United States Territory of the Virgin Islands
Golden Grove Adult Correctional Facility
Settlement Agreement
1:86-cv-00265-WAL-GWC

Court-Appointed Independent Monitor's
Eleventh
Compliance Report
Submitted Mary 29, 2016

Dr. Kenneth A. Ray, DBH, MEd
Court-Appointed Independent Monitor

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Corrections Medicine

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PURPOSE

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

EXECUTIVE SUMMARY AND ASSESSMENT OVERVIEW

This onsite compliance monitoring assessment was conducted March 14-17, 2016, and included a focused and productive Court status conference, which was held on Thursday, March 17, 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 measurable compliance requirements (Provisions). Combined, these six sections contain 133 provisions (sections IV-IX); 123 of these represent five (5) primary substantive sections and their respect sub-sections (IV-VIII), while ten (10) provisions are contained within only one section, Section IX. Implementation. The five substantive sections include:

Agreement Sections & Subsections		Substantive Provisions
1	**IV Safety & Supervision**	**61**
	IV.A. Supervision	4
	IV.B. Contraband	5
	IV.C. General Security	5
	IV.D. Security Staffing	4
	IV.E. Sexual Abuse of Prisoners	1
	IV.F. Classification & Housing	6
	IV.G. Incidents & Reporting	5
	IV.H. Use of Force by Staff on Prisoners	15
	IV.I. Use of Restraints on Prisoners	6
	IV.J. Prisoner Complaints	5
	IV.K. Administrative Investigations	5
2	**V. Medical & Mental Health**	**36**
3	**VI. Fire & Life Safety**	**11**
4	**VII. Environmental Conditions**	**11**
5	**VIII. Training**	**4**
	Total Provisions	**123**

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 advances each Provision once substantive progress is clearly demonstrated by the Territory:

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 demonstrating that implemented policies, procedures, and training are measurably performing within the outcome expectations of this Agreement.

A Provision advances from noncompliance to partial compliance when 1) required policies and procedures for the Provision are approved by the Monitor, United States, and the Territory; 2) when 95% of staff required to be trained on the policies and procedures have done so with a minimum passing score of 80%; 3) the policies and procedures are fully implemented, and 4) the Territory objectively and measurably demonstrates implementation effectiveness. A Provision advances from partial to substantial compliance when continued valid and reliable evaluation of implemented policies, procedures, protocols, plans, etc. clearly justifies advancement. Justification is based on quantitative and/or qualitative evidence: 1) that implementation efforts are producing measurable outcomes intended in the Agreement, and 2) that outcome performance is valid and reliable (performance evaluations are likely to produce consistent and sustainable compliance). 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.

Some Provisions overlap. For example, many medical, mental health, and suicide prevention Provisions involve independent compliance assessment and scoring by both of the Monitor's medical and mental health experts. Such Provisions are advanced to the next level when both experts advance the Provision. The Provision, however, remains at the lowest compliance score when the experts' scores differ.

Revised Compliance Scorecard:

As "scorecard" has been used since the 2013 Baseline assessment to numerically measure compliance progress. A revised scorecard is used for this and future reports. The scorecard will use a point system and color-coding to represent the Monitor's compliance ratings as defined in this Agreement. The three defined compliance ratings are assigned a point value and color to more accurately measure and visualize compliance progress toward dismissal of the Agreement. The chart below shows point values and color-codes used for each compliance rating required under this Agreement.

Non-Compliance	**Non-compliance indicates that Defendants have not met most or all of the components of the Agreement**	**Red**	**0**
Partial Compliance	**Partial Compliance indicates that Defendants achieved compliance on some of the components of the relevant provision of the Agreement, but significant work remains.**	**Yellow**	**1**
Substantial Compliance	**Substantial Compliance indicates that Defendants have achieved compliance with most or all components of the relevant provision of the Agreement.**	**Green**	**2**
Sustained Compliance	**Sustained compliance is not defined in the Settlement Agreement per se. It is used to rate a Provision that has maintained Substantial Compliance for one (1) year, 12 consecutive months. The Agreement shall terminate when Defendants achieve Substantial Compliance with all substantive provisions of this agreement and maintain that compliance level for one (1) year, 12 consecutive months.**	**Blue**	**3**

Additionally, a re-audit of the Agreement determined there are 123 substantive provisions versus 120 as previously report. The monitoring team has assessed and reporting on all provisions; this Monitor inadvertently combined three provisions and simply miscounted the number of provisions.

Measuring Progress toward Dismissal of the Agreement

The new scorecard is used in other CRIPA cases by this Monitor and has shown to be very effective for simply and accurately tracking and visualizing compliance progress for dismissal purposes. Defendants and plaintiffs in similar CRIPA cases found this method helpful for self-

monitoring their progress and compliance status. The United States accepted this method and continues to use it in one case in which this Monitor manages.

There are 123 substantive provisions in this Agreement. The agreement can be dismissed once all 123 provisions have reached and maintained Substantial Compliance for 12 consecutive months (one year). Each compliance rating is assigned a point value to measure progress toward dismissal:

- NonCompliance – 0 Points
- Partial Compliance – 1 Point
- Substantial Compliance – 2 Points
- Sustained Compliance – 3 Points (a provision has maintained Substantial Compliance for 12 consecutive months)

Dismissal of the Agreement, therefore, requires achievement of 369 points (Sustained Compliance (3 points) for each of the 123 substantive provisions (3 points x 123 provisions = 369 points). The scorecard advances or regresses as compliance improves or declines. The example below is shown for the four (4) Supervision section (IV.A.1-4) provisions. Assessment reports one (1) thru 11 are shown horizontally above provision-ratings and color-coding. The number of provisions in each of the four (includes Sustained Compliance) is shown to track progress from report to report. “Progress Points” are the sum of points using the numeric rating method. Finally, the bottom row shows the percentage of provisions that remain in NonCompliance.

Agreement Section & Substantive Provisions		Compliance Assessment Report Number & Scores										
IV.A. Supervision		**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**
1	IV. A1a: Unit Security Stratification & Management	0	0	0	0	0	0	0	0	0	0	0
2	IV. A1b: Post Orders & Unit Office/Supervisor Staffing	0	0	0	0	0	0	0	0	0	0	0
3	IV. A1c: Officer Communications	0	0	1	1	1	1	1	1	1	1	1
4	IV. A1d(i,ii) Security Rounds All Units & Areas	0	0	0	0	0	0	0	0	0	0	0
	# NonCompliance	4	4	3	3	3	3	3	3	3	3	3
	# Partial Compliance	0	0	1	1	1	1	1	1	1	1	1
	# Substantial Compliance	0	0	0	0	0	0	0	0	0	0	0
	# Sustain Compliance	0	0	0	0	0	0	0	0	0	0	0
	Progress Points	0	0	1	1	1	1	1	1	1	1	1
	Percent Out of Noncompliance	0%	0%	25%	25%	25%	25%	25%	25%	25%	25%	25%

A similar scorecard is included herein to track and visualize compliance progress of the Agreement, each section and subsection. Graphs will be included in future reports to improve progress visualization.

Eleventh Assessment Brief Summary

Eleventh Summary & Scorecard

Four (4) Medical/Mental Health provisions advanced from NonCompliance to Partial Compliance as a result of this assessment findings. These provisions include:

1. V.1c: Defined Timely Access/Provision Adequate M/MH Care.
2. V.1d(i,ii,iii, iv): Timely RX Orders & Labs, Timely & Routine Physician Review of RX & Clinical Practices, Qualified Review of RX for Side Effects, Qualified Review of RX for Side Effects. Sufficient RX Upon Discharge for Serious M/MH Needs.
3. V.1f (iii): Appropriate/Timely Chronic/Acute Care/Follow-up w/Clinical Practice Guidelines.
4. V.1f (iv) (1, 2, 3): Adequate Provision of Emergency Care, Defined Emergency Care Training for Staff.

There was no change in the compliance ratings for all other provisions. This is primarily due to the fact that none of the security-related and operational policies and procedures have been officially approved and implemented by the Territory, but much progress has be made to do so. Currently, virtually all of these policies have been either approved by this Monitor and the United States or are in that process. Additionally, the Territory has selected a well-qualified contractor to develop and implemented the required training curricula for these policies and procedures. This progress is very promising and clearly demonstrates the Territory's commitment to complying with agree in this regard.

However, and not withstanding this progress, assessment of several medical provisions were found to have regressed somewhat but compliance ratings but will not be decreased for this assessment period. This regression results from two specific causes. First, nurse staff levels declined since the previous assessment and second, the medical director has developed and maintained positive or functional collaboration among and between health care staff and other health care leaders. Combined, these two issues have impaired medical progress and can ultimately result in decreases in several medical ratings if not corrected quickly.

The new Governor, BOC Director and GGACF leadership seem very determined to make the necessary improvements to comply with this agreement. For example, the Governor recently authorized salary increases for all correctional officers and supervisors. A systematic process for implementing these increases is currently underway. This action can improve GGACF staff recruitment and retention while renewing incumbent staff esprit de corps.

Scorecard

Twenty-three (19%) of the 123 provisions and 14 (39%) of the medical provisions have advance out of NonCompliance; all 23 are in Partial Compliance. Progress toward dismissal of the Agreement is now at 6%, up from 5%.

Agreement Substantive Sections		Compliance Assessment Report Number & Scores										
		Total Provisions	1	2	3	4	5	6	7	8	9	10	11
IV.	Safety & Supervision	61	0	7	8	8	7	6	4	3	3	3	3
V.	Medical & Mental Health	36	0	0	0	0	0	0	0	0	0	10	14
VI.	Fire & Life Safety	11	0	0	0	0	0	0	0	0	0	0	0
VII.	Environmental Health & Safety	11	0	3	6	5	6	6	6	6	6	6	6
VIII.	Training	4	0	0	0	0	0	0	0	0	0	0	0
	Agreement Total Provisions:	123											
	Total Compliance Points Gained:		0	10	14	13	13	12	10	9	9	19	23
	Percent Out of NonCompliance:		0%	8%	11%	11%	11%	10%	8%	7%	7%	15%	19%
	Percent Toward Agreement Dismissal:	369	0%	3%	4%	3%	3%	3%	3%	2%	2%	5%	6%

A large increase in measurable progress is anticipated once all provisions have been reliably implement.

COURT-APPOINTED INDEPENDENT MONITOR'S
ELEVENTH (11th) COMPLIANCE REPORT
GOLDEN GROVE ADULT CORRECTIONAL FACILITY
UNDER DEPARTMENT OF JUSTICE AGREEMENT

IV. SAFETY AND SUPERVISION

Agreement Section & Substantive Provisions		Compliance Assessment Report Number & Scores											
IV. Safety & Supervision		Total Provisions	1	2	3	4	5	6	7	8	9	10	11
1	IV.A. Supervision	4	0	0	1	1	1	1	1	1	1	1	1
2	IV.B. Contraband	5	0	3	3	3	3	3	2	2	2	2	2
3	IV.C. General Security	5	0	0	0	0	0	0	0	0	0	0	0
4	IV.D. Security Staffing	4	0	0	0	1	1	1	0	0	0	0	0
5	IV.E. Sexual Abuse of Prisoners	1	0	0	0	0	0	0	0	0	0	0	0
6	IV.F. Classification & Housing	6	0	0	2	2	1	1	1	0	0	0	0
7	IV.G. Incidents & Referrals	5	0	1	1	1	1	0	0	0	0	0	0
8	IV.H. Use of Force on Prisoners	15	0	2	1	0	0	0	0	0	0	0	0
9	IV.I. Use of Restraints on Prisoners	6	0	0	0	0	0	0	0	0	0	0	0
10	IV.J. Prisoner Complaints	5	0	0	0	0	0	0	0	0	0	0	0
11	IV.K. Administrative Investigations	5	0	1	0	0	0	0	0	0	0	0	0
	Total Provisions:	61											
	# NonCompliance		61	54	53	53	54	55	57	58	58	58	58
	# Partial Compliance		0	7	8	8	7	6	4	3	3	3	3
	# Substantial Compliance		0	0	0	0	0	0	0	0	0	0	0
	# Sustain Compliance		0	0	0	0	0	0	0	0	0	0	0
	Progress Points		0	7	8	8	7	6	4	3	3	3	3
	Percent Out of Noncompliance	0%	0%	11%	13%	13%	11%	10%	7%	5%	5%	5%	5%

Substantive Provisions:

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.

IV.A. Supervision

Progress Summary: As discussed herein, this assessment found not factual basis on which to change any of the Monitor's compliance ratings of the four (4) provisions in this section of the Agreement. However, the Territory is commended for not losing Partial Compliance progress nine (9) consecutive assessments for provision A1c; 25% of this section remains out of NonCompliance. This scorecard is expected to substantively improve upon full implementation of these provisions.

IV.A. Supervision		1	2	3	4	5	6	7	8	9	10	11
1	IV. A1a: Unit Security Stratification & Management	0	0	0	0	0	0	0	0	0	0	0
2	IV. A1b: Post Orders & Unit Office/Supervisor Staffing	0	0	0	0	0	0	0	0	0	0	0
3	IV. A1c: Officer Communications	0	0	1	1	1	1	1	1	1	1	1
4	IV. A1d(i,ii) Security Rounds All Units & Areas	0	0	0	0	0	0	0	0	0	0	0
	# NonCompliance	4	4	3	3	3	3	3	3	3	3	3
	# Partial Compliance	0	0	1	1	1	1	1	1	1	1	1
	# Substantial Compliance	0	0	0	0	0	0	0	0	0	0	0
	# Sustain Compliance	0	0	0	0	0	0	0	0	0	0	0
	Progress Points	0	0	1	1	1	1	1	1	1	1	1
	Percent Out of Noncompliance	0%	0%	25%	25%	25%	25%	25%	25%	25%	25%	25%

Substantive Provisions:

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: Policies and procedures required under this provision have been fully completed and approved by this Monitor, the United States, and the Territory. These policies and procedures well articulate protocols for protecting GGACF prisoners. Successful implementation of these policies and procedures, and achieving their desired outcomes, will ultimately be affected by several factors. These factors include 1) adequate housing and campus security post coverage, 2) timely replacement and repair non-functional locking mechanisms, gate, and doors, 3) implementation

of consistent, thorough, and routine prisoner and facility searches, 4) timely replacement of electronic security-breach detection systems (i.e. metal detectors), 5) timely, reasonable, and consistent monitoring and supervision of staff compliance with these policies and procedures by GGACF leadership.

Housing stratification is specified in the Classification section and related policies and procedures; Policies and procedures required under this provision have been fully completed and approved by this Monitor, the United States, and the Territory.

Preventing and controlling unreasonable risk of harm by other prisoners requires GGACF officials to timely detect and prevent overt harmful actions and prisoner neglect. Overt harmful actions by other inmates and staff can involve intentional acts as well as unintentional acts, such and officer failing to properly apply restraints. Prisoner neglect specifically applies to corrections staff who intentionally or inadvertently fail to provide adequate security, care, and/or custody of the general population and special needs/vulnerable populations. For example, GGACF continues to isolate mentally ill prisoners, albeit, considerable progress has been made to increase the health monitoring of this population by GGACF mental health staff. However, these prisoners continue to languish in very dark cells with very little out-of-cell time and positive social interactions. High temperatures in these housing units are contraindicated for certain prescribed psychotropic medications and can create serious health risks for this population. Other examples come from examination of incident reports and logs for December 1, 2015 to March 26, 2016. The BOC Director has selected a vendor to install exhaust fans in the housing to mitigate this environmental concern; the contracting process is currently underway.

Incident reports and logs for this time period clearly demonstrate an urgent need to implement these and other security-related policies and procedures without unreasonable delay. The following safety and security problems reported by this Monitor in previous reports remain a serious and troubling concern per the incident reporting period examined:

- Prisoner threats and assaults of officers
- Prisoner-on-prisoner assaults and fights
- Door lock tampering by prisoners
- Continue presence of dangerous contraband in housing units and cells
- Prisoner drug trafficking

Although the movement of some 100 prisoners off-island may somewhat mitigate these high-risk safety and security problems, the concomitant redeployment of security staff cannot substitute for full and consistent implementation of these and the approved classification policies and procedures.

RECOMMENDATIONS: Previous recommendations remain appropriate.

1. Train staff on approved policies and procedures.

2. Implement policies and procedures.

3. Identify appropriate alternatives to implement and maintain compliant classification and housing stratification practices.

4. Increase staffing.

5. Ensure adequate and routine monitoring of housing units by shift supervisors.

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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: Policies and procedures required under this provision have been fully completed and approved by this Monitor, the United States, and the Territory.

No post orders were provided to demonstrate compliance with this provisions.

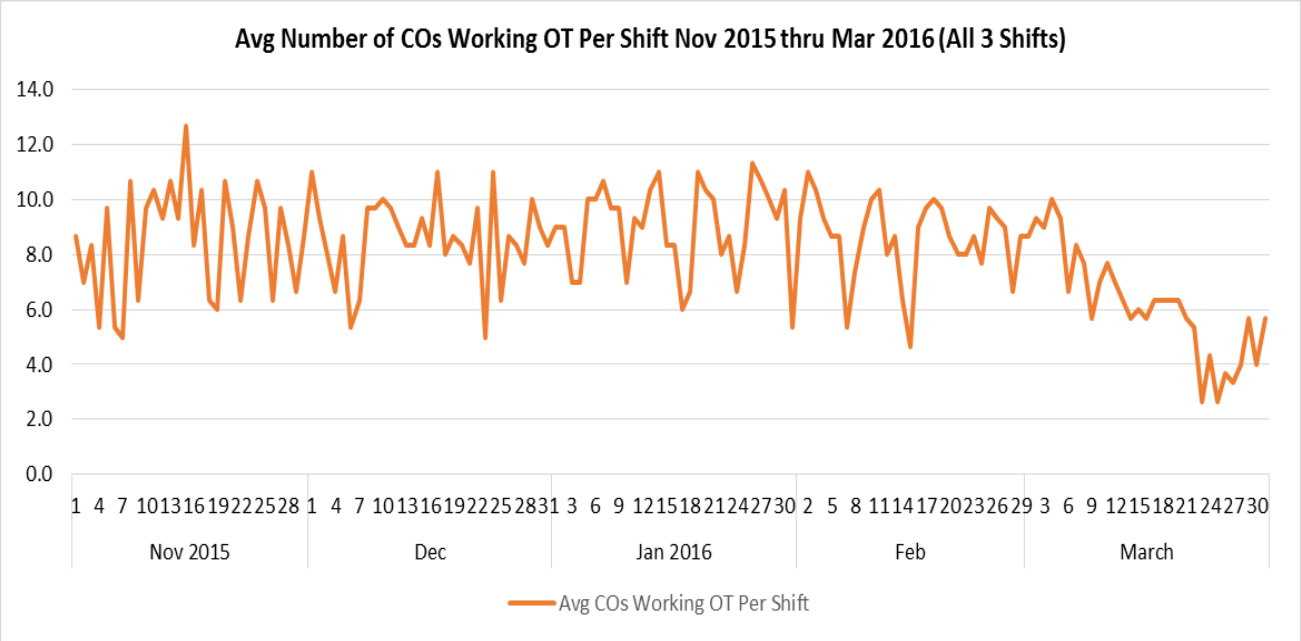
Daily supervisor logs, shift rosters, overtime reports, and supervisor facility inspection documents are used by this Monitor to assist in the assessment of compliance with this provision. These documents record 1) the number of correctional staff working per day per shift and the post they worked, 2) the names and number of security staff and supervisors working overtime per shift, and 3) facility inspections conducted by supervisors per shift. The Territory had not consistently submitted all documents for routine monitoring prior to November 2015 as requested. An audit of document submissions for January 2015 through March 2016 found that 99.6% of the documents were submitted. The table below of audit results from November 2016 thru March 2016 indicated continued positive improvement in the submission of these documents.

