONCOMPLIANCE

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

RECOMMENDATIONS:

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

ASSESSMENT: NONCOMPLIANCE

MENTAL HEALTH FINDINGS: Currently the monitor has not yet received nor approved an adequate training curriculum, however it is forthcoming based on the training schedule. Therefore, this provision remains noncompliant.

RECOMMENDATIONS:

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

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

ASSESSMENT: NONCOMPLIANCE -

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

RECOMMENDATIONS:

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

(vii) availability of suicide resistant cells;

ASSESSMENT: NONCOMPLIANCE - No Substantive Improvement from Previous Visit.

MENTAL HEALTH FINDINGS: 7th Report: By inspection, GGACF continues to operate without any suicide resistant cells. Inmates requiring close observation are housed in the regular housing units. That placement would require that inmates be placed on constant observation. However, even when inmates have been listed as on suicide watch in the past, it has been noted that observation occurred on an intermittent and unpredictable schedule, if at all.

Construction of a small infirmary and suicide prevention housing area within the medical treatment building has come to a halt reportedly due to finances and relocation of inmate workers to off-site facilities (the latter as a remedy to improve inmate officer staffing ratios).

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

RECOMMENDATIONS:

1. GGACF is encouraged to urgently complete renovations in the infirmary in order to provide appropriate and safe suicide and close observation cells. As expressed in the last 2 reports, all measures should be taken to provide adequate space within the cell, suicide resistant sinks and commodes and the absence of any protruding objects within the cell that would facilitate the placement of a ligature. Please refer to all of the detailed **RECOMMENDATIONS** in the Monitor's fifth assessment report regarding the configuration and structure of suicide resistant housing.
2. Security staff will need to be present in the infirmary to monitor inmates on suicide prevention 24 hours per day.
3. Whenever an inmate is housed in the infirmary a nurse must be present 24 hours a day to complete the required monitoring of the patient every shift.

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

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

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

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

inmates. The officers' log also contains no mention that the inmate was on suicide watch between May 18 and May 20, 2015.

2. Inmate 2 is a 25-year-old male who was placed on suicide watch at the end of April. He was seen daily by the psychiatrist, who proceeded to step him down through the suicide observation levels. The registered nurse documented in her progress note that she notified the officer to maintain a 15 min. watch on the individual. Review of the security documentation indicates that 15 min. documented staggered watches were not completed. There are lapses of up to one hour between entries. In addition entries were only entered on April 30, 2015, between midnight and 12:48 PM. The inmate was placed on watch at 4:30 PM April 29, 2015, released on April 30, 2015 at 1:45 PM. In addition, despite being placed on suicide watch at 4 PM on April 29, 2015, the first documented 15 min. check was at midnight.

3. Neither inmate on suicide watch received adequate monitoring by security, which is a serious deficiency. Most correctional systems will require constant 1:1 observation of any inmate on a safety watch whenever the inmate is housed in a non-suicide resistant cell. This rule applies even when the inmate is on a lower level of watch. At GGACF, inmates are not only in hazardous cells but they are not being adequately observed.

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

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

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

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

MENTAL HEALTH FINDINGS: This area of the Settlement Agreement has shown measurable improvement. There are currently two mental health professionals and a psychiatrist. A registered nurse has been identified to assist the mental health team with medication order transcription and laboratory order review.

Ms. Murray, the Mental Health Coordinator, has been busy organizing the service. Under her direction new programming, monitoring, and data collection has been initiated. This will be discussed under a later provision.

While on site, we were notified that a third mental health professional has been identified and has completed the application process. However, this person has not been hired at this time, which appears to be a human resource department issue. The new Medical Director was hired.

Communication among the medical and mental health team appears good. The mental health coordinator meets daily with her team and the psychiatrist. Ms. Murray also meets weekly with the Health Services Administrator and Director of Nursing. Medical staff have a monthly meeting (that does not always occur). There is an agenda and sign-in sheet, but no minutes. The Health Services Administrator also attends a weekly meeting with the Warden and the Warden's team; however, this meeting addresses mostly security concerns.

The Health Services Administrator has been waiting for the medical director to arrive before initiating medical administration meetings and quality improvement meetings.