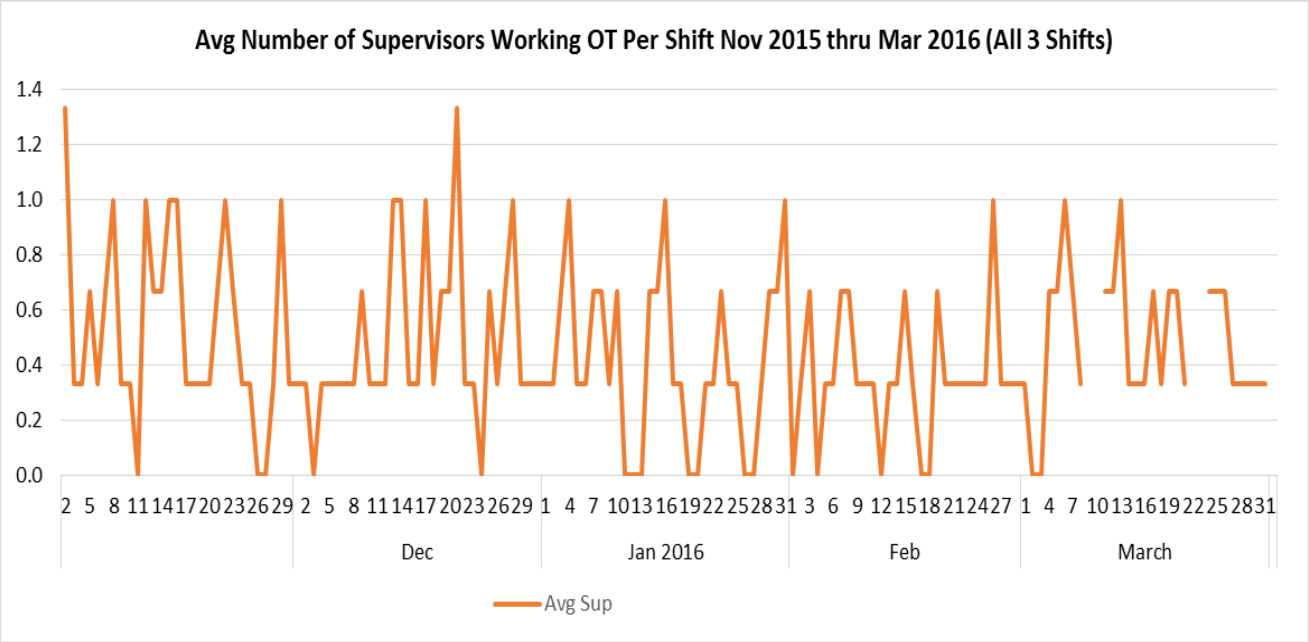
Monthly Shift Rosters Sets Audit						
Year / Month	**2015**		**2016**			
Shift Rosters	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Score**
1st Shift (10p-6a)	93%	100%	100%	100%	100%	100%
2nd Shift (6a-2p)	97%	100%	100%	97%	100%	99%
3rd Shift (2p-10p)	100%	100%	100%	100%	100%	100%
Score	**97%**	**100%**	**100%**	**99%**	**100%**	**99.6%**
Over- Time Report						
1st Shift (10p-6a)	90%	100%	100%	100%	100%	100%
2nd Shift (6a-2p)	97%	100%	100%	97%	100%	99%
3rd Shift (2p-10p)	100%	90%	100%	100%	100%	100%
Score	**96%**	**97%**	**100%**	**99%**	**100%**	**99.6%**
Supervisor Inspection Report						
1st Shift (10p-6a)	93%	100%	100%	100%	100%	100.0%
2nd Shift (6a-2p)	97%	97%	100%	97%	100%	98.9%
3rd Shift (2p-10p)	100%	97%	100%	100%	100%	100.0%
Score	97%	98%	100%	99%	100%	99.6%
GGACF Score	**96%**	**98%**	**100%**	**99%**	**100%**	**99.6%**
Standard: 100%						

Correctional officer overtime needed to cover all three shifts at GGACF remained extremely high for January thru most of March 2016. As previously reported, overtime was documented for all days during each month with approximately 26 officers working overtime per day November 2015 thru the first week of March 2016. The average number of officers working overtime per shift was approximately 8 for this period. However, this trend began to decline beginning the second week of March 2016 with approximately 16 officers working overtime per day and 5.5 per shift. Shift supervisor logs continue to report severe staff shortages during these periods. Supervisor overtime showed no significant change since the previous report; supervisor overtime was documented for most days January thru March 2016. The chart below show correctional officer and supervisor trends for November 2016 through March 2016.

GGACF Analysis of CO & Supervisor Overtime Use November 2015 thru March 2016								
Year	Month	Days in Month	Days Per Month COs Worked OT	Avg Num COs Working OT Per Day	Avg Num COs Working OT Per Shift	Days Per Month Supervisors Worked OT	Avg Num Supervisors Working OT Per Day	Avg Num Supervisors Working OT Per Shift
2015	Nov	30	30	25.52	8.47	27	1.85	0.56
	Dec	31	31	25.68	8.48	29	1.55	0.49
2016	Jan	31	31	26.90	8.97	24	1.63	0.42
	Feb	29	29	25.83	8.61	24	1.29	0.36
	Mar	31	31	18.61	6.20	25	1.60	0.43

Overtime Use Graphs





GGACF leadership is encouraged to continue monitor and improve overtime usage and security staffing levels very closely and continuously for staff and prisoner health and safety reasons.

RECOMMENDATIONS:

1. Use a standardized Shift Roster form that includes **ALL** locations and designate "CLOSED" for all locations that are out of service.

4. Ensure timely and continuous implementation of the staffing plan and staff salary increases.

5. Cease the practice of allowing staff to work high amounts of overtime and ensure that staff working overtime have adequate time away from the facility before returning to work to ensure they are adequately rested.

6. Fast-track completion and implementation of the training plan and policies.

7. Seek Court relief to remove any barriers to rapid remediation of facility safety and security deficiencies that expose people to harm.

8. Subsequent to policy and procedure development and revisions, conduct a complete review of existing specific and general post orders to ensure they are:
    a. post specific;
    b. accurately represent post staffing needs and post resources needed to operate the post safely and consistently;
    c. are numbered, cross-referenced with policies/procedures and formatted in a manner that makes them easy to interpret and apply;
    d. maintained at each post, kept current, and easily accessible;
    e. regularly reviewed, revised, updated;
    f. consistently enforced;
    g. known to staff through preservice, in-service, and ongoing training.

9. Develop a plan that provides for regular review of all log books by supervisors to ensure staffing and other unit safety and security issues are detected and resolved in a timely manner.

10. Ensure that all posts are staffed according to post complexity and dynamics, risks and needs.

11. GGACF upper management must monitor compliance with any written instructions to subordinate supervisors if compliance with such orders are expected to be followed.

12. Create and implement a single standardized shift staffing form for supervisors to accurately record shift staffing levels.

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

ASSESSMENT: PARTIAL COMPLIANCE

FINDINGS: Working portable radios were found in each occupied housing unit and with each field officer. However, a few shift supervisor inspection records reported a radio missing that was ultimately replaced. Supervisors are commended for their attention and reporting of these deficiencies.

RECOMMENDATIONS: Previous recommendations remain appropriate.

1. Implement the approved 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.

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

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

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: As discussed above. Staffing levels remain inadequate to consistently protect inmates from harm as defined previously.

RECOMMENDATIONS:

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. Monitor and ensure continuation of scheduled RNs rounds twice per week; QMHS round once per week.

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

Progress Summary: As discussed herein, this assessment found not factual basis on which to change any of the Monitor's compliance ratings of the five (5) provisions in this section of the Agreement with three of the five (40%) provisions in NonCompliance. This scorecard is expected to substantively improve upon full implementation of these provisions.

Agreement Section & Substantive Provisions		Compliance Assessment Report Number & Scores										
IV.B. Contraband		1	2	3	4	5	6	7	8	9	10	11
1	IV. B1a: Clear Definitions of Contraband	0	1	1	1	1	1	0	0	0	0	0
2	IV. B1b: Prevention of Introduction	0	0	0	0	0	0	0	0	0	0	0
3	IV. B1c(i,ii,iii): Prisoner Supervision, Prisoner Searches, Physical Areas Searching	0	0	0	0	0	0	0	0	0	0	0
4	IV. B1d: Confiscation, Preservation, Destruction	0	1	1	1	1	1	1	1	1	1	1
5	IV. B1e: Admission and Escorts of Visitors	0	1	1	1	1	1	1	1	1	1	1
	# NonCompliance	5	2	2	2	2	2	3	3	3	3	3
	# Partial Compliance	0	3	3	3	3	3	2	2	2	2	2
	# Substantial Compliance	0	0	0	0	0	0	0	0	0	0	0
	# Sustain Compliance	0	0	0	0	0	0	0	0	0	0	0
	Progress Points	0	3	3	3	3	3	2	2	2	2	2
	Percent Out of Noncompliance	0%	60%	60%	60%	60%	60%	40%	40%	40%	40%	40%

Substantive Provisions:

1. Defendants will develop and submit to the 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: Policies and procedures required under this provision have been partially completed and approved by this Monitor, the United States, and the Territory. Final resolution of prisoner access to local newspapers is near conclusion. Initially, the Territory opposed allowing prisoner access to the local newspaper due security concerns and imposed a unilateral ban of local newspapers for prisoners. The BOC Director indicated that BOC prisoners can and have used information gained from the local newspaper to maintain awareness of gang activity and criminal charges of other prisoners. This concern is legitimate as it is well known in the corrections industry that prisoners will use information gained from local newspapers for clandestine, sometimes dangerous, purposes. However, the United States rightfully apposed this ban cited constitutional issues prohibiting such a ban.

On April 7, 2016, a conference call was held with the parties and this Monitor. Following a healthy debate and discussion on this issue, the BOC Director proposed policy language intended resolve this matter. The BOC Director has agreed to allow prisoner access to local newspapers under a structured and tightly controlled process. This matter appears to have been amicably resolved between the parties pending final acceptance of the revised policy by this Monitor and the United States.

Notwithstanding ongoing contraband document quality problems discussed in the previous report, the presence of dangerous and nuisance contraband remains high. Examination of contraband confiscation documents provided by the Territory for December 2015 through March 2016 demonstrate that dangerous and nuisance contraband continues enter the facility and into the hands of prisoners. Data abstracted from confiscation documents suggest a reduction in the volume of contraband, but these data can be positively misleading due to document quality issues and the frequency of facility searches by housing unit officers and the GIST team. No facility or housing unit search activities were observed by the monitoring team during this visit. GIST staff interviewed stated that organized searches are random and occur once or twice monthly. Additionally, current housing unit staffing levels are inadequate to perform routine searches on prisoner cells or prisoners entering and exiting the housing units consistently. Additionally, housing officers are not adequately equipped with electronic metal detection devices to scan prisoners and are, therefore, left to conduct pat-down searches. Pat-down searching is a basic tactic for detecting contraband but is inadequate as the sole method for preventing contraband from entering housing units. The Territory should purchase and distribute at least one electronic hand-held metal detector in each housing unit (not building).

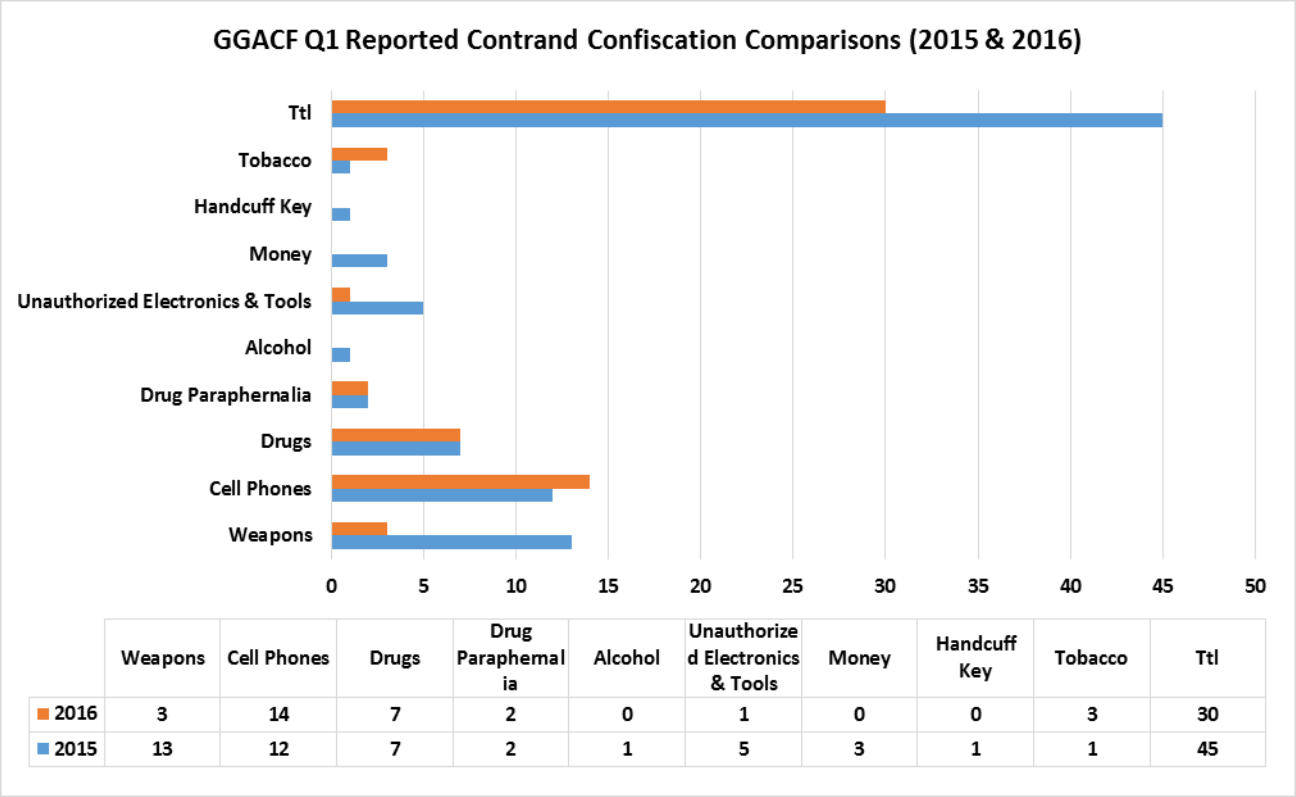
The chart below shows the number of different contraband items confiscated at GGACF for the time periods shown.

Year	Month	Weapons	Cell Phones	Drugs	Drug Paraphernalia	Alcohol	Unauthorized Electronics & Tools	Money	Handcuff Key	Tobacco	Ttl
2015	January	3	2	3	1	1					10
	February	3	2	2	1		3	2			13
	March	7	8	2			2	1	1	1	22
	April	2	8	1	1	1	5				18
	May	1									1
	June	8	8	2	1						19
	July	1									1
	August	4	6	2			1			1	14
	September	2	2	1							5
	October	1	2								3
	November		7					1			8
	December		4				1	6			11
2016	January		6	6	2					3	17
	February	1	4				1				6
	March	2	4	1							7
	Totals:	33	63	19	6	2	13	10	1	5	148
	% Seizures	22%	43%	13%	4%	1%	9%	7%	1%	3%	100%

These data suggest that first quarter reported contraband confiscations decreased by a third (15 items) from 2015 to 2016 (45 to 30 respectively). This quarterly comparison is shown in the table below.

Year	Month	Weapons	Cell Phones	Drugs	Drug Paraphernalia	Alcohol	Unauthorized Electronics & Tools	Money	Handcuff Key	Tobacco	Ttl
2015	January	3	2	3	1	1	0	0	0	0	10
	February	3	2	2	1		3	2	0	0	13
	March	7	8	2	0	0	2	1	1	1	22
Total		13	12	7	2	1	5	3	1	1	45
2016	January		6	6	2	0	0	0	0	3	17
	February	1	4		0	0	1	0	0	0	6
	March	2	4	1	0	0	0	0	0	0	7
Total		3	14	7	2	0	1	0	0	3	30

There appears to be increases, decreases, and no change in reported contraband confiscations of the items included in this assessment. Most notable is a significant decrease in weapons confiscated (2015, 13; 2016, 3). Other decreases in items confiscated include alcohol (none for 2016), unauthorized electronic devices (5 to 1), money (3 to 0), and handcuff key (1 to 0). There were increases in confiscations of cell phones (12 to 14), and tobacco (1 to 3). No change was reported in drugs confiscated (7 and 7) or drug paraphernalia (2 and 2 items). The graph below illustrates these findings.



	Weapons	Cell Phones	Drugs	Drug Paraphernalia	Alcohol	Unauthorized Electronics & Tools	Money	Handcuff Key	Tobacco	Ttl
2016	3	14	7	2	0	1	0	0	3	30
2015	13	12	7	2	1	5	3	1	1	45

Confidence in the veracity of these findings relies patently on the accuracy of reporting and the quality of the reports, both of these conditions remain in question. Additionally, improvement in contraband control at GGACF cannot be inferred by these findings due to reported infrequency of facility and prisoner searches. Nonetheless, these findings seem promising. It is likely that the presence of dangerous and nuisance contraband will be legitimately decreased once housing unit

staff levels are consistently adequate, staff are trained on these policies and procedures, and supervisors consistently monitor staff to ensure compliance with the 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.

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: As discussed above

RECOMMENDATIONS: Previous recommendations remain appropriate.

1. Implement the new policy and procedures.

2. Ensure supervisors comply with supervision rounds requirements.

3. Ensure corrections officers comply with contraband control and related security policies and protocol.

4. Continue positive efforts in searching people before entering the facility.

5. A "stop and check" protocol for inspecting staff packages after initial entry into the facility must be developed and implemented.

6. Provide handheld metal detectors for contraband inspections at facility entry points and as needed for on-campus inspection.

7. Be prepared to thoroughly discuss current vehicle, mail, and package inspection methods and process during the 11th onsite tour and assessment.

8. Train supervisors to provide on-the-job training (OJT) and staff mentoring in the areas of adequate searches, contraband prevention and control, and basic inmate supervision and security.

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

(i) supervision 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 prisoners 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: As discussed above.

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.

6. Develop a structured contraband confiscation tracking system routinely assess and monitor confiscations by location, time, date, housing classification, and person.

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

ASSESSMENT: PARTIAL COMPLIANCE

FINDINGS: As discussed above. Additionally, GGACF management should regularly review the quality and accuracy of contraband confiscation document. As stated in previous reports, the location of the contraband confiscation should be records on the monthly confiscation log.

Additionally, collection and preservation practices are somewhat lax and absent chain of custody protocols to ensure evidence integrity. This possess significant issues for maintaining reliable security and control over seized evidence and contraband needed for reliable criminal and/or prisoner disciplinary purposes. For example, there is no central collection box for such items with custody control protocols. All evidence/contraband seized should be properly marked, bagged,

boxed and tagged. Standard evidence bags for marking items should be used to properly mark and seal all items that can be bagged.

RECOMMENDATIONS: Previous recommendations remain appropriate.

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

2. Implement a continuous quality improvement program (CQI) for the Evidence Log to ensure the record is valid, reliable, and supports effective compliance monitoring.
3. Evidence collection and preservation elements of the new policy can be implemented to resolve the issues described above.
4. Obtain standard evidence collection bags/containers.

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

ASSESSMENT: PARTIAL COMPLIANCE

FINDINGS: There seemed to be improvement in access security at the lobby entrance. One officer staffed the desk while another officer searched visitor bags and possessions. However, one officer reported that the walk-through metal detector and X-ray machined were not reliably functional. This is problematic and should be corrected immediately. These are essential security management devices that should consistently remain in good working order and back-up devices should be purchased and available during repair periods to ensure security continuity.

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.

4. Ensure all electronic security-breach detection devices are consistently reliable as indicated above.

IV.C. General Security

Progress Summary: As discussed herein, this assessment found not factual basis on which to change any of the Monitor's compliance ratings of the five (5) provisions in this section of the Agreement; all provisions remain in NonCompliance. This scorecard is expected to substantively improve upon full implementation of these provisions.

Agreement Section & Substantive Provisions		Compliance Assessment Report Number & Scores										
IV.C. General Security		1	2	3	4	5	6	7	8	9	10	11
1	IV. C1a: Authorized Prisoner & Staff Clothing	0	0	0	0	0	0	0	0	0	0	0
2	IV. C1b: Prisoner, Staff, Visitor Identification	0	0	0	0	0	0	0	0	0	0	0
3	IV. C1c: Locking & Unlocking Gates & Doors	0	0	0	0	0	0	0	0	0	0	0
4	IV. C1d: All Locks Inspections & Maintenance	0	0	0	0	0	0	0	0	0	0	0
5	IV. C1e: Staff Preemployment Checks, Tracking, Supervisor Review of Records	0	0	0	0	0	0	0	0	0	0	0
	# NonCompliance	5	5	5	5	5	5	5	5	5	5	5
	# Partial Compliance	0	0	0	0	0	0	0	0	0	0	0
	# Substantial Compliance	0	0	0	0	0	0	0	0	0	0	0
	# Sustain Compliance	0	0	0	0	0	0	0	0	0	0	0
	Progress Points	0	0	0	0	0	0	0	0	0	0	0
	Percent Out of Noncompliance	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%

Substantive Provisions:

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: Prisoner clothing is adequately addressed in part in the approved Inmate Clothing, Bedding and Linen supplies.

Many of the prisoners were wearing what appeared to be new uniforms. However, some prisoners continue to wear what appears to be personal or "street" clothes in the housing units. The BOC Director stated that prisoners are allowed to wear only BOC issued prison attire; he also stated that he is replenishing prisoner uniforms to ensure compliance with this provision and timely exchange of prisoner uniforms during laundering of the uniforms. Progress toward compliance with this provision appears positive. Progress toward compliance also appears positive as all on-duty staff observed by this Monitor wore official GGACF attire. Partial Compliance with this provision is likely once the policies and procedures have been implemented and an adequately compliance evaluation determines that staff application of these policies is consistent.

RECOMMENDATIONS:

1. Require inmates to wear issued institutional clothing ONLY.

2. Take timely and appropriate corrective action with staff who fail to enforce inmate uniform policies and inmates who refuse to comply with those policies.

3. Ensure that all staff wear their required GGACF uniform at all times, and take timely and appropriate corrective action with staff who refuse to do so.

4. Consider acquiring correctional apparel that provides obvious recognition of the inmates' classification/status.

5. Ensure there is a consistently sufficient supply of uniforms for regular laundry exchanges and changes in an inmate's classification and/or status.

6. Consider developing a correctional industry for making uniforms onsite.

7. Select/make uniforms specifically designed to reduce/eliminate places to hide contraband and weapons.

8. Mark all uniforms with highly visible letters/numbers.

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: This Monitor observed no prisoner wearing their official identification cards during this visit. The monitoring team was required to turn-over their driver's licenses in exchange for GGACF visitor ID each day of the visit.

RECOMMENDATIONS:

1. Ensure staff compliance with this provision.

2. Ensure prisoners comply with this provision.

3. Ensure adequate supplies for making identification cards.

4. Regularly audit identification card inventory and maintain proper controls to prevent inappropriate acquisition of cards. Conduct regular "identification card counts" using methods similar to key control inventories.

5. Consistently enforce identification card policies and procedures.

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

ASSESSMENT: NONCOMPLIANCE – Noted some improvement from previous assessment.

FINDINGS: Ongoing lack of adequate facility maintenance staff and timely access to repair and replacement parts continues to create substantial barriers for improvement in progress. Examination of shift supervisor inspection records for this assessment period report inoperable security doors and gates.

RECOMMENDATONS: Previous recommendations remain appropriate.

1. Repair/replace all broken locks and keys.

2. Develop, revise, implement, and audit lock/key inventory.

3. Regularly inspect keys, locks, and electronic locking systems to ensure reliable functionality, detection of tampering, and timely repair/replacement.

4. Continue to ensure staff are adequately trained in the proper use of mechanical and/or electronic locking systems according to their post assignments.

5. Consistently sanction inmates for attempting to manipulate or manipulating any security locking system or device.

6. Secure access to keys and electronic locking control panels.

7. Keep security doors locked.

8. Replace or upgrade existing unit control panels to provide for remote electronic locking and unlocking of unit and cell doors.

9. 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.

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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: Policies and procedures required under this provision have been fully completed and approved by this Monitor, the United States, and the Territory

Refer to previous discussions regarding housing unit staffing levels and overtime regarding the Territory's abilities and progress toward ensuring housing unit security locking mechanisms.

RECOMMENDATIONS: Previous recommendations remain appropriate.

1. Implement approved policies and procedures.

2. Ensure correctional officer and supervisor staffing levels are adequate to regularly and routinely assess and monitor security locking functionality.

3. Employ and maintain adequate Maintenance staffing levels.

4. As requested in the previous two reports, **develop an "all locks" maintenance plan for review by the Monitor and for incorporation into policies and procedures**. The plan should include a complete inventory of all locks, locking mechanisms, date lock found nonfunctional, date of 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.

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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 provision was not assessed during the previous visit but will be during the June 2016 onsite assessment.

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

IV.D. Security Staffing

Progress Summary: As discussed herein, this assessment found not factual basis on which to change any of the Monitor's compliance ratings of the four (4) provisions in this section of the Agreement. This scorecard is expected to substantively improve upon full implementation of these provisions.

IV.D. Security Staffing		1	2	3	4	5	6	7	8	9	10	11
1	IV. D1a: Staffing Analysis w/Realistic Shift Factor	0	0	0	1	1	1	0	0	0	0	0
2	IV. D1b: Staffing Analysis-Based Staffing Plan w/Timetables	0	0	0	0	0	0	0	0	0	0	0
3	IV. D1c: Periodic Review & Amending of Staffing Analysis & Staffing Plan	0	0	0	0	0	0	0	0	0	0	0
4	IV. D2: Staffing Plan Implementation	0	0	0	0	0	0	0	0	0	0	0
	# NonCompliance	4	4	4	3	3	3	4	4	4	4	4
	# Partial Compliance	0	0	1	1	1	1	0	0	0	0	0
	# Substantial Compliance	0	0	0	0	0	0	0	0	0	0	0
	# Sustain Compliance	0	0	0	0	0	0	0	0	0	0	0
	Progress Points	0	0	0	1	1	1	0	0	0	0	0
	Percent Out of Noncompliance	0%	0%	0%	25%	25%	25%	0%	0%	0%	0%	0%

Substantive Provisions:

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: On March 17, 2016, the court instructed the Territory to file a completed Staffing Plan by April 7, 2016. The Plan was filed as directed by the court, document #976. Additionally, the court instructed the Territory to include in the Plan specific timelines for the authorization and implementation of salary increases for custody staff, which is shown on page six of the Plan. This Monitor considers the file Plan complete and, therefore, approves the Plan for demonstrating progress toward compliance with this provision with one exception pertaining to the staffing analysis.

As stated in previous monitoring reports, the staffing analysis does not reflect accurate security staffing relief factors. This is because the Territory did not provide all data requested by the staffing analyst from the National Institute of Corrections (NIC). GGACF-specific personnel data pertaining to staff time-off was not provided. These data are required to calculate GGACF's Net Annual Work Hours (NAWH). NAWH includes a comprehensive analysis of staff time off for specified years. The results of the NAWH analysis are plugged into final 24/7 staffing level requirements to determine realistic, GGACF-specific relief factors. The absence of these data required the NIC analyst to base relief factors on national averages rather than relief factors that are realistic to GGACF. Therefore, staff levels in the Plan should not be considered realistic or final. However, the staffing analysis did include all security posts and the approved Plan should be considered a solid basis from which to begin implementation of staffing increases.

RECOMMENDATIONS:

1. Implement the approved policy.
2. Continue to implement the staffing plan
3. Monitor Plan effectiveness with regard to prisoner population levels, incidents, and other care and custody work levels.
4. Update the staffing analysis with GGACF-specific NAWH calculations if indicated.
5. This provision can move to Partial Compliance if Plan timelines and staffing outcomes are achieved as written.

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: The Plan delineates implementation guidelines as required and includes timelines for implementation of security staff salary increases. Staff recruitment and retention activities and timelines appear well thought-out but this Monitor is skeptical that the Territory can achieve proposed staffing increases due to 1) the availability of qualified officer candidates, and 2) GGACF's staff attrition history. The approved salary increases may partially mitigate these two concerns for recruitment and retention. Additional, creative strategies may be required down the road to gain Substantial Compliance with this provision.

The timeline for security staff salary increases was examined. Full implementation of this component of the Plan appears to require approximately 101 days as shown below.

GGACF Correctional Officer Salary Increase Timelines		
#	Steps	Days
1	Resolution of union negotiations	Unknown
2	Governor signs Bill 31-0320 upon receipt	10
3	OMB Approval	14
4	DOP sends approval for NOPAs	5
5	NOPAs for COs completed	14
6	Completed NOPAs approved	21
7	Approved NOPAs are transmitted	7
8	Salary increases fully implemented - within two pay cycles of NOPA transmissions	30
9	Days from Governor signing Bill to full implementation of correctional officer salaries	101

On April 12, 2016, this Monitor requested clarification from the Territory on the above table stating, "*Good afternoon, Shari – I have reviewed the Staffing Plan filed with the court and request some clarification. First, is the timeline below accurate per the Plan's descriptions... Second, to which correctional officers will the salary increase apply?*
Thank you for your timely response. Best! Ken".

On May 6, 2016, the Territory responded to the above request for clarification stating*, "Good morning Ken: The Legislature submitted the approved bill to the Governor on or about April 25, 2016. As of May 3, the Governor signed the bill into law and directed the Director of the Division of Personnel ("DOP") to commence the salary implementation process. The increase is for all officers, both rank and file and supervisors. Shari*"
Based on this clarification from the Territory, it appears that the Territory is fully engaged in the implementation process, somewhere between steps three and four.

The Governor and Territory officials are commended for taking this long-needed step toward improving compliance with this Agreement and the quality of life for correctional staff. This provision can move into Partial Compliance once the Territory can demonstrate that the staffing plan is reasonably achieving compliance based on documented results of an adequate evaluation process.

RECOMMENDATIONS:

1. Continue to implement the Staffing Plan and salary increases as indicated.

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: Policies and procedures required under this provision have been fully completed and approved by this Monitor, the United States, and the Territory.

RECOMMENDATIONS:

1. Implement final policies and procedures.

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: The Territory has initiated implementation of the staffing plan.

RECOMMENDATIONS:

Continue and monitoring implementation of the staffing plan.

E. Sexual Abuse of Prisoners

Compliance Summary: As discussed herein, this assessment found not factual basis on which to change any of the Monitor's compliance ratings of one (1) provision. This scorecard is expected to substantively improve upon full implementation of these provisions.

Agreement Section & Substantive Provisions		Compliance Assessment Report Number & Scores										
IV.E. Sexual Abuse of Prisoners		1	2	3	4	5	6	7	8	9	10	11
1	IV. E1: Substantive PREA Requirements Implemented	0	0	0	0	0	0	0	0	0	0	0
	# NonCompliance	1	1	1	1	1	1	1	1	1	1	1
	# Partial Compliance	0	0	0	0	0	0	0	0	0	0	0
	# Substantial Compliance	0	0	0	0	0	0	0	0	0	0	0
	# Sustain Compliance	0	0	0	0	0	0	0	0	0	0	0
	Progress Points	0	0	0	0	0	0	0	0	0	0	0
	Percent Out of Noncompliance	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%

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: Policies and procedures required under this provision have been fully completed and approved by this Monitor, the United States, and the Territory. The Territory has resolved the 24/7 hotline issue to ensure prisoner access to confidential, outside reporting of abuse. The Territory has initiated a Memorandum of Understanding (MOU) with the USVI Police Department to conduct criminal investigations of sexual misconduct at GGACF. It was unclear, however, whether or not this MOU has been signed by both entities.

Mr. James Warren is charged with the duty to conduct administrative investigations of sexual misconduct at GGACF. Since our previous site visit, the BOC has hired an additional administrator investigator to assist in conducting administrative investigations and they are in the process of hiring an additional investigator. The investigative team will have responsibility for conducting administrative investigations both at GGACF and the St. Thomas facility. The new investigator is Ms. Angelyna Boyd. The monitoring team interviewed Ms. Boyd and found her to be very well-educated and has a clear understanding of the task at hand with respect to assisting in conducting administrative investigations, including PREA related investigations. Ms. Boyd has already availed herself to an on-line PREA investigations course and plans on further availing herself to additional investigative related trainings.

The BOC Director informed the monitoring team that VIOMB approved the position; it is fully funded. The BOC Director hired the PREA Coordinator, Garvin Simon. Mr. Simon started on May 16, 2016. He completed certain PREA courses trainings; certification of training completion was provided for inspection.

Since our last onsite visit, Mr. Warren reported that he has worked on three (3) PREA related investigations. The monitoring team reviewed those investigations. The completed investigations were promptly investigated by Mr. Warren after they were assigned to him by the Director, as we

reported in our previous report. However, the dates of the incidents, as reported in the previous Monitor's report, occurred in May and September 2015. Both of these investigations were adequate. In one of the investigations, Mr. Warren determined it to be unfounded, and the other one was sustained. The monitoring team noted that the sustained investigation did not contain a recommended remedy or final action to be taken by the BOC. We also noted that the investigations do not contain a tracking number. During our exit briefing with BOC staff, we recommended that they should devise a tracking system for all investigations, including the assignment of a tracking number for reference/tracking purposes. The third PREA-related investigation was completed on April 7th. From our discussion with the investigative team, it appeared that the allegation made was credible and was reported by a staff member. It did not appear that the staff member (a contract employee) had been administratively removed from her job assignment upon staff being informed of this alleged PREA-related incident. The contract employee was terminated.

Subsequently, the involved inmate was reportedly transferred to another facility off-island. It should be noted that there must be zero tolerance for any form of sexual misconduct at the facility, and when credible information is obtained that such misconduct may be occurring, the alleged perpetrator should be removed from his/her job assignment until the investigation has been completed and final action taken on the matter. During this monitoring period, the monitoring team was provided with the completed investigations regarding the May 2015 incident and the September 2015 incident, as noted above.

It should also be noted that during our previous site visit we requested that an investigation be undertaken regarding the alleged allegation by an inmate of excessive force by a GIST officer on July 29, 2015. It does not appear that such investigation has been launched.

The BOC has continued to work with outside entities to further advance GGACF's PREA obligations and to develop a staff and inmate training strategy on the final PREA policies and procedures followed by full implementation.

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. 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.

4. Complete the PREA Self-Audit.

5. Fill additional investigator position slated for a 6/16 hire date, according to the Territory.

IV.F. Classification and Housing of Prisoners

Agreement Section & Substantive Provisions		Compliance Assessment Report Number & Scores										
IV.F. Classification & Housing		1	2	3	4	5	6	7	8	9	10	11
1	IV.F1a: Objective System Annually Validated / Timelines	0	0	0	0	0	0	0	0	0	0	0
2	IV.F1b: Classified Prisoner Housing/Separation	0	0	0	0	0	0	0	0	0	0	0
3	IV.F1c: Other Unit Access Prevention System for Prisoners	0	0	0	0	0	0	0	0	0	0	0
4	IV.F1d: Specified Re-Classification System	0	0	1	1	0	0	0	0	0	0	0
5	IV.F1e: Specified Incident Data Collection/Reporting	0	0	1	1	1	1	1	0	0	0	0
6	IV.F1f: Regular Review Prisoner Segregation/Out-time	0	0	0	0	0	0	0	0	0	0	0
	# NonCompliance	6	6	4	4	5	5	5	6	6	6	6
	# Partial Compliance	0	0	2	2	1	1	1	0	0	0	0
	# Substantial Compliance	0	0	0	0	0	0	0	0	0	0	0
	# Sustain Compliance	0	0	0	0	0	0	0	0	0	0	0
	Progress Points	0	0	2	2	1	1	1	0	0	0	0
	Percent Out of Noncompliance	0%	0%	33%	33%	17%	17%	17%	0%	0%	0%	0%

Compliance Summary: As discussed herein, this assessment found not factual basis on which to change any of the Monitor's compliance ratings of the six (6) provisions in this section of the Agreement; all provisions remain in NonCompliance. This scorecard is expected to substantively improve upon full implementation of these provisions.

Substantive Provisions:

1. Defendants will develop and submit to USDOG 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: Policies and procedures required under this provision have been fully completed and approved by this Monitor, the United States, and the Territory. On May 11, 2016, the Territory notified this Monitor that the classification instrument had been validated by its original author, Dr. James Austin. The approved policies and procedures, and the classification instrument account for prisoner classification measures required in this provision. Further discussion about this progress will be provided in the 12th report following review of Dr. Austin's report by this Monitor.

RECOMMENDATIONS:

1. Provide 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. Ensure classification staff are well-trained in classification protocols and routinely monitor classification documents for accuracy.

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: Same as 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. Mental health staff must continue to conduct a serious, comprehensive assessment of all prisoners on both the detention and sentenced side lockdown units to determine mental health needs and direct mental health staff to determine if a different, less punitive housing placement is available.

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

ASSESSMENT: NONCOMPLIANCE – Minor improvement noted, but not yet substantive or sustained.

FINDINGS: Same as above

RECOMMENDATIONS:

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

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

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: Same as above

RECOMMENDATIONS: Previous recommendations remain appropriate.

1. Refer to recommendations related to grievance and disciplinary policies and procedures.

2. Ensure accuracy of monthly disciplinary committee reports.

3. The Territory must correct problems reported in the monthly disciplinary committee reports.

4. Train classification staff to accurately and consistently complete initial and reclassifications, accordingly.

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: No documentation was provided by the Territory to determine the existence of this practice.

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 an 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

FINDINGS: Out-of-cell time remains problematic but is improving. However, lack of adequate staffing and the closure of several housing units pinches the Territory's options for complying with this provision.

Mentally ill prisoners continue to languish in isolated segregation but there has been some increase in the frequency and duration of out-of-cell time for many of these prisoners. The Territory must redouble its efforts to make further progress for this population. Additionally, some general population and higher-risk prisoners are segregated (locked-down) in their cells for extended periods for disciplinary and protective purposes. For example, due to inadequate housing capacity and staffing levels, out-of-cell time is scheduled to keep rival gang members apart to control violence. Segregation review documents indicated regular in-person assessments and review of these prisoners. However, inadequate housing capacity and/or housing unit staffing levels cannot be the driving reason for these practices.

RECOMMENDATIONS:

1. Minimize time in segregation.

2. Provide adequate opportunities for out-of-cell time for inmates.

3. Ensure regular and consistent monitoring by medical and mental health staff.

4. Ensure inmate hygiene is maintained while housed in segregation.

5. Track and document (log) segregation housing conditions of confinement and inmate status.

6. Continue to ensure inmates with special needs are monitored frequently as indicated by a security and health risk/needs assessment. A routine schedule for conducting these rounds must be continuously monitored for compliance.

7. Develop and implement a monthly segregation housing unit log that tracks lengths of stay and compliance with this provision.

8. 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.

9. Improve the quality and completeness of segregation review documentation.

IV.G. Incident and Referrals

Compliance Summary: As discussed herein, this assessment found not factual basis on which to change any of the Monitor's compliance ratings of the five (5) provisions in this section of the Agreement; all provisions remain in NonCompliance. This scorecard is expected to substantively improve upon full implementation of these provisions.

Agreement Section & Substantive Provisions		Compliance Assessment Report Number & Scores										
IV.G. Incidents & Referrals		1	2	3	4	5	6	7	8	9	10	11
1	IV.G1a: Reporting of Ten (10, i-x) Defined Incidents Categories	0	0	0	0	0	0	0	0	0	0	0
2	IV.G1b: Mgmt. Review of Incidents for Administrative/Criminal Investigations, Incident Trends	0	1	1	1	1	0	0	0	0	0	0
3	IV.G1c: Preservation of Incident Evidence	0	0	0	0	0	0	0	0	0	0	0
4	IV.G1d: Centralized Incident Tracking System	0	0	0	0	0	0	0	0	0	0	0
5	IV.G2: Prompt Reporting, Reviews, Corrective Action Per Specific Timelines	0	0	0	0	0	0	0	0	0	0	0
	# NonCompliance	5	4	4	4	4	5	5	5	5	5	5
	# Partial Compliance	0	1	1	1	1	0	0	0	0	0	0
	# Substantial Compliance	0	0	0	0	0	0	0	0	0	0	0
	# Sustain Compliance	0	0	0	0	0	0	0	0	0	0	0
	Progress Points	0	1	1	1	1	0	0	0	0	0	0
	Percent Out of Noncompliance	0%	20%	20%	20%	20%	0%	0%	0%	0%	0%	0%

Substantive Provisions:

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;**

ASSESSMENTS: NONCOMPLIANCE

FINDINGS: Policies and procedures required under this provision have been fully completed and approved by this Monitor, the United States, and the Territory.