RECOMMENDATIONS:

1. Efforts should be made to bring the third mental health professional position online so that all inmates can receive the required initial mental health assessment and treatment programs can be fully implemented.
2. Once there is a full complement of mental health staff, a meaningful staffing analysis can be completed in 6-12 months to determine if additional staff is needed to complete the mission of the service.

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

ASSESSMENT: NONCOMPLIANCE. No substantive improvement from previous assessment.

MEDICAL FINDINGS: The medical program requires an administrative assistant to assist the Administrator as well as the Director of Nursing and others in the leadership team as well as at least 1.4 FTE RN hours to insure that the night shift is covered by an RN seven days a week. It is our understanding that nurses have been identified and the process has been initiated for their hire.

RECOMMENDATIONS:

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

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

ASSESSMENT: NONCOMPLIANCE. No substantive improvement from previous assessment.

MEDICAL FINDINGS: Although access clearly has improved, as evidenced by my direct observations as well as statements from medical staff, the training has not yet occurred and therefore the findings cannot be advanced towards substantial compliance.

RECOMMENDATIONS:

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

MENTAL HEALTH FINDINGS: No change since the 7th report.

Given the absence of sufficient mental health programming, it remains impossible for the facility to determine what the adequate numbers of correctional officers are to properly supervise prisoners' serious mental health needs.

RECOMMENDATIONS:

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

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

ASSESSMENT: NONCOMPLIANCE. No substantive improvement from previous assessment.

MEDICAL FINDINGS: The medical program is now capable of studying processes with regard to parameters like timeliness or continuity. The professional performance of nursing can be also assessed by the head nurse. The overall clinical professional performance is the responsibility of the new Medical Director. With regard to timeliness of services and nursing appropriateness, I would like to see studies that document data looking at timeliness of intake and sick call as well as professional performance on intake and sick call. In addition, I would like to see continuity with regard to both unscheduled and scheduled offsite services with regard to primary care clinician follow-up visits.

RECOMMENDATIONS:

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

MENTAL HEALTH FINDINGS:

Continuous Quality Improvement polices have been approved and training was completed August 24-26, 2015. It is reported that since our last visit there still have been no meetings of the Medical Administration Committee or the Quality Improvement Committee. Hence, there were no meeting minutes available to review.

RECOMMENDATIONS:

1. Essential monthly or quarterly management meetings should be occurring. Although it is useful for the medical director to be present, this should not be an essential component blocking communication between medical staff and other department leaders. Failure to implement these critical committees delays essential communication between administration and medical and remains a major deficiency.

m. Adequate dental care;

ASSESSMENT: NONCOMPLIANCE

MEDICAL FINDINGS: We did find improvements, especially in access to services. About 90% of scheduled appointments are being seen. For this, custody and the dental program should be commended. Less than 10% of the total appointments resulted in unexcused no-shows. This is a significant improvement. We have also looked at the ratio of extractions to restorations, which currently has a ratio of about 10 to 4. We encourage programs to attempt to achieve, if possible, a 1 to 1 ratio.

RECOMMENDATIONS:

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

MENTAL HEALTH FINDINGS: Dental hygiene is important for good mental health. However, this vulnerable population may be overly reluctant to seek oral care even when in pain. It is very important that GGACF health care services are proactive in monitoring the dental hygiene of this population.

RECOMMENDATIONS:

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

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

ASSESSMENT: NONCOMPLIANCE. No substantive improvement from previous assessment.

MEDICAL FINDINGS: We have reviewed the policy, but although there was a recent death, no one has reviewed it. Since the new Medical Director had no role in the care of the patient who died she would be the perfect person to perform a review, which she and I could discuss at our next visit.

Although this case was in the hospital a long time, the review must focus on care provided at GGACF.

RECOMMENDATIONS:

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

MENTAL HEALTH FINDINGS: No deaths were reported this quarter or significant mental health morbidities. No change since the 7th Monitor's Report.

RECOMMENDATIONS:

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

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

ASSESSMENT: NONCOMPLIANCE.

MEDICAL FINDINGS: As we understand it, a nurse is making rounds three days a week and mental health is making rounds weekly. This particular element may achieve substantial compliance at the next visit. We would look for consistency of the presence of the medical and mental health staff as well as documentation of cases referred over a period of three months based on those rounds.