There has been marginal improvement in the quality and completeness of written incident reports but continued GGACF supervisor and leadership attention to this issue remains necessary. An examination of incident reports continues to find incomplete reports approved by shift supervisors.

Additionally, no structure and systematic process for responding to patterns of incidents was provided during this visit.

RECOMMENDATIONS:

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

2. Develop a unified incident coding system for valid and reliable information and data collection, reporting, and analysis.

3. Establish regular monthly quality assurance meeting process involving all major department team leaders to review serious incident reports and recommend evidence-based remedial measures for eliminating/mitigating incident frequency and severity.

4. Train staff in applying adopted policies and use of forms, implement a continuous quality assurance protocol.

5. Require supervisors to carefully review all incident reports for completeness, accuracy, and consistency.

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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 above

RECOMMENDATIONS: Previous recommendations remain appropriate.

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

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c. Requirements for preservation of evidence; and

ASSESSMENT: NONCOMPLIANCE

FINDINGS: As stated above and in the Contraband section.

RECOMMENDATIONS: Previous recommendations remain appropriate.

1. Refer to similar recommendations regarding contraband.

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d. Central tracking of the above incidents.

ASSESSMENT: NONCOMPLIANCE

FINDINGS: The incident logging system is currently the only tracking system used by the Territory. Historically, incident logs have shown to be inaccurate, incomplete, and somewhat confusing to interpret. Similar to the incident report quality, Territory officials are encouraged to give more attention to ensuring the quality of incident logs. Additionally, a more formal incident tracking system must be developed to comply with this provision. Such a tracking system will include specific data to measure incident activities and metrics to assess whether mitigating interventions are effective.

RECOMMENDATIONS:

1. Refer to previous recommendations regarding incident reporting and tracking.

2. Consider implementation of an electronic jail management system for centralization of incident reporting and data analysis.

3. Implement a quality assurance process that consistently ensures incident log accuracy and completeness.

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: Refer to previous discussion in this section

RECOMMENDATIONS:

Develop and implement corrective action protocols to address staff noncompliance with adopted policies and procedures.

1. 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.

IV.H. Use of Force by Staff on Prisoners

Compliance Summary: As discussed herein, this assessment found not factual basis on which to change any of the Monitor's compliance ratings of the fifteen (15) provisions in this section of the Agreement. A shown in the scorecard below, all provisions remain in NonCompliance. This scorecard is expected to substantively improve upon full implementation of these provisions.

Agreement Section & Substantive Provisions		Compliance Assessment Report Number & Scores										
IV.H. Use of Force by Staff on Prisoners		1	2	3	4	5	6	7	8	9	10	11
1	IV.H1a: Permissible Forms of Physical Force & Use of Force Continuum	0	0	0	0	0	0	0	0	0	0	0
2	IV.H1b: Circumstances for Permissible Forms of Physical Force	0	0	0	0	0	0	0	0	0	0	0
3	IV.H1c: Impermissible Force i.e. Restrained Prisoner, For Verbal Threats, Unnecessary/Excessive Force	0	0	0	0	0	0	0	0	0	0	0
4	IV.H1d: Defined Competency & Scenario-Based Pre-Service/Annual UOF Training	0	0	0	0	0	0	0	0	0	0	0
5	IV.H1e: Pre Training/Certification for Authorized Weapons	0	0	0	0	0	0	0	0	0	0	0
6	IV.H1f: Comprehensive/Timely Reporting of UOF by User and Witnesses	0	1	0	0	0	0	0	0	0	0	0
7	IV.H1g: Supervision & Videotaping of Planned UOF	0	0	0	0	0	0	0	0	0	0	0
8	IV.H1h: Appropriate Armory Operations and Permitting of Deadly Force at Authorized Posts	0	0	0	0	0	0	0	0	0	0	0
9	IV.H1i: Prompt Medical Evaluation, TX After UOF, Photographic Documentation of Injuries	0	0	0	0	0	0	0	0	0	0	0
10	IV.H1j: Prompt Admin Review of UOF Report Accuracy	0	1	1	0	0	0	0	0	0	0	0
11	IV.H1k: Timely Referral for Criminal/Admin Investigation Per Specified Clear Criteria	0	0	0	0	0	0	0	0	0	0	0
12	IV.H1l: Admin Investigation of UOF	0	0	0	0	0	0	0	0	0	0	0
13	IV.H1m: Defined UOF Tracking All UOF, Periodic Evaluation for Early Staff Intervention	0	0	0	0	0	0	0	0	0	0	0
14	IV.H1n: Specified Supervisory UOF Reviews	0	0	0	0	0	0	0	0	0	0	0
15	IV.H1o: Staff Re-training / Sanctions as Indicated	0	0	0	0	0	0	0	0	0	0	0
	# NonCompliance	15	13	14	15	15	15	15	15	15	15	15
	# Partial Compliance	0	2	1	0	0	0	0	0	0	0	0
	# Substantial Compliance	0	0	0	0	0	0	0	0	0	0	0
	# Sustain Compliance	0	0	0	0	0	0	0	0	0	0	0
	Progress Points	0	2	1	0	0	0	0	0	0	0	0
	Percent Out of Noncompliance	0%	13%	7%	0%	0%	0%	0%	0%	0%	0%	0%

Substantive Provisions:

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 retraining of staff found to engage in unnecessary or excessive force. Such policies, training, and systems will include the following:

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: Policies and procedures required under this provision have been fully completed and approved by this Monitor, the United States, and the Territory.

Examination of incident reports and use of force reviews for this reporting period found no serious use of force events or force events that were not reviewed.

RECOMMENDATIONS: Previous recommendations remain appropriate.

1. Ensure all force incidents are properly reported and document complete supervisory reviews of all reported force incidents.

2. Implement a continuous quality improvement protocol to ensure all incident reports and supervisory review of documents are 1) complete, 2) accurate, and 3) comprehensive.

3. All planned uses of force must be monitored and controlled by an onsite supervisor.

4. GGACF must promptly and thoroughly investigate all inmate complaints of excessive force and take necessary corrective action to protect inmates and staff.

5. Strictly prohibit electronic control device (ECD) use except for emergency situations requiring that level of force to prevent imminent physical harm to staff, the inmate, or other inmates.

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: As stated above in this section.

RECOMMENDATIONS: Previous recommendations remain appropriate.

1. Implement policy and procedures once approved.

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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: As stated above in this section.

RECOMMENDATIONS: Implement policy and procedures once approved.

---

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: GGACF recruits continue to be trained using the existing training program. This program was previously determined by this Monitor to be inadequate. The new UOF policy and training plan include all elements needed to comply with this provision. However, development the proposed UOF training curriculum is pending. The United States and this Monitor will closely examine draft training documents to ensure compliance with this provision.

RECOMMENDATIONS:

1. Implement approved policies and procedures.

2. Provide this Monitor and USDOJ with the new training curriculum.

3. Continue to monitor staff use of force and efforts to avoid and minimize force use.

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: As discussed above in this section. Additionally, it was very troubling to learn that certain officers carry electronic control weapons (ECW / stun guns) without documented authorization or training. GIST carries unauthorized ECW flashlights into the facility (in contravention of the new UOF policies) and there was no final resolution onsite of how the Territory was going to prohibit this practice immediately. It appears that GIST would continue to bring and use their own person weapon devices at the facility unchecked. This is a serious finding requiring immediate attention and resolution. Specifically, no weapon of any kind can be authorized at any BOC management level unless such authorization complies with this provision.

RECOMMENDATIONS:

1. Same as above.

2. Comply with this provision without delay.

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: Same as above.

RECOMMENDATIONS:

1. Implement supervisory quality improvement review for all reports to ensure accuracy and completeness before approval.

2. As requested in the previous report, the Territory must develop a use of force tracking log that includes elements to verify that reports are submitted complete and timely.

3. Comply with Monitor's request for documents.

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g. Supervision and videotaping of planned uses of force;

ASSESSMENT: NONCOMPLIANCE

FINDINGS: Same as discussed above.

RECOMMENDATIONS: Implement policy once approved.

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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: Same as discussed above.

RECOMMENDATIONS: Previous recommendations remain appropriate.

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

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS:

RECOMMENDATIONS:

1. Provide Monitor documentation of Compliance with this Provision.

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

ASSESSMENT: NONCOMPLIANCE
FINDINGS: There were few use of force events documented during this reporting period. These incidents included documentation of administrative reviews but two reviews were submitted late to this Monitor. It is unknown whether these reviews were timely.

RECOMMENDATIONS: Previous recommendations remain appropriate.

1. Ensure that the 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.

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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: Two complaints of excessive force from different prisoners were examined during this assessment period. Both complaints were filed by these prisoners as grievances and both complaints involved the same corrections officer. An administrative investigation was requested for one complaint, no administrative investigation was conducted on the second complaint.

Prisoner excessive use of force complaint not investigated:

Examination of the grievance log found one prisoner use of force complaint recorded for March 23, 2016. The log records March 23rd as the date the complaint was received but the log's Summary column for this complaint records March 19th as the date the prisoner signed the compliant. The log does not explain this four-day difference in time. The log also records that this complaint was issued to a GGACF chief for resolution on March 30th for resolution. The stated resolution and return of the findings to the inmate was also recorded as March 30th.

The recorded description of this complaint states, *"CO XXXX used excessive force while detainee hands were in handcuff. That officer XXXX stated he will send him to STT where he will be killed".* The recorded chief's March 30th response states, "Chief XXXX stated that searches are performed for detainee's safety as well as the officers. Searches also include strip searches of detainees. *If you feel Officer XXXX harassed you it will be addressed. However, you need to be mindful of your behavior and what you say when you get upset. A cell phone was found also several drugs paraphernalia were found in your cell".*

This March 30th response to this complaint fails to specifically address the excessive force claim except to advise the complaining prisoner that any officer harassment will be addressed "if [the prisoner] feels" the officer harassed him. The chief's response also seems to blame the alleged excessive on the prisoner by stating, "…*you need to be mindful of your behavior and what you say when you get upset."* Assuming the prisoner's complaint is legitimate, this response essentially informs the inmate that excessive physical force by an officer is justified for verbal abuse of that officer. Assuming the complaint is not legitimate, the chief's recorded response fails to provide the prisoner with information about how the matter will be investigated and resolved.

Examination of the incident report (#GGACF-03-0037-16-IR) related to this complaint indicates no excessive force was used during this event. The report articulates that this incident involved cell extraction of this prisoner during a cell search by three officers. The report states that this

inmate was in possession of a broken cell phone and no other contraband. The report also states the prisoner was hand-cuffed and removed from his cell during the cell search then un-cuffed and returned to his cell following the search. The report states the prisoner became verbally abusive and threatening to officer who the prisoner accused of excessive force. Nothing written in this incident report would trigger a use of force investigation or review, nor does the chief's March 30th response to this allegation deal with the excessive force complaint. It is assumed that no administrative investigation was conducted to determine the veracity of this complaint as such documents were not provided to this Monitor for examination. It appears that this excessive force complaint was not adequately resolved, but informally handled by giving complete deference to the officer(s) reported description of the incident. Although this inference may be incorrect, there were no other documents provided to this monitor to determine otherwise.

It is not uncommon in correctional facilities to incorrectly handle such prisoner complaints in this manner, especially when the complaint involves a troublesome prisoner. However, resolving such a complaint in this manner can expose the jurisdiction and staff to unnecessary and expensive legal actions before the matter is resolved in favor of the defendant. Or, result in serious legal consequences if a court determines that the jurisdiction was deliberatively indifferent to such prisoner complaints as a customary practice.

To fully comply with this provision of the agreement, the Territory must ensure that all prisoner complaints of excessive force are adequately investigated and resolved in a timely manner and well documented.

This incident compels this Monitor to more closely scrutinize all incident reports and inmate complaints for possible excessive force issues.

Prisoner excessive use of force complaint investigated:

On October 28, 2015 a prisoner filed a complaint about excessive force by a corrections officer. This Monitor notified the Territory about this complaint and requested administrative investigation documentation. The Investigative Summary fact sheet records that the investigation was received by the investigator January 8, 2016 and records the investigation was completed January 15, 2016. Administrative investigation documentation was provided to this Monitor January 19, 2016.

This complaint involves a prisoner who alleged being choked by a corrections officer during a verbal altercation with this officer after the prisoner was fired from a work assignment. The investigation report records the complaint was unfounded because the prisoner recanted his allegation and stated no force was used by the officer. The report also records that this inmate apologized to the accused officer and his work assignment was in instated.

The conclusions and final determinations of this case seem appropriate. However, administrative investigation documentation is missing the accused officer's written statement and documentation of any prisoner disciplinary action taken as a result of the prisoner's abusive behavior toward the officer or for making a false allegation about excessive use of force. The report should also document whether there were witnesses to the alleged excessive force and their written statements if witnesses were present.

This case demonstrates the need for GGACF leadership to ensure timely and complete administrative investigations. This prisoner complaint was filed on October 28, 2015 and not

investigated until January 8, 2016 at the request of this Monitor. The investigation was completed seven days after it began, which seems to be an appropriate time period. However, the fact that no investigation was initiated until requested by the monitor is troubling. As indicated in the case discussed previously, GGACF officials must take more proactive and deliberate steps to timely and completely investigate all prisoner complaints of excessive force, even if a vast majority of those complaints are perceived or determine to be false allegations.

RECOMMENDATIONS:

1. Ensure response to prisoner complaints of excessive force are adequately investigated, resolved, and documented.

2. GGACF leadership should routinely monitor all incident reports and inmate complaints to ensure any excessive force complaint is adequate handled.

3. GGACF should serious consider forming a Use of Force Review Committee to review all use of force events and complaints of excessive force.

1. Administrative investigation of uses of force;

ASSESSMENT: NONCOMPLIANCE

FINDINGS: As discussed above

RECOMMENDATIONS: As discussed above in this section.

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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: Documentation of a centralized force tracking system has not been provided to this Monitor by the Territory.

RECOMMENDATIONS:

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

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: As stated previously in this section. Also, current review process determinations are made by one GGACF administrator. Although this process may seem efficient, the recommended

review committee method could improve the quality and perceived credibility of final conclusions and determinations. In the alternative, GGACF should consider assigning all use of force incident reviews and prisoner complaints of excessive force to an investigator. This could strengthen the perceived objectively and credibility of final conclusions and determinations.

RECOMMENDATIONS: As stated above.

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o. Retraining and sanctions against staff for improper uses of force.

ASSESSMENT: NONCOMPLIANCE

FINDINGS: The incidents discussed directly above provide good examples of easily corrected deficiencies in complying with this provision. In the first case, no documentation was provided to determine whether retraining and/or sanctions were warranted. Although, it is very likely that these remedial measures were not indicated for this incident, the lack of adequate documentation prevents this Monitor from making a positive assessment about the Territory's compliance with this provision, and causes this Monitor concern about the Territory's use of force control practices.

RECOMMENDATIONS: As previously stated in this provision

IV.I. Use of Physical Restraints on Prisoners

Compliance Summary: As discussed herein, this assessment found not factual basis on which to change any of the Monitor's compliance ratings of the six (6) provisions in this section of the Agreement. As shown in the chart below, all provisions remain in NonCompliance. This scorecard is expected to substantively improve upon full implementation of these provisions.

Agreement Section & Substantive Provisions		Compliance Assessment Report Number & Scores										
IV.I. Use of Restraints on Prisoners		1	2	3	4	5	6	7	8	9	10	11
1	IV.I.1a: Permissible/Unauthorized Types of Restraints	0	0	0	0	0	0	0	0	0	0	0
2	IV.I.1b: Defined Circumstances for Restrain-Type Uses	0	0	0	0	0	0	0	0	0	0	0
3	IV.I.1c: Duration of Permitted Restraint Use	0	0	0	0	0	0	0	0	0	0	0
4	IV.I.1d: Required Observation of Prisoners in Restraints	0	0	0	0	0	0	0	0	0	0	0
5	IV.I.1e: Restraint Limitations on MI Prisoners, Appropriate Consultation w/MH Staff	0	0	0	0	0	0	0	0	0	0	0
6	IV.I.1f: Required Termination of Restraints	0	0	0	0	0	0	0	0	0	0	0
	# NonCompliance	6	6	6	6	6	6	6	6	6	6	6
	# Partial Compliance	0	0	0	0	0	0	0	0	0	0	0
	# Substantial Compliance	0	0	0	0	0	0	0	0	0	0	0
	# Sustain Compliance	0	0	0	0	0	0	0	0	0	0	0
	Progress Points	0	0	0	0	0	0	0	0	0	0	0
	Percent Out of Noncompliance	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%

Substantive Provisions:

1. Defendants will develop and submit to the 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: Policies and procedures required under this provision have been fully completed and approved by this Monitor, the United States, and the Territory.
Documentation provided by the Territory for this assessment period is inadequate to fully assess this provision. Unfortunately, the excessive force complaint previously discussed is the only record provided to make and assessment.

RECOMMENDATIONS: Same recommendations as stated for Use of Force sections.

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: As stated above and in the Use of Force sections.

RECOMMENDATIONS: Same as above.

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: As stated above and in the Use of Force sections.

RECOMMENDATIONS: Same as above.

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d. Required observation of prisoners placed in restraints;

FINDINGS: As stated above and in the Use of Force sections.

RECOMMENDATIONS: Same as above.

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: As stated above and in the Use of Force sections.

RECOMMENDATIONS: Same as above.

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f. Required termination of the use of restraints.

ASSESSMENT: NONCOMPLIANCE

FINDINGS: As stated above and in the Use of Force sections.

RECOMMENDATIONS: Same as above.

J. Prisoner Complaints

Compliance Summary: As discussed herein, this assessment found not factual basis on which to change any of the Monitor's compliance ratings of the five (5) provisions in this section of the Agreement. All provisions remain in NonCompliance as shown in the scorecard below. This scorecard is expected to substantively improve upon full implementation of these provisions.

IV.J. Prisoner Complaints		1	2	3	4	5	6	7	8	9	10	11
1	IV.J1a: Defined Complaint System, Confidential Access and Reporting, Assistance for C/DD Prisoners	0	0	0	0	0	0	0	0	0	0	0
2	IV.J1b: Timely Complaint Investigations/Prioritized for Safety, Medical/MH Care	0	0	0	0	0	0	0	0	0	0	0
3	IV.J1c: Defined Corrective Action for Staff as Indicated	0	0	0	0	0	0	0	0	0	0	0
4	IV.J1d: Centralized Complaint System w/ Disposition	0	0	0	0	0	0	0	0	0	0	0
5	IV.J1e: Periodic Mgmt. Review for Trends/Individual/Systemic Issues	0	0	0	0	0	0	0	0	0	0	0
	# NonCompliance	5	5	5	5	5	5	5	5	5	5	5
	# Partial Compliance	0	0	0	0	0	0	0	0	0	0	0
	# Substantial Compliance	0	0	0	0	0	0	0	0	0	0	0
	# Sustain Compliance	0	0	0	0	0	0	0	0	0	0	0
	Progress Points	0	0	0	0	0	0	0	0	0	0	0
	Percent Out of Noncompliance	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%

Substantive Provisions:

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 prisoner's 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: Policies and procedures required under this provision have been fully completed and approved by this Monitor, the United States, and the Territory.

In addition to the deficiencies previously discussed in the two excessive use of force complaints, this assessment found marginal improvement in the prisoner complaint system and process. The grievance tracking log appears to be more complete. However, the narrative entries in this record remain inadequate to clearly determine whether complaints are resolved properly, or whether prisoners are consistently informed of a resolution to their complaints.

The inmate grievance coordinator was interview about progress with this provision during this site visit. The coordinator stated that she is not consistently provided documented response to prisoner complaints from staff responsible for submitting those responses. She also stated that some responses are too vague to adequately complete the grievance log. She suggested that GGACF should take a more active role for ensuring the quality response documentation and timeliness.

RECOMMENDATIONS:

1. Conduct monthly administrative reviews of the inmate complaint reporting and tracking process to measure and verify program compliance, take timely and appropriate remedial and corrective 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 with consistent, dedicated, and comprehensive attention.

4. Develop a valid and reliable tracking and 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.

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: The quality of the grievance tracking log impairs accurate assessment of this provision. Improvement in the quality of this log was discussed and the new Warden agreed to improve the quality of the log for assessment and monitoring purposes. The previously discussed prisoner complaints of excessive force demonstrate the need for GGACF officials to ensure timely investigations of prisoner complaints.

RECOMMENDATIONS: Same as above.

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: As previously stated.

RECOMMENDATIONS:

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

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: As previously stated

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.

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: No documentation for assessing compliance with this provision was provided by the Territory. Examination of the grievance log suggests a significant need for improvement in this area.

RECOMMENDATIONS: Same as above, and:

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.

IV.K. Administrative Investigations

Compliance Summary: As discussed herein, this assessment found not factual basis on which to change any of the Monitor's compliance ratings of the five (5) provisions in this section of the Agreement. The scorecard below shows that all provisions from in NonCompliance. This scorecard is expected to substantively improve upon full implementation of these provisions.

Agreement Section & Substantive Provisions		Compliance Assessment Report Number & Scores										
IV.K. Administrative Investigations		1	2	3	4	5	6	7	8	9	10	11
1	IV.K.1: Timely Prisoner/Staff Interviews Involved in Incidents	0	0	0	0	0	0	0	0	0	0	0
2	IV.K1.2: Defined Adequate Investigation Reports, Attempt to Resolve Statement Inconsistencies	0	0	0	0	0	0	0	0	0	0	0
3	IV.K1.3: Defined Centralized Tracking/Supervisory Review of Admin Investigations for Systemic/Staff Actions.	0	0	0	0	0	0	0	0	0	0	0
4	IV.K1.4: Defined Pre/In-Service Investigator Training	0	0	0	0	0	0	0	0	0	0	0
5	IV.K1.5: Disciplinary Action for Staff Misconduct	0	1	0	0	0	0	0	0	0	0	0
	# NonCompliance	5	4	5	5	5	5	5	5	5	5	5
	# Partial Compliance	0	0	0	0	0	0	0	0	0	0	0
	# Substantial Compliance	0	0	0	0	0	0	0	0	0	0	0
	# Sustain Compliance	0	0	0	0	0	0	0	0	0	0	0
	Progress Points	0	1	0	0	0	0	0	0	0	0	0
	Percent Out of Noncompliance	0%	20%	0%	0%	0%	0%	0%	0%	0%	0%	0%

Substantive Provisions:

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: Policies and procedures required under this provision have been fully completed and approved by this Monitor, the United States, and the Territory.

The Territory has filled the second investigator position. Examination of the new investigator's resume provided by the Territory indicates this person has some experience in community corrections investigations involving criminal probationers, but no experience or training regarding administrative investigations or institutional investigations of any kind. The new investigator seems well-educated and enthusiastic. Professional development of the new investigator will involve adequate supervision of her work and additional training on conducting administrative investigations in law enforcement (corrections-specific) settings. A review of this person's resume and lengthy interview by this Monitor indicates the new investigator can be a positive asset to the Territory's investigation team and work.

During previous onsite visit, this Monitor discussed with the Territory and Chief investigator the need to develop and maintain an administrative investigations tracking log. The Territory agreed to this recommendation at that time. No tracking log has yet been developed.

The two administrative investigations previously discussed in the Prisoner Complaints section demonstrate deficiencies found in assessing compliance with this provision. Those deficiencies are easily corrected with proper administrative oversight of the administrative investigation program and additional training of the investigators. The BOC Director issued the new administrative investigation policies and procedures to the investigators for implementation. Although a formal training curriculum for these policies and procedures will be developed, the investigators can being implementing those policies under the supervision of the Director.

RECOMMENDATIONS: Same as previous report.

1. Fill the third investigator position.

2. Provide experienced supervision and necessary training to the new investigator(s).

3. Develop and implement the agreed administrative investigations tracking log.

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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: Same as above, and:

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

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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: As stated above. A central tracking system for administrative investigations has not been developed.

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.

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: No documentation was provided to verify whether any such training has been provided to the administrative investigators.

RECOMMENDATIONS:

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

4. Provide adequate training of investigative staff on topics in areas of incident scene investigation and appropriate administrative investigation methods, processes, techniques, legal and ethical issues, etc.

5. Provide training for administration/leadership staff in the areas of administrative investigation oversight, coordination, and management.

6. Develop and implement, as an adjunct to these policies and procedures, an “Investigator’s Manual” that provides guidance to staff responsible for oversight and investigative activities.

7. Provide the Monitor qualification documents for the newly appointed chief Investigator for review upon his/her appointment.

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: No documentation of disciplinary action taken against GGACF staff was provided during this assessment. However, BOC has a history of taking disciplinary action to include staff termination and filing criminal charges against staff engaged in regulatory and/or statutory misconduct.

RECOMMENDATIONS: Continue to:

1. Integrate the information in the above into the administrative policies and procedures previously discussed.

2. Record and maintain onsite records of staff misconduct investigative reports and determinations.

3. 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.

4. Provide training to supervision staff in the appropriate use of this information for purposes of staff supervision, counseling, discipline, promotion, etc.

5. 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

Compliance Summary: As discussed herein, this assessment found factual basis on which to upgrade to Partial Compliance three (3) of the 36 the Monitor's compliance; these include V.1c (Defined Timely Access/Provision Adequate M/MH Care), V.1d(i,ii,iii,iv) (Timely RX Orders & Labs, Timely & Routine Physician Review of RX & Clinical Practices, Qualified Review of RX for Side Effects, Qualified Review of RX for Side Effects, Sufficient RX Upon Discharge for Serious M/MH Needs), V.1f (iii) (Appropriate/Timely Chronic/Acute Care/Follow-up w/Clinical Practice Guidelines) and, V.1f(iv)(1,2,3) (Adequate Provision of Emergency Care, Defined Emergency Care Training for Staff). This section of the Agreement now has 14 provisions in Partial Compliance, up from ten (10) from the previous assessment, approximately 39% of the provisions in this section are out of NonCompliance. The scorecard below shows revised progress.

Agreement Section & Substantive Provisions		Compliance Assessment Report Number & Scores										
V. Medical & Mental Health		1	2	3	4	5	6	7	8	9	10	11
1	V.1a: Adequate Intake for Serious Med/MH by QMMHS	0	0	0	0	0	0	0	0	0	1	1
2	V.1b: Comprehensive Initial/Follow-up Assessments by QMMHS w/in 3 Days of Admission	0	0	0	0	0	0	0	0	0	1	1
3	V.1c: Defined Timely Access/Provision Adequate M/MH Care	0	0	0	0	0	0	0	0	0	0	1
4	V.1d(i,ii,iii, iv): Timely RX Orders & Labs, Timely & Routine Physician Review of RX & Clinical Practices, Qualified Review of RX for Side Effects, Qualified Review of RX for Side Effects, Sufficient RX Upon Discharge for Serious M/MH Needs,	0	0	0	0	0	0	0	0	0	0	1
5	V.1e: Defined Prisoner Health Records Adequacy	0	0	0	0	0	0	0	0	0	1	1
6	V.1f(i): Adequate/Timely Sick-Call, Triage, Physician Review, Logging, Tracking, Responses by QMMHP	0	0	0	0	0	0	0	0	0	1	1
7	V.1f(ii): Adequate Tracking, Care, Monitoring of Prisoners w/ Med/MH Needs.	0	0	0	0	0	0	0	0	0	1	1
8	V.1f (iii): Appropriate/Timely Chronic/Acute Care/Follow-up w/Clinical Practice Guidelines	0	0	0	0	0	0	0	0	0	0	1
9	V.1f(iv)(1,2,3): Adequate Provision of Emergency Care, Defined Emergency Care Training for Staff	0	0	0	0	0	0	0	0	0	0	1
10	V.1f(v): Adequate/Timely Referral to Specialty Care	0	0	0	0	0	0	0	0	0	1	1
11	V.1f(vi): Adequate Care/Follow-up After Return From Outside DX or TX	0	0	0	0	0	0	0	0	0	1	1
12	V.1g: Adequate Care for Alcohol/Drug intoxication/Detox	0	0	0	0	0	0	0	0	0	0	0
13	V.1h: Infection Control, Guidelines, Precautions, Testing, Monitoring, TX Programs	0	0	0	0	0	0	0	0	0	0	0
14	V.1i(i): Suicide Prevention - Defined Immediate Referrals Prisoner Suicide or SMI Needs to QMHP/S	0	0	0	0	0	0	0	0	0	0	0
15	V.1i(ii): Suicide Prevention - Constant Observation Pending QMHP Assessment of Supervision Needs	0	0	0	0	0	0	0	0	0	0	0
16	V.1i(iii): Timely Suicide Risk Assessment/Instrument by QMHP Not to Exceed 24Hrs of SP Placement	0	0	0	0	0	0	0	0	0	1	1
17	V.1i(iv): Readily Available, Safety Secured Suicide Cutdown Tools	0	0	0	0	0	0	0	0	0	0	0
18	V.1i(v): Scenario-Based SP Response &Cutdown Tool Training	0	0	0	0	0	0	0	0	0	0	0
19	V.1i(vi):Suicide Prevention, ID Risk, Instruction & Competency-Based Training	0	0	0	0	0	0	0	0	0	0	0
20	V.1i(vii): Availability of Suicide Resistant Cells	0	0	0	0	0	0	0	0	0	0	0
21	V.1i(viii): Protocols/Constant / Close Supervision of Suicidal Prisoners as Indicated by Assessed Risk	0	0	0	0	0	0	0	0	0	0	0
22	V.1i(ix)(1,2,3): Assurance of QMHP Directives for Care & confinement, Removal from SP Watch, Follow-Up Assessment at Clinically Appropriate Intervals	0	0	0	0	0	0	0	0	0	0	0
23	V.1j: Clinically Adequate Med/MH Staffing Levels, Periodic Staffing Analysis/Plans	0	0	0	0	0	0	0	0	0	0	0
24	V.1k: Adequate CO Staffing/Training -ID/Refer/Supervise Prisoners with Serious M/MH Needs	0	0	0	0	0	0	0	0	0	0	0
25	V.1l: Protocol/Periodic Assessment of Compliance with PPs re ID, Handling, Care of Prisoners w/Med/MH Conditions	0	0	0	0	0	0	0	0	0	0	0
26	V.1m: Adequate Dental Care	0	0	0	0	0	0	0	0	0	0	0
27	V.1n: Defined Morbidity/Mortality Reviews	0	0	0	0	0	0	0	0	0	0	0
28	V.1o:Medical/MH Rounding Isolation/Segregation to Provide Access to Care/Avoid Decompensation	0	0	0	0	0	0	0	0	0	0	0
29	V.1p: Defined Isolation SMI Prisoners Prohibited, Regular Reviews	0	0	0	0	0	0	0	0	0	0	0
30	V.1q: QMMHP Review/Consults of Proposed Disciplinary Action MI Prisoners for Specified Determinations	0	0	0	0	0	0	0	0	0	0	0
31	V.1r: Medical Facilities, Scheduling/Availability of Appropriate/Private Clinical Spaces	0	0	0	0	0	0	0	0	0	0	0
32	V.1s(i) Mental Health Treatment Timely, Current, Adequate TX Plans and Implementation	0	0	0	0	0	0	0	0	0	1	1
33	V.1s(ii): Mental Health Programming for SMI Adequacy	0	0	0	0	0	0	0	0	0	0	0
34	V.1s(iii): Psychotropic RX Practices/Side Effects Monitoring/Informed Consent Adequacy	0	0	0	0	0	0	0	0	0	1	1
35	V.1s(iv): Comprehensive CO/Clinical Staff Training on Prisoner MH Needs as Specified	0	0	0	0	0	0	0	0	0	0	0
36	V.1s(v): Cease Placement of SMI in Seg Housing or Lock Down as Substitute for MH TX	0	0	0	0	0	0	0	0	0	0	0
	# NonCompliance	36	36	36	36	36	36	36	36	36	29	5
	# Partial Compliance	0	0	0	0	0	0	0	0	0	10	14
	# Substantial Compliance	0	0	0	0	0	0	0	0	0	0	0
	# Sustain Compliance	0	0	0	0	0	0	0	0	0	0	0
	Progress Points	0	0	0	0	0	0	0	0	0	10	14
	Percent Out of Noncompliance	0%	0%	0%	0%	0%	0%	0%	0%	0%	28%	39%

Compliance progress with this section of the Agreement is, however, jeopardized by two primary issues. First, RN staffing levels decreased since the previous assessment due to resignations and slowed re-hiring. Remaining RN staff are working overtime to provide prisoner care but provision of adequate compliance can easily degrade without adequate staffing levels. Second, medical leadership has not established effective interprofessional collaboration with mental health leadership or meaningful integrated care practices. For example, the medical director intentionally failed to involve the mental health director nor the entire mental health clinical team in preparing numerous mentally ill prisoners who were recently transferred off-island. Some of these prisoners suffered from chronic serious mental and chronic diseases and at high risk of psychiatric decompensation. As a result, none of these mentally ill prisoners received adequate pre-transfer consultations with their primary care providers. This is appalling and vividly demonstrates deliberate indifference for the psychiatric suffering and needs of these prisoners. All of these prisoners should have received at least one (1) pre-transfer individual treatment session with Dr. Sang and the clinical team. Additionally, Dr. Sang and the entire MH team should have been requested by the medical director to fully engage the pre-transfer process to ensure all necessary health care information was provided to the receiving transfer facility. The BOC Director was advised of this issue by this Monitor; he seemed noticeable concerned and stated that he would immediately correct any medical leadership issues required to comply with this Agreement and to ensure such issues do not reoccur.

This scorecard is expected to substantively improve upon full implementation of these provisions.

Substantive Provisions.

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: PARTIAL COMPLIANCE (Progress has regressed since previous assessment. Compliance rating will be decreased to NONCOMPLIANCE if similar findings exist during the next assessment)

MEDICAL FINDINGS: With regard to policies and procedures in general, all of the medical policies and procedures have been drafted and training is occurring with a focus on the correctional officer training. This will be completed by early July. In addition, more than 95% of

the medical staff have been tested and have received scores of better than 80%. The training materials were reviewed with regard to infection control, intoxication and detoxification, and discharge planning. With regard to infection control, both the policy and the training materials as well as the exams appear to be consistent with the plans for implementation.

With regard to discharge planning, we suggested some additions to the existing policy based on what is expected to be the process for discharge planning for each of the sentenced inmates as well as for the detainees. Given that there is far more time to perform a more comprehensive discharge planning process for the sentenced inmates (since their release date is known in advance), we only recommended that a clearer distinction be made between the two processes. With regard to the detainee population, where discharge or release is determined at a court hearing, we suggested the procedures to be utilized be clarified in the policy. Therefore, for the detainee population, it will be incumbent on the classification team to immediately notify medical staff responsible for insuring that patients with chronic medical problems leave with a two-week supply of their medications. If this is not possible, at a minimum, a designated pharmacy will contain a prescription for a two-week supply of medication, for which the Bureau of Corrections will pay when the released detainee receives it. In addition, for patients with chronic mental health problems, the nurses can notify mental health staff so that they can participate in the discharge plan for each of their patients. All patients will receive a document that includes contact information for each of the community medical centers as well as mental health centers.

With regard to the intoxication and detoxification policy, we suggested that the Medical Director determine the CIWA or COWS score to which the nurses are mandated to contact the Medical Director in order to guide the nursing staff. This is a common part of jail intoxication policies. These minor additions will be provided to all health care staff as they are formalized.

Since our last visit in December, four of the six registered nurses have departed the program. We believe that a major issue is the lack of competitive compensation. We reviewed 10 intake records of patients who entered between the time of our last visit and the first week of March of this year, 2016. Among those records, we found one record of a patient whose nurse screen was performed approximately 35 hours after his arrival. We also reviewed records of patients whose intake screen occurred 20 hours after arrival, 22 hours after arrival, and 17 hours after arrival. Thus, 40% of the 10 records we reviewed did not have a nurse intake screen for more than 12 hours after they had arrived. For some of these, the shortage of filled RN positions certainly may have contributed to the delays. With the exception of the patient who did not receive his nurse screen for 35 hours, the nine remaining records did contain a nurse screen within the first 24 hours. As I indicated earlier, the goal should be to complete the screen within four hours, and that standard clearly is not being approached.

One patient who had a severe psychiatric disorder missed his injectable antipsychotic medication. When he arrived he was not cooperative. The nurses must document daily that they have seen the patient and offered him to participate in a nurse intake screen. In addition, this patient apparently was uncooperative in relation to the absence of his antipsychotic medication. We were informed that on St. Thomas, as a matter of course, police routinely pick up these patients on the date of their injection and bring them to the clinic. This is to insure that there is no disruption of the antipsychotic medication. Additionally, one patient identified as having a newly positive TB skin test but the patient was released before the chest x-ray was obtained. This information obligates the nursing staff to contact the Department of Health TB control unit to make them aware of this particular patient's problem. Overall, the quality of the screens was reasonably appropriate.

However, timeliness of the screen appears to be a problem, with a few occurring after 24 hours and several more than 12 hours after arrival.

Patient #1
This is a 45-year-old who arrived on 12/16/15 at 7:50 a.m. His nurse screen was not until 12/17 at 6:50 p.m. His blood pressure was elevated at 160/100 and at repeat was 170/100. His pulse rate was also elevated at 101. He had a history of gout, coronary artery disease and hypertension. He also had his history and physical on the same day as his intake screen because he was an acuity level 1. However, the history and physical were woefully inadequate. There was no mention of the gout, no mention of the blood pressure issues, and no mention of the stents. He was not referred for chronic medical care and he has not been part of the chronic care program.

Patient #2
This is a 47-year-old who arrived on 12/27/15 at 5:25 p.m. He had his nurse screen on 12/28 at 4:45 p.m., or 23 hours after he arrived for booking. His blood pressure was borderline elevated at 134/96 and he was listed as an acuity level 2. He was seen for his history and physical and his blood pressure was increased at 136/98. He also lacked any referral to the chronic care program or even monitoring of his blood pressure.

Patient #3
This is a 30-year-old who arrived on 1/25/16 at 6:58 p.m. He had his screen on 1/26 at noon, approximately 17 hours later. He reported he had a seizure a day ago. His vital signs were normal. He was assessed as an acuity level 1 and was seen by the physician on the same day as the screen. His blood pressure was recorded as 143/80; however, it is not clear from the record why he was not being followed in the seizure clinic. In talking with the Medical Director, she indicated that during one of his reported seizures, she was able to converse with him, thus raising a question as to whether he was actually having seizures. However, this is not documented in the record in a manner that makes it clear that there is a question as to the validity of his seizure disorder.

Patient #4
This is a 44-year-old who arrived on 2/20/16 at 6:00 p.m. He had a screen performed on 2/21 at 4:00 pm., approximately 22 hours after his arrival. He was found to have a positive TB skin test. However, he was released before a chest x-ray could be performed. Given the fact that this is a newly positive TB skin test, the Department of Health TB control program should have been notified and this should be documented in the record.

Patient #5
This is a 32-year-old who arrived on 1/23/16 at 4:57 p.m. Vital signs showed a blood pressure of 141/84. The screen was done more than a day later. Although the screen was incomplete because of the lack of cooperation of the detainee, there was no documentation of daily offering to complete the screen. This patient has been on long-acting antipsychotic medication injections and apparently missed his injection.

RECOMMENDATIONS:
1. Fill the registered nurse positions, whose vacancies are creating a severe stress on the remaining two nurses, each of whom is working at least six days a week and at least 10 hours a day.
2. The goal should be to perform the nurse intake screen within four hours of arrival.

3. When a patient is uncooperative, nurses must document daily offering of the nurse intake screen to the patient until the intake screen is successfully completed.
4. When a patient is found to be newly positive for tuberculosis and is released before the chest x-ray is performed, the Department of Health TB control section must be notified and that notification documented in the medical record.

MENTAL HEALTH FINDINGS: See above noted medical findings as they relate to the timeliness of the intake screenings.