RECOMMENDATIONS:

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

MENTAL HEALTH FINDINGS: Soon after the time of the April 2015 site visit, I was informed that Ms. Murray initiated segregation rounds. While on site, I accompanied the mental health professional while she completed these rounds. It was quite evident that the inmates are accustomed to seeing her on a regular basis. The noise level and chaos within the segregation units was noticeably absent during his rounds. Her rapport with the inmates was excellent and rounds were conducted in a competent and effective manner. Not only did she see inmates on the mental health list, but she also conducted rounds on all segregation inmates as well as any identified mental health caseload inmate who was in special housing or restriction on non-segregation units. Ms. Murray developed a tracking form for these rounds that gives information regarding the inmate's general well-being, condition of his cell, and any specific needs that he or she may have.

A review of the segregated rounds log from June 2, 2015 was completed. Four inmates who received a rating of poor under “appearance and behavior of the inmate” received a chart review. All four were being followed regularly by the psychiatrist. One was attending weekly groups.

RECOMMENDATIONS:

1. The Mental Health Coordinator will keep documentation of weekly rounds and this provision will be monitored at the time of the next site visit.

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

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

MENTAL HEALTH FINDINGS: There is no change in the findings for this provision since the baseline visit. Inmates with serious mental illness continue to be housed on a long-term basis in disciplinary/administrative segregation units. This reviewer also observed three inmates with serious mental illnesses being housed in locked single cells (protective custody) for vulnerabilities secondary to their mental illnesses in a general population detainee unit. These inmates are allowed congregant out-of-cell unstructured time for two hours each evening. Of note, since our last visit mental health has initiated group therapy at least weekly with these three inmates. During segregation rounds, the mental health professional and I visited these men who all seemed calmer, better organized, and clearly enjoying the programming provided to them.

There is currently no formal enhanced programming for seriously mentally ill inmates in isolation or segregation. However, Mr. Rosas has been able to include some of these inmate in his general group therapy sessions held in the medical treatment building. The facility has moved forward in initiating renovations to the group room on the segregation units. Once these are completed it is hoped that mental health will be able to do a variety of activities with inmates housed in these areas.

RECOMMENDATIONS:

1. As per the provisions of this Settlement Agreement, inmates with serious mental illnesses may not be placed in isolation. The Bureau of Corrections needs to develop a corrective action plan with specific recommendations for capital improvements and dates to remedy this deficiency.
2. During the time that inmates remain in segregation with serious mental illnesses, mental health staff should be aware that these inmates be offered a minimum of 10 hours a week of unstructured out-of-cell time by security. In addition, mental health staff is encouraged to develop supportive group or individual therapeutic activities, generally recommended being a minimum of 10 hours per week per inmate in order to support the inmate's mental state as well as assist inmates in acquiring skills to move them off the segregated status and sustain themselves in the general population setting.
3. Medical services needs to ensure that communications regarding inmate needs gathered in administrative or other meetings be formally entered onto a referral sheet to the clinic for improved follow up.

q. Review by and consultation with a qualified mental health provider of proposed prisoner disciplinary sanctions to evaluate whether mental illness may have impacted rule violations

and to provide that discipline is not imposed due to actions that are solely symptoms of mental illness;

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

MENTAL HEALTH FINDINGS: No change in practice since the 7th report. Currently mental health receives no notifications when an inmate is placed on disciplinary status.

RECOMMENDATIONS:

1. GGACF should develop a form that can be sent to the Mental Health Coordinator, completed by mental health staff and submitted to the disciplinary committee. The committee can use the same form to communicate back to the mental health staff the outcome of the hearing proceeding.
2. GGACF needs to develop an effective policy and process to provide mental health review and input into the disciplinary process.
3. Mitigating factors discovered by the mental health professional must be considered by the disciplinary committee.
4. Mental health services should track the effectiveness of their input in mitigating sanctions or terminating sanctions as appropriate.
5. Alternative housing and treatment services are an essential component in diverting seriously mentally ill inmates committing infractions due to their impaired judgment and mental processing. Again, it is recommended that GGACF provide appropriate staffing and housing alternatives for this population. (See V.1.p.)

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

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

MEDICAL FINDINGS: We are seeing some progress in the completion of the examination rooms. However, progress remains very slow. The most advanced rooms were exam rooms in L and K, but even those lacked a few basic elements needed for use. All the other exam rooms were substantially behind with regard to both equipment and basic supplies like soap, wastebaskets, sink hook-ups, etc. Additionally, the infirmary is fairly close to completion. Two rooms should be made suicide-proof, the dental operatory needs to be moved and appropriately equipped and other relevant equipment needs to be provided for both the pharmacy and medical area. A patient call system needs to be made available.

RECOMMENDATIONS:

1. Complete the exam rooms in all of the housing units.
2. Complete the infirmary including suicide-proof rooms, patient-to-nurse call system, pharmacy equipment and other requirements of the infirmary.

MENTAL HEALTH FINDINGS: The psychiatrist and MHP are using private offices in the treatment building. However, once the medical director and other medical providers are on-site running clinics, space may yet again be an issue.

Private examination offices are being renovated in all of the housing units on the prison side. Once complete, these will be available for medical sick call and provider encounters. It is also hoped that mental health professionals can access these offices when medical staff is not utilizing them for private individual counseling or psychiatric visits. As mentioned previously, the facility is renovating some of the multipurpose rooms on the segregation units for use by mental health staff for group programming.

RECOMMENDATIONS:

1. Continue with current renovations.

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

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

MENTAL HEALTH FINDINGS: No change since the last site visit but this area of treatment planning is being addressed by the Mental Health Coordinator. Access to care has been addressed under other provisions in this agreement. Documentation of weekly group notes was observed in multiple charts reviewed. Inmates that were interviewed on rounds during this visit also expressed their pleasure with the current groups offered and found them to be of great benefit. Follow up visits noted during chart reviews were timely based on the expected return date documented in the prior note.

Currently, the facility and the island rely on Dr. Sang as the only psychiatrist on St. Croix. GGACF should consider telemedicine as a backup for Dr. Sang during her planned vacations and also for offsite medical consultations. This mode of treatment is well accepted and commonly used in the states, particularly in rural jails and prisons. Besides the obvious benefit of greater access to numerous consultants there are marked reductions in costs due to decreased or absent transportation costs to the facility.

RECOMMENDATIONS:

1. Based on policy and developed protocol, treatment plan should be updated at set frequencies based on inmate need and changing conditions in the inmate status. It is strongly recommended that supervisory review occur to ascertain the appropriateness and completeness of the treatment plans generated.
2. When indicated, in-service training on treatment plan development is recommended to ensure consistency between staff members in developing measurable objectives toward marked improvement in those inmates followed by the mental health team.

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

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous visit.

MENTAL HEALTH FINDINGS: Mental health is currently providing six groups per week in the facility. There is one group for the female inmates. Weekly segregation rounds are occurring. During performance of the segregation rounds the mental health professional does check the officers' log books and will schedule individual follow-up when the need is identified. Ms. Drigo, the medical case manager, continues to work with classification on discharge planning. She will notify mental health whenever someone is scheduled to parole from the facility and she will make outside appointments. The medical/mental health service is planning to initiate a needs assessment as soon as a policy is approved.

RECOMMENDATIONS:

1. The mental health team will need to develop a global treatment menu designed to meet the needs of inmates at different levels of housing and treatment needs as discussed in detail in the recommendations in the 7th report regarding required programming for special populations.

2. Group programming should be designed to meet the clinical needs of individuals who should be assigned to those programs based on their needs assessment on their individual treatment plan.

3. The facility should consider how it might create a special population housing unit to make the delivery of services more efficient to those who require enhanced mental health services.

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

ASSESSMENT: NONCOMPLIANCE

MENTAL HEALTH FINDINGS: See V.1.c. & d

RECOMMENDATIONS:

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

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

MENTAL HEALTH FINDINGS: No change since the 7th report. This will be covered in the upcoming training slated for 2016.

Correctional officers at GGACF should be commended for continuing to comprehensively complete behavioral checklists to initiate referrals for mental health services.