Mental health staff continues to perform initial mental health assessments on all new admissions. Staff is also continuing to note and assess cases where the initial mental health assessment identifies individuals in need of mental health treatment who were not identified as such during the intake screening process.

RECOMMENDATIONS:

1. Track data to support evidence of successful implementation of the policy and demonstrate adequacy of the quality of the screening process.

2. Continue to examine cases where an inmate with a negative mental health screen is later identified as an inmate in need of mental health services, and then explore options for altering the mental health screening process (be it the content and/or the conditions under which it is performed) so as to minimize the number of such false negative mental health screenings.

3. Assure that the mental health training that will eventually be provided to corrections officers helps them to appreciate the importance of their use of the 'behavioral checklist' and enhances their ability to use the 'behavioral checklist', given that the 'behavioral checklist' is one of the ways to identify inmates who are suffering from mental health problems that were not identified at intake.

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

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

ASSESSMENT: PARTIAL COMPLIANCE (Progress has regressed since previous assessment. Compliance rating will be decrease to NONCOMPLIANCE if similar findings exist during the next assessment)

MEDICAL FINDINGS: We have informed the Medical Director that she must review the records of the physicians and discuss the cases with them in order to get improved performance on the quality of the initial history and physical. We found a record of a patient whose history and physical was woefully inadequate. The patient came in with coronary artery problems and a history of coronary stents, an elevated blood pressure and gout, and yet this patient was not referred to the chronic care program. We also identified two other cases with elevated blood pressures that were identified yet no referral occurred to the chronic care program. This is unacceptable care. The Medical Director must review the work of the clinicians and provide counseling and feedback for them. If

their work does not improve, action must be taken with regard to their providing services. There is a new physician who, beginning April 1, 2016, will be onsite two days per week. The Medical Director should carefully review his work and make sure that the practice is in conformance with the guidelines.

We were also informed that for a period of time, according to the Medical Director close to three months, the laboratory at the local hospital that performs the laboratory services for Golden Grove was having problems and therefore laboratory services were not available. However, she indicated to me that the hospital never closed. This indicates that the hospital had obtained alternate laboratory services that were not provided to inmates. This is completely unacceptable. In order to provide care consistent with reasonable community standards, patients who enter with a variety of diagnostic problems or chronic diseases need to have laboratory testing for either confirmation or monitoring the degree of control. For a program such as this not to have laboratory services available, even for a few days, is not acceptable. The Medical Director is obligated as the professional responsible for the quality of care to insure that laboratory services are accessible either through the local hospital or through an emergency outside contractor. This situation must never be allowed to happen again. I have indicated to the Medical Director that the memorandum of agreement with the local hospital should add a section that obligates the hospital to provide the required services or procedures even if they temporarily use an outside source. The services that they provide to their patients must also be provided to BOC patients.

Patient #1
This is a 42-year-old who arrived on 3/6/16 at 7:18 p.m. The nurse screen was done also on 3/6, and the patient had bipolar disorder and was assigned an acuity level 1 on that basis. Within 24 hours, the patient had the history and physical that demonstrated a blood pressure of 170/96 and 165/94. However, there was no referral to the chronic care program and no follow up.

Patient #2
This is a 47-year-old who had a blood pressure of 134/96 and 136/98; however, the history and physical makes no mention of the elevated blood pressure. There was no referral for either monitoring or for any type of follow up.

Patient #3
This is a 45-year-old who arrived on 12/16/15 and whose nurse screen occurred 35 hours later. The history and physical was done on the same day as the nurse screen, but whereas the nurse screen identified a history of gout, elevated blood pressure and a history of coronary artery disease, this was not identified or mentioned in the history and physical. In addition, there were no laboratory tests to determine whether the problems still persisted nor was there any referral for the chronic care program.

RECOMMENDATIONS:

1. The Medical Director must review the work of both physicians, including the one who has been with the facility for several years, as well as the new physician and provide feedback to them with regard to their performance and where that performance needs to improve.
2. The Medical Director should provide feedback to the head nurse with regard to the appropriateness of the acuity level assignment from the nurse screen.
3. The Medical Director should develop a procedure that insures a timely initial chronic care visit based on disease control. If the patient meets disease control criteria of good control, then the

initial chronic care visit must be no later than three to four weeks. If the patient meets the criteria of fair control, no more than two weeks, and if the patient meets the disease control criteria for poor control, no more than one week for the scheduled initial chronic disease visit.

4. When there is any service disruption, one of the Medical Director's responsibilities is to insure that the time of disruption is minimized and that patients have access to the required services as soon as possible. This may require working closely with the Director of Corrections.

MENTAL HEALTH FINDINGS: This most recent review of the 'psychosocial assessment intake log' indicates that initial mental health assessments continue to be performed on all new admissions the day of or the day after the mental health unit receives the intake screening. Therefore, comprehensive mental health assessments are continuing to be performed well within three days of admission.

As was previously noted, the 'psychosocial assessment intake log' was modified prior to the 10th monitoring visit so as to include information on when the psychiatrist actually saw the subset of new admissions who had been referred to her following their initial mental health assessment (previously, the form had only indicated the date the inmate was referred to the psychiatrist). Therefore, during this 11th monitoring visit, the review of the log also clearly documented that the psychiatrist is performing initial psychiatric evaluations in a timely manner, upon receiving a referral for such an evaluation. However, given that there is only one part-time psychiatrist, the availability of video conferencing/tele-psychiatry for use in emergency situations continues to be important, and the Territory has now provided this to the psychiatrist.

Substantial progress has been made in efforts to perform psychosocial assessments on inmates who entered the facility prior to the time when such assessments were being performed on all new admissions. This is especially the case with regard to inmates who are currently on the mental health caseload. However, this effort has now been disrupted since most of those who were still in need of a psychosocial assessment have been transferred to another facility.

As was also noted in the 10th Monitoring Report, the 'initial mental health assessment form' was expanded to include a more rigorous assessment of any history of serious trauma, especially violent trauma, and the presence of any resultant clinically significant trauma-related symptoms and/or developmental difficulties, especially those that might render an inmate vulnerable to deterioration and/or development of behavioral difficulties while incarcerated. That expanded form is now in use, and such trauma-related information is being gathered. It will now be important for the mental health unit to monitor individuals with a significant trauma history so as to determine how best to serve that population so as to keep them as stable as possible.

RECOMMENDATIONS:

1. Continue to track inmates entering the facility and monitor time from admission to screening to initial psychosocial assessment, and to initial psychiatric assessment for those referred for an initial psychiatric assessment.

2. Continue performing initial mental health assessments on all new inmates, and continue efforts to perform such assessments on those who entered the facility prior to the time the current initial mental health assessments were being performed.

3. To the extent that the initial psychosocial assessment fails to identify any inmates with serious mental health difficulties (later picked up as a result of a referral to mental health by way of a 'behavioral checklist'), explore for factors that might have contributed to the failure of the initial assessment process to identify that inmate's mental health needs.

4. Develop a protocol or procedure for responding to inmates who refuse to engage in an initial mental health assessment.

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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: ASSESSMENT: PARTIAL COMPLIANCE (Medical progress has regressed since previous assessment. Compliance rating will be decrease to NONCOMPLIANCE if similar findings exist during the next assessment)

MEDICAL FINDINGS: We have used this section to address medical sick call, focusing on the acuity part of the section. A separate section deals with chronic care needs. The sick call log was consistently utilized, and again we are able to report that either a nurse or occasionally a clinician, that is a physician, saw the patient timely. Most patients continue to be seen by a nurse on the same day as receipt of the request. However, we did identify some quality issues, particularly with regard to one of the practitioners and with regard to nursing in relationship to inadequate history taking. Also, we reviewed the record of a patient seen in February whose note was not in the medical record and later it was discovered in the "to be filed" pile, which apparently extended back through January. We are extremely concerned with the availability of only two RNs, each of them working six days a week and averaging about 10 hours per day. This is not an arrangement that can be sustained. Virtually all of the nurse sick call does occur in the housing unit exam rooms.

Patient #1
This is a 65-year-old, who on 2/23/16 requested services due to swelling of his right foot, which had gone on for a long time. The physician saw him on the same day the slip was submitted. At that time, his blood pressure was 158/91. The rest of the vital signs were normal. His diagnosis was left leg and ankle edema. He did not have a history of high blood pressure. Labs were ordered, which were not in the medical record, and an x-ray was ordered; this also was not available. In addition, the physician did not do anything regarding the elevated blood pressure, not even ordering the blood pressure to be monitored on some regular basis.

Patient #2
This is a 38-year-old who, on 2/14/16, requested services for an earache and a sore throat. A nurse saw him on 2/16, but again the note was not in the record. It was later retrieved from the "to be filed" pile. This note was adequate.

Patient #3
This is a 39-year-old with asthma, hypertension and anemia. On 2/8/16, he requested health services regarding a cough, a headache, and chest pain. The nurse who talked with the doctor saw him the same day, and he was given some medicine. The headache was never addressed by the nurse, although the cough and chest pain were.

RECOMMENDATIONS:

1. The Medical Director should review the work of the physicians and provide feedback to them with a summary that indicates what number of records were discussed with each physician, the areas of concern, and whether or not a discussion took place.
2. The head nurse should review the work of the nurses and counsel them with regard to areas in need of improvement.

MENTAL HEALTH FINDINGS: A review of the logging of referrals made to the mental health unit via a 'behavioral checklist' or self-referral, a review of the 'sick call log', and a review of the 'mental health follow-up log' reveals that prisoners have timely access to mental health care whether they are already on the mental health caseload or a person newly identified as in need of mental health care. More specifically, evaluations are performed in a timely manner, and any required treatment is initiated as quickly as might be required.

During this monitoring visit, the mental health monitor randomly selected cases from the mental health case load for a more detailed review with regard to the provision of adequate mental health care. The review included a comparison of the information contained in the 'mental health follow-up log' with the information contained in the inmate's medical/mental health chart, including the 'treatment plan' and all records of the provision of therapeutic interventions. In addition, the mental health monitor held a case conference with the entire mental health staff to review and discuss their evaluation and treatment of each of this same set of randomly selected inmates. Several very positive findings emerged from this process.

First of all, the information gathered from each of these sources of information was very complete; the information gathered from each source was consistent with the information gathered from the other sources; and the information gathered demonstrated the provision of well-considered and adequate mental health care.

This review process also revealed that prior recommendations had been further explored and responded to, including recommendations for a review of the frequency of psychiatric follow-up visits, an expansion of the use of non-pharmacologic interventions (such as the group therapy program), and the judicial use of individual sessions. More specifically, the frequency of psychiatric follow-up visits had been increased where appropriate, and now appears to be all the more responsive to the mental health status and treatment needs of each individual inmate, as well as consistent with prevailing standards of practice. The group therapy program has been expanded to include previously recommended groups; the renovation of the group therapy room has been completed, which has made it easier to run a fuller group therapy program; and a new group for inmates who suffer from a combination of intellectual disability and other serious mental health difficulties has clearly helped to better stabilize that population. The judicious use of individual sessions, especially for inmates in crisis and/or for inmates who require more targeted support, has also helped to increase stability for selected inmates.

In addition, this review revealed that mental health staff had significantly increased their focus on the subset of seriously mentally ill inmates who had previously refused treatment or failed to consistently comply with treatment (this group was discussed in the 10th Monitoring Report). Given this finding, the mental health monitor expanded this review to include a similar review of some of the unit's historically most difficult to manage/most resistant to treatment inmates. This expanded review revealed that mental health staff had developed individual approaches to each of these

inmates, often with dramatic results. Some of these results included, for example, the development of an actual connection with some of these inmates who had previously been totally withdrawn and isolative; some had actually begun to communicate with mental health staff in a reasonable and, in some instances, even a meaningful way; some evidenced significant improvements in hygiene and grooming; some had even begun to have increased interaction with other inmates; and for some, there was improved compliance with psychopharmacologic interventions. This expanded review also revealed that mental health staff had given considerable thought to more clearly establishing a point at which inmates should be considered clearly resistant to or non-responsive to reasonable efforts to provide therapeutic interventions, and staff has begun to outline steps that should be taken at that point depending on an inmate's mental status, behavior and any existing security concerns.

Given the above noted efforts of mental health staff, and the response of the inmates under their care, especially those inmates who had historically been so isolative and unresponsive, the sudden and unexpected (at least for the inmates and the mental health staff) transfer of such a large number of those inmates to another facility was extremely distressing for mental health staff for multiple reasons. More specifically, staff were not given an opportunity to prepare the inmates for such a transfer, which is extremely unfortunate given that mental health treatment is so tied into the relationship between the provider and the recipient of treatment. Staff feared that inmates would feel abandoned by them, especially those inmates who had only recently begun to engage with staff; staff feared that some inmates would feel that staff must have known about the transfer and just didn't tell them; and of course, staff were concerned that given the way the transfer was managed, it was likely that this would result in a loss of the gains that many of the inmates had made. Staff members were also not given the opportunity to prepare some type of transfer summary for each inmate, which might have at least helped to increase the possibility that there would be some continuity of care, and at least helped to minimize any loss in gains that had been made. Then in addition, staff had no knowledge about the mental health services available at the receiving facilities, including the ethno-cultural competency of those mental health services, and so therefore they had no idea how inmates who had been under their care would be treated.

It is the understanding of this monitor that now, after the fact, mental health staff will have an opportunity to be in contact with providers at the receiving facility to share information on each inmate who was on the mental health caseload. In addition, a teleconference session between mental health staff and each such inmate is being considered, which can hopefully be used to help address any of the above noted issues that might have come up for inmates in response to the abrupt and unexpected disruption of their therapeutic relationships with mental health staff persons.

Making sure that mental health staff are fully aware of their responsibilities under PREA and are prepared to accept those responsibilities continues to be an issue. The monitor discussed this issue again with all involved parties, and the monitor has been assured that appropriate parties will meet with mental health staff to begin addressing this issue.

RECOMMENDATIONS:

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

2. Continue to expand non-psychopharmacologic treatment options, which will include addressing some of the impediments to such an expansion noted above.

3. Formalize the protocol or procedure for responding to inmates for whom psychopharmacologic intervention is indicated yet refuse to take medication. This is especially important for those inmates who are being held in seclusion because they are not receiving treatment despite the fact that they are so severely mentally ill.

4. Take the above noted necessary steps to help mental health staff understand their expected roles and responsibilities with regard to PREA and prepare to assume those roles and responsibilities.

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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: ASSESSMENT: NONCOMPLIANCE (Medical) PARTIAL COMPLIANCE (Mental Health)

MEDICAL FINDINGS: We were informed that the time of ordering to the time of receipt by the patients is usually within 24 hours. However, there is no data to support this. Also the Medical Director has not yet begun to review the use of medications, particularly by practitioners other than herself. Although there is a discharge planning process, especially for sentenced inmates, there is no data to suggest that the process for detainees is even somewhat effective. We are recommending that a group of stakeholders, including nursing, medical, mental health and custody, including classification, meet in order to both map out the processes that must be implemented and develop a documentation capability such that as people are released from the facility it is documented as to whether or not they have been receiving medications or refusing them.

During this visit, we observed a morning medication pass. Due to the transfer out of approximately 100 sentenced inmates, the med passes in general are shorter. Almost all of the inmates or detainees cooperated with the identification process, bringing water to aid in ingestion and cooperating in the mouth check. The exception was one female who refused the post-ingestion mouth check. We were told that she is a difficult person with a personality disorder and that may have accounted for this behavior. However, she must be counseled regarding the requirements of receiving medication and that if she does not meet the requirements she will not receive the medication.

We still identified problems with the documentation. The nurse, in order to complete the administration more quickly, waited to enter some of the medications after she completed the entire medication pass. That is not acceptable. She must spend the time when she is in a housing unit to complete the documentation.

RECOMMENDATIONS:

1. The custody and health care leadership should convene a task force, including medical, nursing, mental health, classification and custody working in the release area to map out the sequence of procedures to fully implement the discharge-planning program. Part of this task force's responsibility is to implement forms such that data may be available to be collected in order to demonstrate that the process is effective.
2. The QI program should, with the Medical Director and head nurse, perform a study of a sample of orders provided by clinicians and then track the time of the order along with the time of the receipt. For the overwhelming majority of orders, the requirement is that receipt should occur within 24 hours.
3. The patient who refused the mouth check post-ingestion must be counseled about the rules that are required for participation in the medication program.
4. The nurses should be provided a carrying container that allows segregation of each patient's regimen within a particular housing unit.
5. Documentation should occur as close as is feasible to the medication administration.

MENTAL HEALTH FINDINGS: See above medical findings with regard to medication administration.

As noted above, there is now a timely and routine physician/psychiatric review of medications and clinical practices. Treatment logs reflect that the frequency of such reviews is timely and consistent with clinical practice guidelines. Medical records document that inmates are being routinely evaluated for known side effects of medication, and the records also indicate how any identified unacceptable adverse effects were addressed. Medical records and treatment plans also document routine assessment of the efficacy of the medications prescribed as related to target symptoms, and in incidences where efficacy is lacking, document the need for dosage adjustment or a change of medication.

Although the impediments to discharge planning and providing those being released with an adequate supply of medication was raised in the 10th Monitoring Report, these impediments had not been addressed by the time of the 11th monitoring visit. However, during the course of the 11th monitoring visit, efforts were made to begin to address this issue. Therefore, during the next monitoring visit it will be important to determine if any real progress has been made in this regard.

RECOMMENDATIONS:

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

2. 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.

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

4. The above noted impediments to the implementation of a discharge plan must be addressed so that inmates who are released receive an adequate supply of medication and a thoughtful referral to an appropriate treatment program/facility.

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

ASSESSMENT: PARTIAL COMPLIANCE (Medical progress has regressed since previous assessment. Compliance rating will be decrease to NONCOMPLIANCE if similar findings exist during the next assessment)

MEDICAL FINDINGS: During this visit, there were several notes as well as laboratory reports that were delayed more than a month in being filed. In fact, the "to be filed" pile contained documents, both lab reports and encounter notes, dating as far back as January. This is clearly a step backward from the prior site visit. In part, this may have been attributable to a hospital lab problem, but it also may be attributable to the loss of health care staff, which has been dramatic and has compromised potentially many aspects of the health care services program. Clearly, an electronic record in which the laboratory results enter into the electronic record automatically would solve some of these problems.

RECOMMENDATIONS:

1. Fill the vacant nursing positions.
2. Explore the implementation of an electronic record.

MENTAL HEALTH FINDINGS: The organization of the mental health section of inmate charts has continued to improve, and charts are now organized in a consistent manner. Charts are also more complete, in that they include a more detailed treatment plan that clearly indicates the focus, goals and therapeutic objectives of each intervention, and also documented in the chart is evidence all of the various therapeutic interventions that each inmate is receiving, including non-pharmacologic interventions.

RECOMMENDATIONS:

1. Now that mental health records are appropriately organized and filed, a quality improvement tool needs to be developed to track ongoing compliance with this provision.

2. Although the treatment planning process is much improved and better documented, information contained on the approved 'treatment plan' form should be expanded to describe planned

interventions for those who have refused medication or other important therapeutic interventions.

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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: PARTIAL COMPLIANCE (Medical progress has regressed since previous assessment. Compliance rating will be decrease to NONCOMPLIANCE if similar findings exist during the next assessment)

MEDICAL FINDINGS: See letter (c) findings and recommendations.

RECOMMENDATIONS: See letter (c) findings and recommendations.

MENTAL HEALTH FINDINGS: The 'sick call log' and sick call procedures have been previously described, and a review of the log indicates that the response to sick call requests is consistently timely and complete.

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

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

ASSESSMENT: PARTIAL COMPLIANCE. Medical progress has regressed since previous assessment. Compliance rating will be decrease to NONCOMPLIANCE if similar findings exist during the next assessment.

MEDICAL FINDINGS: From our intake records, we identified four records of patients that should have been entered into the chronic care program at the time of diagnosis, and as a result of this oversight, the patients had not been appropriately followed up. Needless to say, this is unacceptable. We can indicate that we found some forms filled out by the Medical Director and the documentation in those forms reflects an overall improvement in the chronic care documentation. However, when patients are not enrolled in the chronic care program, even if the Medical Director follows all the enrollees, a void is still created which potentially compromises the outcomes of patients. In addition, for many diseases it is impossible to practice in a manner consistent with written guidelines when laboratory services are unavailable. This problem has been corrected, but it must be prevented and avoided at all costs in the future. Finally, the delay in filing lab reports also compromises the information available to the clinician at the time of the chronic care visit. All of these problems should be corrected by the time of our next visit. To identify patients who should have been enrolled, see the patient description for sections (a) and (b).