RECOMMENDATIONS:

1. Continue to utilize the Behavioral Checklist process.

2. Conduct a facility quality improvement morbidity review that can be submitted to the monitoring team for review.

(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: There continues to be no improvement in this area. Inmates with serious mental health issues continue to be maintained in segregation due to the lack of appropriate housing, programming, and coordination with security and classification.

The Warden has established a weekly meeting which does include the Health Services Administrator. Hopefully, this meeting will evolve into an effective forum to develop alternatives for this group of individuals.

RECOMMENDATIONS: No change since the 7th report

1. The Health Services Administrator needs to coordinate monthly Medical Administration Committee (MAC) and Quality Improvement meetings, documented by minutes and attendance sign-in sheets. These meetings should include the Warden or her designee.

VI. FIRE AND LIFE SAFETY

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

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

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

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from the previous assessment. However, with the assignment of a full-time fire safety officer, there was an incremental improvement in the conducting of monthly fire safety inspections of all areas of the facility and soliciting the expertise of the Fire Safety Marshal to help develop the GGACF fire safety program.

FINDINGS: The Territory reported that they have been working with Corrections Corporation of America (CCA) to help develop the facility policies and procedures. However, at the time of our site visit, the policies and procedures governing Fire Safety had not yet been addressed. Since the visit, the draft policy was sent to the Monitor and United States for review and returned to the Territory for further revisions. The finalization, approval, staff training and implementation of these policies and procedures remains vital.

Inadequate housing unit staffing levels and contraband control practices continue to enable inmates to ignite various materials in the housing units as evidenced by our April 2015 and June 2015 inspections of the housing units. During these inspections, I observed lit wicks and smoke emanating from them in several housing units. Supposedly, inmates use the smoke from the lit wicks to ward off insects. However, aside from the contraband problem stemming from the use of wicks, it also continues to create fire hazards. It appears that staff have relented to the use of lit wicks by inmates and do not prohibit their use. Cigarette butts were again observed on the ground in the recreation yard for the Gulf housing unit.

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

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

During our inspection, I also observed exposed electrical wiring throughout various areas of the Facility, including the kitchen, housing units and maintenance shops. Maintenance staff addressed the problem with clutter and exposed wiring in the electrical and boiler rooms that I re-inspected from our last site visit. In the kitchen I continue to observe boxes stacked in the dry storage area nearly up to the ceiling (should be stacked no higher than 30 inches below the ceiling). This was an identical finding in our last two reports. These findings, in addition to previous findings, reveal the urgent need to develop and implement a comprehensive fire safety program at GGACF.

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

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

RECOMMENDATIONS:

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

1. Finalize and implement fire safety policies once approved and according to the Monitor's schedule.
2. Repair/replace/install fire detection and suppression systems throughout the entire campus and structures.
3. Train all staff on this plan.
4. Install self-contained breath apparatuses (SCBAs) or an appropriate alternative at all locations where staff would need to search for or evacuate people.
5. Conduct and document quarterly fire drills for all shifts and document those activities.
6. Officials must continue to critically review staffing levels to ensure adequate inmate supervision and flammable contraband control in the housing units, fire detection, response, suppression, evacuation, and incident security.

7. Additional part-time fire safety officers should be selected from the officer corps, trained, and participate in the administration of a comprehensive fire safety program. It is unrealistic to expect one expert to develop and oversee such a complex program.
8. Supervisors should conduct routine, scheduled and unscheduled physical inspections of occupied structures, taking particular note of fire risks and hazards, document and report those findings to administration for timely and appropriate corrective action.
9. The fire inspection program was detailed in the draft fire safety policies and procedures that the monitor provided to the parties, and they should become a fundamental element of pre-and in-service training once policies and procedures are finalized, approved, and implemented. It is anticipated that the new policies and procedures that CCA is helping the BOC develop meet all of the requirements of Settlement Agreement.

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

ASSESSMENT: NONCOMPLIANCE

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

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

GGACF staff continue to indicate that sprinkler heads may be replaced in the "newer" buildings at some point in 2015. During previous inspections, we were provided with a letter, dated November 24, 2014, directed to the Department of Interior from the BOC Director requesting to allocate funding to aid in the replacement of the fire suppression system and for refurbishing the Kitchen at GGACF. However, the scope of work for the fire suppression system seems to only include the purchase and installation of fire sprinkler heads and related parts in areas of the Facility where there is a fire sprinkler system, but does not seem to address the need to install a fire sprinkler system such as in the old housing units where there is no fire sprinkler system. This needs to be clarified. The estimated cost for the fire sprinkler heads and related parts is approximately $89,700.00. Moreover, GGACF plans to continue to house individuals in the "older" buildings, and has no plans to update or install fire suppression equipment in those buildings. As reported in earlier monitoring reports, GGACF will never come into compliance with these provisions if that remains the case

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

RECOMMENDATIONS:

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

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: Documentation demonstrating compliance with this Provision was not provided during this assessment. In our previous report, GGACF staff indicated that fire drills have not been conducted on a regular basis. The Fire Safety Officer has commenced a process for conducting fire drills. The Fire Safety Officer reported that during the recent inspection by the Local Fire Safety Marshal, a joint fire drill was conducted in Housing Unit 9D. Hopefully the results of this fire drill will be addressed in the June 2015 Fire Marshal's report. It is laudable that the new Fire Safety Officer has started addressing the necessity to conduct fire drills. The failure of GGACF staff to conduct fire drills on a regular basis of all facility areas continues to put inmates at risk of injury or death, should a fire break out that cannot be suppressed by the hand-held fire extinguishers present in the officer control pods of housing units.

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

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

During this inspection I inspected the cells in the intake area, which at times houses juveniles or high level protective custody prisoners. We again observed that these cells had padlocks on the cell doors. If this fire safety practice remains, coupled by the fact that when inmates are housed in these cells where there is not constant and direct supervision, or a functioning smoke alarm system or fire sprinkler system, it will continue to put the prisoners at a high risk of harm.

RECOMMENDATIONS:

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

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

ASSESSMENT: NONCOMPLIANCE

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

There is not a written preventative maintenance program or a regular security inspection program in place for checking that cell locks are functional and are not jammed from the inside or outside of the cell, nor a system for ensuring that all facility remote locking cell mechanisms are functional. Although the maintenance supervisor reported that there has been a decrease on call outs for lock repairs. During this monitoring visit we continue to observe evidence of inmates compromising the cell locks by inserting various materials in the locking mechanisms.[4] We also continue to observe numerous housing unit grills whereby the locking mechanism was inoperable and the grills left open. For example, in Housing Units 9A and 9B we observed that all entry grills were open with the exception of the grill leading into the 9A Housing Unit.

[4] Further evidencing the problem with inmates/detainees jamming their cell doors, the Hearing Officer in her May 2015 monthly report addressed this problem and concern about inmate/detainees being able get out or in of their cells by tampering or jamming the cell door locks.

BOC is processing the financial document (purchase order) that must accompany the contract. This should be completed soon. Thereafter, the Director will sign the contract and the contract will then be submitted to the Department of Property & Procurement, Department of Justice and then the Office of the Governor.

RECOMMENDATIONS: Same as above.

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

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: Although the previous Fire Safety Officer reported that he was involved in training staff on fire and life safety procedures, we were unable to ascertain its' validity because as stated in the previous reports and in our current site visit, no records have been provided to verify that all staff have been trained and tested on safety procedures. The new Fire Safety Officer reported that he is in the process of setting up a hands-on training on the fire extinguishers, which is a good start. However, this provision of the SA requires a more comprehensive program for testing of all staff regarding fire and life safety procedures.

RECOMMENDATIONS:

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

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

ASSESSMENT: NONCOMPLIANCE

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

During our previous monitoring visit we observed that GGACF has had the necessary equipment for installing a manual fire alert notification system stored in an office for about two (2) years. It appears that in order to install this system, the facility needs to provide the

necessary electrical components. However, in light of the acting BOC Director's comments regarding the fire safety upgrades, a fire notification system is contemplated in that project.