RECOMMENDATIONS:

1. The Medical Director must begin reviewing and counseling the clinicians who perform all of the intake history and physicals, especially insuring that chronic care enrollments do take place. It is impossible to maintain an accurate list when patients have not been enrolled.

2. The program at GGCAF must always have access to laboratory services. Any disruption must be avoided or be minimized to a day or two.

MENTAL HEATLH FINDINGS: As noted above, the 'mental health follow-up log' has been carefully maintained and is up-to-date. All patients on the mental health caseload are consistently being seen and receiving treatment at appropriate intervals except those who have refused treatment; all modalities of treatment are logged; and the therapeutic interventions being employed appear to be appropriate.

RECOMMENDATIONS:

1. See section '1c' for recommendations regarding the 'mental health follow-up log'.

2. As the 'treatment plan' is expanded to include all services and the therapeutic goal(s) for each intervention, the development of an integrated treatment log for all interventions continues to be a recommendation.

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

ASSESSMENT: PARTIAL COMPLIANCE

MEDICAL FINDINGS: See f (ii).

RECOMMENDATIONS: See f (ii)

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

RECOMMENDATIONS: See sections '1b', '1c', '1d', and '1f' subsections I and ii.

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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: PARTIAL COMPLIANCE. Medical progress has regressed since previous assessment. Compliance rating will be decrease to NONCOMPLIANCE if similar findings exist during the next assessment. Non-compliance for Mental Health.

MEDICAL FINDINGS: We reviewed six records of patients listed in the unscheduled service log as having utilized unscheduled services, almost all of whom were sent out to the hospital. The problems that we identified included lab reports not being in the record, offsite service reports not being in the record, as well as the utilization of outdated lab reports when being followed in the chronic care program, and in one instance, failure to order an important laboratory test. These issues tie in with both the laboratory access that we have commented on previously as well as medical record availability of documents in the record.

Patient #1
This is a 31-year-old with a history of seizure disorder after a head injury. On 1/6/16, the Medical Director was called and ordered seizure precautions and a CT scan. This patient had arrived on 10/7 and had his history and physical on 10/10, but the initial history and physical did not enroll him in the seizure chronic care program and he had not been seen since. Clearly, this failure might have been avoided.

Patient #2
This is a 61-year-old who was sent out on 1/8/16 for weakness, vomiting, and lethargy. He had diabetes, hypertension, degenerative joint disease, and diabetic retinopathy along with hypertriglyceridemia. He was sent out in midafternoon on 1/8 and returned on 1/9, also in the afternoon. The physician saw him on 1/11, and ordered new laboratory tests. However, there were no results available from the hospital. The patient was seen on 1/11, noted on a chronic disease form but results were utilized from prior testing months earlier. The hospital report was in the medical record but relevant lab results were not in the hospital document. The diagnosis was vasovagal reaction but there is not a clear basis for this diagnosis.

Patient #3
This is a 23-year-old with asthma, sent out on 1/15/16 for neck stiffness and diaphoresis. He was seen before he was sent out by a physician, who diagnosed tardive dyskinesia and extrapyramidal symptoms. The psychiatrist and the Medical Director were called. There was no ER report available. He was on an antipsychotic medication that tends to cause extraparamydial symptoms, but he had not been given in the same order the antidote to these symptoms. When he returned, he was given that medicine. We were told that when he was at the hospital he failed to sign a release of information form and therefore the hospital has not provided the hospital documents. His signature should not be necessary on a release form in order for the hospital to provide the relevant documents to the caring physicians. A meeting with the hospital needs to take place during which this clarification needs to be discussed and arrangements made so that this breakdown in follow up no longer occurs.

Patient #4
This is a 52-year-old with a history of transient ischemic attacks, vertigo, hypertension, and seizure disorder. On 1/19/16, at about 10:45 a.m. he presented with an apparent seizure. He had been in the facility since March of 2011. He had been followed up in chronic care for two years. The ER report was available but not in the chart. The seizure medicine level was ordered but there is no result available and there has been no follow up blood testing since his return.

RECOMMENDATIONS:

1. Meet with the hospital and ensure that they understand that they have an obligation to provide hospital documents for those patients that you are clinically responsible for independent of the presence of a signed release form.
2. Ensure that lab and hospital documents are filed timely.
3. Ensure that no breakdown of access for laboratory or other services occurs in the future.

MENTAL HEALTH FINDINGS: Training on mental health policies and procedures is now underway and appears to be going quite well. Partial Compliance can be achieved following requisite staff training and evidence-based demonstration of policy and procedure compliance.

RECOMMENDATIONS:

1. Complete staff training in recognizing mental health emergencies and other mental health policies and procedures.

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

ASSESSMENT: PARTIAL COMPLIANCE

MEDICAL FINDINGS: We reviewed five records of patients sent to specialists and we found problems with reports being available in the medical record as well as absence of follow up documentation by the physician of counseling of the patient. We had a discussion with the Medical Director regarding whether if a result was normal it was acceptable to have the counseling performed by a nurse. We explained that the only circumstance in which that would be acceptable was if there was a routine screening test performed in the absence of symptoms and the nurse understood the guideline recommendations. However, in other circumstances where the patient had an active symptom, the fact that the report is normal in no way resolves the active symptom. She agreed that those circumstances would require a physician counseling.

Patient #1
This is a 24-year-old with chronic bronchial asthma. On 11/26/15, there was an order for a dermatology consult scheduled for 12/10/15. The consult occurred on 12/10 and this was with a diagnosis of acne for which topical and systemic medications were recommended but no prescriptions were written. There is no note by the Medical Director regarding the basis for the absence of prescriptions.

Patient #2
This is a 64-year-old with high blood pressure and HIV disease with peripheral neuropathy as well as chronic kidney disease and anemia of chronic disease. A dermatology appointment was requested also for this patient and he was seen on 12/10. His CD-4 count improved in February, as did his viral load, which decreased. In this case, there was no sign-off on the consult report and no follow up visit with the physician.

RECOMMENDATIONS:

1. Ensure that scheduled offsite services result in a follow up visit with a physician in which there is documentation of the results of the consultation as well as a discussion of the findings and plan. The only exception should be when routine screening procedures are performed in the absence of symptoms and the results are normal, then a nurse may document this counseling.

MENTAL HEALTH FINDINGS: Adequate housing and care for prisoners with acute and/or severe mental illness is not available in the Territory. This population is housed on the mainland for care but whether that care is adequate is unknown to this Monitor. It is, there, important for GGACF to maintain regular care status reports from these off-island providers.

RECOMMENDATIONS:

1. Maintain complete and regular care status reports from off-island providers of specialty care provided to prisoners with acute and/or severe mental illness.

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

ASSESSMENT: PARTIAL COMPLIANCE

MEDICAL FINDINGS: We used this section to document scheduled offsite procedures. We reviewed five records of patients sent offsite for procedures, such as radiology procedures, gastroenterology procedures or cardiac procedures. In three of the five records, we did not find a relevant follow up note.

Patient #1
This is a 55-year-old with hypertension and a lipid disorder. She had a mammogram ordered on 2/9/16 that was done on 2/19. The report came back benign findings but there was no follow up note by anyone.

Patient #2
This is a 38-year-old who was complaining of lower back pain. MRI was done on 2/8/16. The report revealed mild disk bulging throughout the lower back but there has been no follow up with a practitioner.

Patient #3
This is a 60-year-old with diabetes type 2, hypertension, retinopathy, degenerative joint disease, and hypertriglyceridemia. There was an order for a stress test on 1/31/16, and this in fact was completed on 2/3. A report was received 3/1. The stress test was negative except for abnormal heartbeats. This was reviewed by the Medical Director on 3/1, but there has been no follow up visit.

RECOMMENDATIONS:

1. Ensure timely follow up with documentation of a discussion with the patient of the findings and any plans.

MENTAL HEALTH FINDINGS: Refer to medical findings and recommendations.

RECOMMENDATIONS: Refer to medical findings and recommendations.

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

ASSESSMENT: NONCOMPLIANCE

MEDICAL FINDINGS: We have no cases to review that demonstrate any implementation of this particular policy. We did comment that the policy should require the Medical Director to set a score that mandates a nurse make contact with a physician. This has not yet occurred. We have as of yet to review any records in which detoxification monitoring has been implemented. We were told that there is an agreement for the local methadone clinic to continue to provide medications for patients when they are brought over there.

RECOMMENDATIONS:

1. Complete the training and examinations on this area.
2. Provide documentation to use of this agreement and add this to the intoxication and detoxification policy.

MENTAL HEALTH FINDINGS: The monitor remains concerned about the management of the subset of individuals suffering from substance abuse difficulties who also suffer from some other major psychiatric difficulty, whether that other major psychiatric difficulty is evident while the individual is intoxicated and/or becomes evident during detoxification. In either case, it is well recognized that with such individuals, the management of substance abuse difficulties *and* such other mental health difficulties must be done in an integrated and coordinated way if interventions are to be effective.

RECOMMENDATIONS:

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

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

ASSESSMENT: NONCOMPLIANCE

MEDICAL FINDINGS: This item requires training for the staff and oversight of training of the officers, which will be completed by early July.

We have previously discussed with regard to intake the recommendation to ensure that nurses re-query patients regarding active TB symptoms when they find a positive skin test. This must be documented in the medical record. We did identify a case sited under the intake cases in which the patient was identified as newly positive but there was no documentation at that time of the TB symptom questions.

RECOMMENDATIONS:

1. Complete the training of officer staff.
2. Begin to develop data to be utilized regarding skin infections as well as other common diseases such as tuberculosis.
3. There should be a quarterly report on infection control matters presented at the quality improvement meeting.

MENTAL HEALTH FINDINGS: Defer to medical findings and recommendations

RECOMMENDATIONS: None.

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i. Adequate suicide prevention, including:

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

ASSESSMENT: NONCOMPLIANCE

MENTAL HEALTH FINDINGS: As was noted in prior reports, reviews of 'behavioral checklists', sick call requests, and the 'behavioral checklist/sick call log' indicate that there continues to be clear corrections officer referrals and inmate self-referrals for serious mental health concerns, including suicide concerns. These documents and records also indicate an immediate response to these referrals by the mental health unit. However, what is difficult to determine is how quickly corrections officers identified serious mental health needs and then completed a 'behavioral checklist', which is the other key element in addressing this issue.

Training of corrections officers on suicide prevention and the identification and management of other mental health emergencies is now underway, and completion of this training is required for this provision to move to the point of partial compliance. This monitor's discussions with the trainers indicates that the questions asked during the training and the new insights shared by trainees appear to indicate that the training will help corrections officers increase their ability to more quickly identify individuals who are suffering from serious mental health difficulties, including suicide-related difficulties. Once all officers have been trained, the impact of the training on officers can be more fully assessed.

RECOMMENDATIONS:

1. Continue to monitor and review future behavioral health checklist referral tracking logs.

2. Because all staff have not yet been trained with an approved curriculum for suicide prevention, this provision remains noncompliant. It is recognized that despite not having been trained, the security staff does an excellent job completing these forms when behavioral problems are identified. However, there should also be an assessment of how early in the process of the emergence of suicidal ideation or other mental health emergency that such difficulties are identified by security staff.

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

ASSESSMENT: NONCOMPLIANCE

MENTAL HEALTH FINDINGS: The monitor reviewed the monitoring log being used by security to document constant observation of prisoners who are suspected to be suicidal until the time that such prisoners are assessed by a qualified mental health professional. The monitor has also not seen any other evidence that such prisoners are, in fact, being constantly observed until they are assessed 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. Similarly, the facility will need to develop a means of documenting whether or not an inmate is being observed consistent with the level of suicide watch ordered following an evaluation by mental health.

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: PARTIAL COMPLIANCE

MENTAL HEALTH FINDINGS: Staff has been trained on this approved policy and procedure; a well-developed suicide risk assessment instrument is in place; and the instrument is being utilized by qualified mental health professionals as indicated in the approved policy and procedure.

A review of the various logs and other records maintained by the mental health unit indicates that individuals referred by security because they are suspected to be suicidal and individuals who are self–referred are assessed by a qualified mental health professional almost immediately, and clearly within 24 hours. A review of randomly selected assessments, coupled with a consultation with the staff person who performed the assessment, indicates that the assessments are clinically sound.

RECOMMENDATIONS:

1. Continue to utilize the suicide risk assessment tool, and continue to review existing logs that demonstrate compliance with this provision with regard to the timeliness of suicide risk assessments.

2. Develop quality assurance data to demonstrate the quality of the suicide risk assessment as that relates to compliance with this provision.

3. Ensure required annual training is completed as required.

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

ASSESSMENT: NONCOMPLIANCE

MENTAL HEALTH FINDINGS: Suicide cut-down tools are in place and safely secured. However, to consider such tools 'readily available', correction officers must know how to quickly retrieve these tools from their location. They must also then learn how to use these tools.

Training of correction officers on this policy is underway, and such training will include the retrieval and use of cut-down tools. Once this training has been completed and corrections officers have been able to demonstrate their skills, this provision can be changed to partial compliance.

RECOMMENDATIONS:

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

2. Complete training.

3. Demonstrate compliance with approved policy following completion of requisite training.

(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:

RECOMMENDATIONS: See above section on cut-down tools. It should also be noted that other issues related to suicide prevention are also included in the training that is currently underway.

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

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

ASSESSMENT: NONCOMPLIANCE

MENTAL HEALTH FINDINGS: Training has commenced but has not been completed.
As noted above, the identification of individuals who might require mental health services as early as possible in the course of their illness is ideal. With regard to suicide prevention, recognizing that individuals are evidencing suicide risk factors might allow for such early intervention, a better treatment outcome, and decreased morbidity. Therefore, the goals of the mental health training should include helping corrections staff to recognize individuals at high risk of becoming suicidal and refer such identified individuals for mental health evaluation and treatment before they actually make some type of suicidal attempt.

RECOMMENDATIONS:

1. The facility proposed to complete this training by July 31, 2016 for all staff.

2. Effectiveness of the training will need to be demonstrated by the use of competency measuring tools and follow-up quality improvement studies.

(vii) availability of suicide-resistant cells;

ASSESSMENT: NONCOMPLIANCE

MENTAL HEALTH FINDINGS: The suicide resistant cell in the Intake Area has been essentially completed (there was still a problem with one of the ceiling light fixtures) and will be available for use. It is positioned near the corrections officer who is always posted in the Intake Area, which would allow for whatever level of observation/monitoring by security is required. As previously noted however, this location makes it more difficult for nursing staff and mental health staff to monitor any inmate that is placed there.

The suicide resistant cell in the medical building has not been completed, but it is the understanding of the monitor that there are still plans to complete the renovation of that cell. However, it is also the understanding of this monitor that at present, even if that cell was completed, there is not enough security staff at the facility to monitor a suicidal inmate placed in that cell/in the medical facility.

It should again be noted here that the provision of a suicide-resistant cell somewhere at the facility where there is a corrections officer posted does not fully address this provision – the availability of a suicide-resistant cell is not particularly helpful in the absence of an ability of staff and otherwise to use the suicide-resistant cell. More specifically, a nurse is also required to be part of the monitoring process; at present, there is also a shortage of nurses; and this shortage of nurses coupled with the fact that a nurse would have to run back-and-forth between intake and the medical building to perform the monitoring is a big issue. Of course in addition, mental health staff also has to repeatedly assess the individual, and that means that a qualified mental health professional must also be running back-and-forth between intake and the medical building.

RECOMMENDATIONS:

1. GGACF is encouraged to complete the renovation of the proposed suicide resistant cell in the medical building. Completing this renovation and addressing security staffing issues will be a fuller and more appropriate response to this provision.

2. Train staff on approved suicide prevention policies and demonstrate proficient use of the suicide resistant cells.

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

ASSESSMENT: NONCOMPLIANCE

MENTAL HEALTH FINDINGS: The medical/mental health records and a log maintained by the mental health coordinator clearly track and provide information obtained from ongoing evaluation of suicidal inmates regarding indications for the various levels of suicide watch ordered. A review of medical/mental health records and the tracking log also indicates that the protocol for the mental health evaluation and supervision of actively suicidal inmates is clear, consistent with current standards of medical/psychiatric practice, and carefully followed.

It has become clear to the monitor that when mental health places an inmate on suicide watch, security is given a 'mental health/psychiatry observation level sheet', which notes which risk level the inmate has been placed on and the protocol for that level of risk, including how frequently the inmate is to be observed by security. Mental health also provides security with a 'special observations monitoring sheet', which is to be used to document each time the inmate is observed, the corrections officer who did the observation, and the inmate's behavior at the time of the observation (there is a simple coding system for this right on the form).

Although the monitor has seen a completed 'mental health/psychiatry observation level sheet' (which is essentially a medical/psychiatric order for initiation of a suicide watch), the monitor has never seen a completed 'special observations monitoring sheet' or any substitute documentation of the monitoring of suicidal inmates by security. Therefore, the monitor has no way of knowing whether any such monitoring has ever occurred.

RECOMMENDATIONS:

1. Complete the process of training on suicide prevention and observation policy, implementation and monitoring.

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

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

ASSESSMENT: NONCOMPLIANCE

MENTAL HEALTH FINDINGS: As noted above, the protocol for the ongoing mental health evaluation of suicidal inmates and the care of such inmates, including their placement on and removal from suicide watch, is being carefully followed by the mental health staff and well documented. Furthermore, a review of their work in this regard indicates that clinical decisions have been consistently appropriate, both during the period of an inmate's active suicidality and during the prescribed period of follow-up after an active level of suicidality has remitted.

However, as also noted above, there continues to be concern about the implementation of directives that result from the evaluation and the development of care plans for suicidal inmates when such directive must be implemented by staff outside of the mental health unit.

RECOMMENDATIONS:

1. Complete the training on suicide/suicide prevention and the training on the policies and procedures specifically related to this issue.

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

3. Assure that appropriate mechanisms are in place to facilitate the notification of security staff of mental health directives and care plans for suicidal inmates; monitor the effectiveness of such mechanisms for notification; and monitor the implementation of the directives that security staff are responsible for.

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

ASSESSMENT: NONCOMPLIANCE

MEDICAL FINDINGS: The staffing has dramatically shrunk as a result of two-thirds of the registered nurses departing since our last visit. This has resulted in the remaining two nurses working six days per week, roughly 10 hours a day. This situation is not sustainable. We understand that one of the reasons for departure is adequacy of compensation. We were informed that to work per diem at the Golden Grove facility provides compensation at $24.00 per day. To work at the hospital provides compensation for a registered nurse of $48.00 per day. This doubling of the pay must be mitigated at least to some extent. Leadership of BOC must address this problem.

RECOMMENDATIONS:

1. Fill the nursing hours to complete staffing component.

MENTAL HEALTH FINDINGS: At present, the mental health staff includes the mental health coordinator (Ms. Murray, LCSW), a part time psychiatrist (Dr. Sang), and a mental health counselor (Mr. Rosas, MHC). The prior mental health nurse, Ms. Randolph, RN, is no longer at the facility; she has not been replaced and as noted above, and currently there is an overall shortage of nurses; and so at present, there is more limited support from nursing.

At least one additional staff person is required to address all of the provisions of this agreement. It is the understanding of this psychiatrist that a line has now been created and funded for that additional staff person.

The existing staffing pattern for the mental health treatment program called for this additional staff person to be another MHC. However, as the mental health treatment program has developed, it has become clear that the monitoring, reporting and other administrative responsibilities of the mental health coordinator, coupled with her responsibilities for things like segregation review and performing special assessments for disciplinary cases, etc. have all become so extensive that it leaves her much less time than had been expected to perform other more clinical/direct treatment-related duties, such as initial mental health assessment, targeted individual sessions, etc. Given that the mental health coordinator is also the only LCSW on the mental health treatment team, the question has been raised as to whether or not the now available line for another MHC can be used to hire another LCSW or a licensed clinical psychologist, even on a less than full-time basis, who could then assume some of the more clinical/direct treatment-related responsibilities that are now totally carried by the mental health coordinator.