RECOMMENDATIONS:

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

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

ASSESSMENT: NONCOMPLIANCE

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

RECOMMENDATIONS:

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

h. Fire suppression;

ASSESSMENT: NONCOMPLIANCE

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

RECOMMENDATIONS:

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

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: The requirements for this provision are addressed in the draft Fire and Life Safety Policies and procedures that were provided to the parties in December 2014. Unfortunately, however, they were not addressed in the CCA newly revised policy and procedures on Fire and Life Safety that were submitted to the Monitor and USDOJ on July 24. USDOJ returned the

policy and procedures to the Territory with comments. Once adequately revised and approved, staff must be trained on them and they need to be fully implemented.

RECOMMENDATIONS:

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

j. Control of highly flammable materials.

ASSESSMENT: NONCOMPLIANCE

FINDINGS: Many inmate cells contain considerable personal property, thus creating a fire and safety risk. Identical to previous reporting, flammable storage areas/cabinets in the Carpentry shops do not appear to be properly vented.

RECOMMENDATIONS:

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

VII. ENVIRONMENTAL HEALTH AND SAFETY

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

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

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

ASSESSMENT: PARTIAL COMPLIANCE

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

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

The Maintenance Supervisor maintains preventative maintenance schedules for various components of the GGACF physical plant, including the emergency generator.

However, during this inspection we continued to observe inoperable doors and grills, inoperable showers, mold in showers, non-functioning water fountains, plumbing leaks and security fencing breaches.

RECOMMENDATIONS:

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

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

b. Adequate ventilation throughout the facility;

ASSESSMENT: NONCOMPLIANCE

FINDINGS: As stated in previous reports, ventilation throughout all housing units remains troubling. High summer temperatures and humidity make the housing units and cells constantly uncomfortable for breathing. High temperatures and poor ventilation can contribute to and exacerbate pulmonary illness, and potentially jeopardize the health of inmates on psychotropic medications (many such medications can cause harmful reactions when body temperatures are elevated). During this site visit we took random heat index reading of some housing unit dayrooms and cells.

Most of the housing unit exhaust fans remain inoperable. This is especially harmful for inmates unable to afford to purchase fans and inmates with serious mental illness on certain medications.

During previous inspections the Monitoring team was provided with a draft proposal regarding a Detailed Energy Audit conducted by Energy Systems Group, dated November 10, 2014. This proposal includes measures to retrofit the lighting system, the air conditioning system, the PV Panels and for conducting plumbing upgrades at the Facility at an estimated cost of approximately $8,425,106.69. However, during our last inspection we were informed by the acting BOC Director that there is no long term plan to address the ventilation issues. Certainly upgrades are necessary for the continued operation of GGACF.

RECOMMENDATIONS:

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

action to mitigate environmental conditions that create health risks caused by those conditions.
6. Medical and mental health professionals should closely monitor inmates being administered medications that are adversely affected by high body temperatures and take appropriate steps to eliminate adverse effects.

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

ASSESSMENT: PARTIAL COMPLIANCE

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

RECOMMENDATIONS:

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

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

ASSESSMENT: PARTIAL COMPLIANCE

FINDINGS: Very little change since previous inspections. This provision remains in partial compliance but no decline in performance was found. Identical to our previous inspection, we noted that the overhead door to the storage area of the Kitchen is not properly sealed and rodents and vermin can easily infiltrate the Kitchen. Inmates in the housing units complained of insect presence. Some inmates have lit "wicks" made, apparently, of toilet paper on their cell windows and floor, hoping that the smoke will deter insects. We also observed missing or broken screens on many facility windows.

The BOC has contact with a private vendor (Oliver Exterminating of St. Croix) to provide pest control services at GGACF.

RECOMMENDATIONS:

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

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

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

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

RECOMMENDATIONS:

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

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

ASSESSMENT: NONCOMPLIANCE – No substantive improvement from previous assessment.

FINDINGS: No substantive change from previous assessment.

There is no formal sanitation plan or protocols covering compliance with neither this Provision nor a formal training program for staff or inmates on this topic. Staff and inmates must be trained and demonstrate competence in handling bio-hazardous materials, provided and instructed on the proper use of bio-protective clothing and supplies, and supervisors must closely monitor biohazard clean-ups. Remaining in noncompliance with this Provision can jeopardize the health of staff and inmates.

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

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

Spill clean-up kits were available in the medical area.

RECOMMENDATIONS:

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

g. Mattress care and replacement;

ASSESSMENT: PARTIAL COMPLIANCE

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

RECOMMENDATIONS:

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

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

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

ASSESSMENT: PARTIAL COMPLIANCE

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

RECOMMENDATIONS:

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

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

ASSESSMENT: NONCOMPLIANCE

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

RECOMMENDATIONS:

1. Finalize, approve, and implement relevant policies and procedures.
2. Cease the practice of allowing inmates to wash personal and issued clothing in toilets and sinks.
3. Cease the practice of allowing inmates to dry clothing on make-shift clotheslines in their cells.
4. Routine and consistent replacement of damaged mattresses, mattress cleaning, cleaning of bedding.

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

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: During previous inspections, Territory officials reported the initiation of a major project to repair and clean-up the kitchen area. A scope of work for the project was submitted to the BOC Director on July 11, 2014. The acting BOC Director reported that the BOC received a federal grant last year for approximately $400,000.00 for GGAC kitchen improvements, but also included an outside project. The acting Director reported that he was trying to reorganize the grant disbursement to be used only for GGACF.

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

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

RECOMMENDATIONS:

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

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

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

k. Sanitary and adequate supplies of drinking water.

ASSESSMENT: NONCOMPLIANCE

FINDINGS: No major improvement was again observed in the housing units during this assessment with the exception of X-Dorm.

The lack of constant reliable access to drinkable water further prevents GGACF from ensuring that inmates live in a healthy environment. Many of the cell sinks were still inoperable and inmates rely on officers to provide water before and during lock down. Access to drinkable water is generally available during the "out of cell" periods but inmates must rely on the presence and actions by officers following lock down. Inmates have no access to drinkable water when there are no officers on the units to provide it and water from cell-sinks is considered not safe for drinking. In previous site visits, inmates consistently complained of seeing particles of rust in the ice that is provided to the housing units. Since our last visit this area seems to have improved. However, a long-term solution to the problem still needs to be addressed.

In X-Dorm we had been reporting a consistent problem regarding the lack of drinking water for this unit. However, since our last site visit GGACF officials have addressed this problem by installing portable water bottles in the dorm.

RECOMMENDATIONS:

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

VIII. TRAINING

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

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

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: Draft training policies and procedures remain under review and revision for final approval. These documents include required content listed in this provision.

RECOMMENDATIONS: Previous recommendations remain appropriate.

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

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

ASSESSMENT: NONCOMPLIANCE

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

RECOMMENDATIONS: Finalize and implement approved training policies and procedures.

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

ASSESSMENT: NONCOMPLIANCE

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

RECOMMENDATIONS: Same as above.

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

ASSESSMENT: NONCOMPLIANCE

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

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

IX. IMPLEMENTATION

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

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

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

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

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

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

FINDINGS: As stated above.

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

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

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

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

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

FINDINGS: The Territory filed the required quarterly report on June 4, 2015. This report does not describe actions defendants have taken to implement each provision of the Agreement. This report, however, does appear to comply with the Court following the March 5, 2015 status conference. Going forward, the Territory is encouraged to develop a standard document format to describe progress with all provisions of the Agreement. This Monitor remains willing to assist the Territory with this matter if requested.

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: Despite delay in a few notifications and follow-up incident documentation, including the Territory's failure to provide any documentation as to serious suicide attempts, as required by the policy and requested by the USDOJ on May 12, 2015, there has been marked improvement with this requirement.

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

FINDINGS: The Territory continues to revise and develop new documents to demonstrate compliance with this Agreement. However, quality management of many records remains problematic. These issues, for example, were previously discussed with regard to incident reports, shift rosters, segregation review forms, and the grievance log. The Territory is encourages to implement the Monitor's recommendations regarding document quality assurance and management. Doing this will significantly support the Territory's ability to demonstrate compliance.

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

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

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

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

X. Monitoring

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

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

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

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

APPENDIX A
ASSESSMENT METHODOLOGY

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

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

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

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

   In general, compliance assessment will include the following activities:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A) Corrections Information:

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

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

B) Medical and Mental Health Information:

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

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

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

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

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