RECOMMENDATIONS:

1. Consider the possibility of using the newly created and funded line for an MHC to instead hire another LCSW or a licensed clinical psychologist, even on a less than full-time basis (i.e., further assess the need for such an alteration in the staffing pattern and explore the possibility and feasibility of making any such alteration in the staffing pattern if it appears to be indicated).

2. As mental health staff continue efforts to address all of the provisions of this agreement, staffing analyses should continue to assure adequate staffing of the mental health unit.

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

ASSESSMENT: NONCOMPLIANCE

MEDICAL FINDINGS: Very recently, 100 detainees were shipped off the island to facilities in the United States. This occurred one week before our visit and therefore we have no data with regard to its impact. We do believe that there will be additional officers available for escort but we will not be able to ascertain whether that has occurred until our next visit. We were told that there are delays with regard to dental access and sometimes with regard to medical access. We could not determine whether the redeployment has eliminated those delays.

RECOMMENDATIONS:

1. Ensure sufficient staffing to accomplish all of the health care services in a timely fashion.

2. Ensure that trainees are not assigned the medical function with regard to medication administration or running the building.

MENTAL HEATLH FINDINGS: Refer to medical findings

RECOMMENDATIONS: As per medical recommendations.

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

ASSESSMENT: NONCOMPLIANCE

MEDICAL FINDINGS: We have been informed that there have been no quality assurance/quality improvement activities. We were shown no document reflective of organized activity in this area. We are available to consult with the leadership in providing suggestions on how this may be organized.

RECOMMENDATIONS:

1. We look forward to working with the medical leadership team to develop this program.

MENTAL HEALTH FINDINGS: The mental health unit already maintains a range of logs (described above and in previous monitoring reports) that track and document compliance with many of the provisions of this agreement and many of the specific policies and procedures that have been developed. These logs are available for review and assessment at any time. More

specifically, these logs document that new admissions are being assessed in a timely manner; that those who are later referred by corrections staff or self-referred for mental health services are being assessed in a timely manner; that mental health emergencies, including those involving suicide attempts and/or suicidal ideations, are being assessed in a timely manner; and that all those who are assessed who also require a psychiatric evaluation receive a psychiatric evaluation in a timely manner. These logs also document what specific mental health services are provided to each inmate who has been placed on the mental health caseload, and how frequently the inmate receives each of the various services; which inmates have been placed on suicide watch, placed in segregation and/or had other difficulties; and how quickly treatment plans are developed and other interventions, directly therapeutic or otherwise, are initiated. Therefore, data is already available and the mechanism is already in place for periodic assessment of issues such as these by the mental health unit and this monitor.

The mental health unit has begun to look at the quality of the referral process and the quality of the various types and levels of assessment by gathering information that would allow for a comparison of the findings of each. The findings will hopefully improve and the significance of the findings will be all the more important once all of the mental health training has been completed. However, it remains to be determined whether or not more information should be gathered and what is the best way to assess the information that is gathered in order to have a meaningful assessment of the quality of referrals and the various types of assessments performed.

Although clinically there is a clear sense that the treatment provided is of good quality, a more formal assessment of the quality of the treatment provided, ranging from the development of a treatment plan to the provision of the various therapeutic interventions, has not been initiated. Outcomes that can be used for such a more formal assessment must be determined; an approach to measurement against such outcomes must be developed; and then a way to document this process so that it can be readily reviewed must be developed. Woven into this process will be the identification of impediments to quality treatment, including those that are outside of the control of the mental health unit, such as the availability of the various types of physical spaces required to provide mental health treatment programs, and the monitoring of suicidal patients by security staff.

The mental health unit will also have to join with other facility staff to develop mechanisms for assessing compliance to certain other provisions of this agreement that mental health plays a role in but are not entirely under the control of the mental health unit. These areas include, for example, segregation review, disciplinary review, etc.

RECOMMENDATIONS:

1. The mental health staff should develop compliance reports that indicate any failures to comply with developed policies and procedures, and the result of investigations into the reasons any such failures to comply occurred.

2. The mental health team should also assess the overall quality of the mental health services provided, with an eye toward identifying, developing, and implementing any quality improvements that should be made.

3. Scheduled regular monthly or quarterly management meetings with medical staff and other department leaders should be occurring consistently. Mental health staff should be using these meetings as an opportunity to continue to raise quality assurance issues that are not

totally under their control. The raising of such issues and any identified approaches to addressing such issues should be documented in the minutes of these management meetings.

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m. Adequate dental care;

ASSESSMENT: NONCOMPLIANCE (Partial Compliance for Medical and Noncompliance for Mental health)

MEDICAL FINDINGS: The pattern of inconsistent escorting continues intermittently to interfere with access. We expect to see that at least 90% of patients scheduled to be seen are in fact seen unless there is a refusal form signed by the prisoner and witnessed by a qualified medical staff person.

RECOMMENDATIONS:

1. Provide sufficient officers such that access is unimpeded.

MENTAL HEALTH FINDINGS: Refer to medical findings.

RECOMMENDATIONS:

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

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

ASSESSMENT: NONCOMPLIANCE

MEDICAL FINDINGS: There have been no morbidity reviews that we are aware of and since there have been no mortalities we would not expect any but some hospitalizations are worth reviewing and that process has not yet been started.

RECOMMENDATIONS:

1. Have the Medical Director perform a review of the care provided at GGACF for patients who died or became hospitalized.

MENTAL HEALTH FINDINGS: Refer to medical findings.

RECOMMENDATIONS:

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

2. When such reviews result in the identification of issues that need to be addressed (whether failure to comply with policies and procedures or the possible inadequacy of existing policies and procedures), a plan for corrective action should be developed.

3. The incidences that prompt such a review and the review and its outcomes should be shared with the monitor.

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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: Although we do believe a nurse has been making rounds until very recently, three days per week in segregation, we have not been able to receive a list of patients who were seen in the segregation unit on the rounds for which problems have been identified and treatment provided.

RECOMMENDATIONS:

1. Maintain documentation of patients seen each day in segregation, by whom the patient was seen, either by the nurse or for whom a note was written.

MENTAL HEALTH FINDINGS: As previously reported, there is weekly mental health rounding in isolation/segregation cells performed by Mr. Rosas, and monthly mental health rounding in isolation/segregation cells performed by Ms. Murray. In both cases, all inmates in isolation/segregation are seen – not just those on the mental health caseload – and there are logs kept for both sets of rounding that indicate when the inmate was seen, the inmate's general well-being, the condition of the inmate's cell, and any specific mental health needs that the inmate might have. The goals of this rounding are to identify those in need of mental health services and facilitate their access to mental health care, and to monitor for any mental health impact that isolation/segregation might be having on inmates.

Ms. Murray's monthly rounding is also in connection with the larger segregation review process. In that regard, the information she brings to the segregation review process is also informed by Mr. Rosas' weekly rounding and any other information gathered from other mental health staff. During the 10th monitoring visit, the form used for this larger segregation review process was revised, allowing for more detailed input from mental health, including any specific recommendations that mental health might have, particularly with regard to the continued use of segregation for any particular inmate.

During this monitoring visit it was clear that Ms. Murray has now been completing the mental health section of the segregation review form, and listing specific recommendations when indicated. Of particular concern for Ms. Murray and the rest of the mental health team was an inmate who was clearly deteriorating while in segregation, and so they recommended an early termination of his stay in segregation. She also reported that when she has concerns, those concerns are discussed with the other members of the segregation review team during the segregation review process; but her recommendations have never been acted upon; and there

has never even been any follow-up/feedback offered to her after a monthly review team meeting. It is the understanding of this psychiatrist that these recommendations from mental health, along with the rest of the segregation review form and recommendations of the review team, are to be forwarded to the warden for her review and a final decision. However, during discussions with the warden, she noted that she has never received any such recommendations from mental health to accept or reject, and she noted that she will look into why that has been the case.

RECOMMENDATIONS:

1. The Mental Health Coordinator will continue to keep documentation of weekly and monthly rounds, and will keep documentation of information provided and recommendations offered during the monthly isolation/segregations review process.

2. The Warden will assure that she receives any recommendations from mental health, along with the rest of the input from the segregation review process, so that she can either accept or reject the recommendations, or request additional information.

3. Monitor how mental health recommendations made during the monthly isolation/segregation review process are integrated into and impact on the monthly isolation/segregation review process.

4. Continue to document the need for certain alternative therapeutic interventions (most of which have been noted in other sections of this report) that would allow many mentally ill inmates to be removed from segregation, and continue to advocate for the provision of such interventions.

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

ASSESSMENT: NONCOMPLIANCE

MENTAL HEALTH FINDINGS: <u>As has been repeatedly noted in prior monitoring reports, despite this patent prohibition, there are still inmates with serious mental illness who are being held in isolation/segregation.</u> Dr. Ray, the Court-Appointed Monitor, has written extensively on this matter in previous reports that includes analyses of segregation conditions and monitoring. Despite noted improvements in the segregation review process, no practices other than a complete elimination of isolation of mentally ill prisoners will comply with this Provision.

Since many of these inmates were included in the mass transfer of inmates to other facilities and are therefore no longer at the facility, the total number of seriously mentally ill inmates in isolation/segregation has decreased. However, there continues to be seriously mentally ill individuals in isolation/segregation, and so this provision has still not been addressed.

The various reasons why there are seriously mentally ill inmates in isolation/segregation has also been repeatedly summarized in prior reports; those reasons remain the same; and so a full discussion of those reason will not be repeated here. However in summary, some are in isolation/segregations because they have refused treatment and are considered to be dangerous;

some are in isolation/segregation because although involved in treatment, they are considered vulnerable and in need of protection from other inmates; and some are in isolation/segregation due to disciplinary infractions.

Again, it should also be noted that the above noted section on isolation/segregation rounds and the isolation/segregation review process, and the following section on the role of mental health in addressing prisoner disciplinary sanctions are very clearly relevant to this issue of the placing of seriously mentally ill prisoners in isolation/segregation. Therefore, those sections should be reviewed again for the relevance to this issue, especially as they relate to efforts to minimize time in segregation and the success or lack of success of those efforts.

Mental health staff has made considerable efforts to increase opportunities for out-of-cell time for inmates suffering from serious mental health difficulties who are being housed in isolation/segregation, despite the continued absence of renovated space that would readily allow for enhanced programming for such seriously mentally ill individuals. However, the monitor has discovered that security is not consistently supportive of this effort to increase out-of-cell time, despite the fact that demonstrating such an effort is a critical part of the response to several provisions of this agreement. More specifically, for example, many such inmates have been prescribed group therapy, as indicated in their treatment plan. However in some cases, security has allowed them to attend group therapy, while others have not been allowed to attend, and still others are allowed to attend sometimes and yet not allowed to attend at other times. No explanation for this differential treatment has been given to mental health; this monitor was unable to figure out why this has occurred; but in the absence of the articulation of some clearly defined, acute security concern (which does *not* appear to be the issue), placement in isolation/segregation shouldn't result in denying an inmate access to prescribed treatment, psychopharmacologic or otherwise.

RECOMMENDATIONS:

1. **As per the provisions of this Settlement Agreement, inmates with serious mental illnesses may not be placed in isolation.** This infraction should be repeatedly documented during the rounds of isolation/segregation cells performed by the mental health staff, and corrective action taken. This writer intends to request court intervention via Dr. Ray if this practice remains in effect at the next assessment visit.

2. For those seriously mentally ill inmates who refuse treatment, the mental health staff needs to opine as to whether or not such inmates are a sufficient danger to themselves or others that they would require isolation/segregation. In addition, a protocol must be developed for that subset of inmates that are a danger to themselves or others, focusing on attempting to get them to voluntarily accept treatment and outlining steps that should be taken for those who ultimately continue to refuse treatment.

3. With regard to those seriously mentally ill inmates who are currently in isolation/segregation for their own protection, the Bureau of Corrections needs to develop a corrective action plan with specific recommendations for capital improvements that will provide a more appropriate housing unit for such inmates, with dates to remedy this deficiency. In addition, once an alternative to the isolation/segregation of such inmates has been developed, mental health staff will need to develop enhanced programming for them.

4. With regard to those seriously mentally ill inmates with an alleged disciplinary infraction, see the next section of this report.

5. During the time that inmates with serious mental illnesses remain in segregation, mental health staff should be aware that these inmates should be offered a minimum of 10 hours per week of unstructured out-of-cell time by security. Additionally, mental health staff is encouraged to develop supportive group or individual therapeutic activities, generally recommended being a minimum of 10 hours per week per inmate in order to support the inmate's mental state as well as assist inmates in acquiring skills to move them officer the segregated status and sustain themselves in the general population setting whenever possible.

6. Security staff should assure that mentally ill inmates housed on isolation/segregation units continue to have access to prescribed mental health treatments, whether they are psychopharmacologic or non-psychopharmacologic interventions. Mental health staff should advise security administrators when inmates are denied such access so that security administration could look into the matter.

7. Mental health staff need to repeatedly raise all of these concerns during management and administrative meetings as a reminder to all levels of staff that these concerns remain and must be addressed. In such management meetings there should be a particular focus on issues that clearly relate to security concerns, space allocation, and other above noted issues that are under the control of those outside of the mental health unit.

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

ASSESSMENT: NONCOMPLIANCE

MENTAL HEALTH FINDINGS: During the 10th monitoring visit there was considerable discussion between the monitors, mental health staff, security staff, and corrections administrators regarding this issue.

During those discussions, it was clearly established that there should be mental health input into the disciplinary review process when there is some indication that the prisoner has mental health issues. However, it remained unclear as to how, if at all, such mental health input might be considered and/or how it might actually impact on the disciplinary review process. In addition, it became clear that the apparent lack of a range of disciplinary sanctions other than isolation/segregation further complicates this issue, by essentially limiting the disciplinary decision to isolation/segregation or no disciplinary action, regardless of the inmate's mental health status.

During this most recent monitoring visit it became clear that there has been absolutely no progress made on this issue. Mental health staff had not been asked for input on any prisoner involved in a disciplinary action, despite the fact that that had at least appeared to be the one issue where there was some consensus. A review of the list of inmates who had disciplinary charges during this most recent period revealed that there were multiple inmates on that list who were also on the

mental health caseload; during prior discussions, being on the mental health caseload had been considered to be one of the ways to identify the subset of inmates undergoing disciplinary proceedings for whom mental health input should be obtained; but no mental health input was sought for these inmates. During prior discussions, it was also noted that suspicion that an inmate might be suffering from mental health issues, regardless of whether or not such suspected issues were thought to be directly causative of the disciplinary infraction, would be another reason to request mental health input into the disciplinary process; it was decided that in such cases, a 'behavioral checklist' would be completed for the inmate, noting that the inmate is now involved in the disciplinary review process; but no disciplinary-related 'behavioral checklists' were received during this most recent period. It is impossible to determine exactly why no 'behavioral checklists' were filed as part of the disciplinary review process, but options range from there simply were no inmates who were suspected to have mental health issues (presumably including those on the mental health caseload, diagnosed with major psychiatric disorders), to those involved in the disciplinary review process were unable to recognize indicators that an inmate might be suffering from mental health difficulties, to those involved in the disciplinary review process are simply ignoring the need to implement this provision.

It remains to be determined whether or not the mental health training that is currently underway will increase the capacity of those involved in the disciplinary review process to identify the subset of inmates undergoing disciplinary review who might be suffering from mental health difficulties, *and* increase their understanding of why it is so important to request mental health involvement in the disciplinary review process for such inmates. However, it may very well be that specific training focused on this provision and designed for all of those directly involved in the disciplinary review process – i.e., covering policies, procedures and the knowledge and skills required to at least suspect that an inmate might be suffering from mental health difficulties – will be required.

As noted above, even if those involved in the disciplinary review process increase their capacity to identify the subset of inmates who might be suffering from mental health difficulties, and even if they then seek mental health input for that subset of inmates, what happens next (the other issues noted above) still has to be resolved before there can be any meaningful progress made on this provision.

RECOMMENDATIONS:

1, GGACF should continue to work on the development of an effective policy and process to provide mental health review and input into the disciplinary process.

2. Mental health staff must be prepared to quickly assess inmates with alleged disciplinary infractions, with an eye toward determining whether or not the alleged infraction was likely a product of any mental illness that the inmate might be suffering from, and the likely impact of potential sanctions on the inmate's mental health status.

3. GGACF should develop a form that can be sent to the Mental Health Coordinator, completed by mental health staff and submitted to the disciplinary committee, which outlines the findings of the mental health assessment. The committee can use the same form to communicate back to the mental health staff the outcome of the hearing proceeding.

4. Mitigating factors discovered by the mental health professional must be at least considered by the disciplinary committee.

5. Mental health services should track the effectiveness of their input in mitigating sanctions or terminating sanctions as appropriate.

6. Alternative housing and treatment services are an essential component in diverting seriously mentally ill inmates committing infractions due to their impaired judgment and mental processing.

7. Again, it is recommended that GGACF provide appropriate staffing and housing alternatives for this population. (See V.1.p.)

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

ASSESSMENT: NONCOMPLIANCE

MEDICAL FINDINGS: We were told that the Medical Director has developed a new plan and we performed a walk-thru of the medical area. We have seen that there is a new mental health group room that has been almost completed and is currently being utilized. Other rooms, including dental services, have been reconfigured. There are minor things under the new plan that need to be completed, such as removing doors, providing a plastic boat for the suicide room, replacing the porcelain fixtures with stainless steel, and the reconfiguration of the dental area. We performed a walk-thru with the Warden, who supported all of the changes and indicated that many of these could take place. We also observed the suicide room in the intake area. This has been completed; however, the nurse screening room where the nurse would perform the intake screen has not yet been completed.

RECOMMENDATIONS:

1. Complete all the minor changes that are recommended for the clinic building and complete the nurse screening room in the intake area.

MENTAL HEALTH FINDINGS: As noted above, the renovation of the group therapy room in the medical building has been completed; the renovation was extremely well done; and now the room is in use for group therapy.

As also noted above, the renovation of a cell in intake to make it a suicide-resistant cell has been essentially completed. Although the renovation of this particular cell increases the possibility that security will appropriately monitor/observe inmates on suicide watch, the location of the cell in the intake area makes it difficult for nursing staff and mental health staff to monitor such inmates who are being held there. In contrast, the renovation of the cell in the medical building to make it suicide-resistant remains incomplete.

The renovation of other space designated for mental health programming also remains incomplete and therefore unusable. Of particular concern is the renovation of multipurpose rooms on the segregation units so that the space can be used for expanded mental health programming for seriously mentally ill inmates who are housed there. The completion of this renovation would be

a significant step towards removing seriously mentally ill inmates from segregation/isolation into a more appropriate setting where they can receive appropriate mental health services.

RECOMMENDATIONS:

1. Continue with current renovation plans as quickly as possible.

2. Continue to assess the need for additional space for developing mental health programming.

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

ASSESSMENT: PARTIAL COMPLIANCE

MENTAL HEALTH FINDINGS: As noted above, during this monitoring visit the monitor did a more detailed review of randomly selected inmates on the mental health caseload. This review included a review of each inmate's treatment plan, the information about each inmate contained on the various treatment logs, and each inmate's medical/psychiatric record, as well as a discussion of the inmate with all mental health staff in the context of a clinical case conference held by the monitor. The results of that review process have been described above. However, to be clear with regard to this particular provision, the monitor found that treatment plans were well done; plans included a formulation of the inmate's mental health difficulties and the goals of treatment; therapeutic interventions were linked to particular treatment goals; timelines for the meeting of each goal were noted; and for those who had been in treatment for some time, updates were also included, and where appropriate, the updates also noted any required changes in the treatment plan.

As noted in prior monitoring reports, this monitor recognizes that the adequacy of treatment plans might, at times, be compromised by some of the above noted problems that are outside of the control of mental health staff. When this is the case, this monitor expects to see any such required compromises noted in the treatment plan, so as to make it clear that there is a more appropriate intervention that is simply not currently available at the facility. Therefore, a treatment plan might note, for example, that an inmate will be switched to a specific, more appropriate modality of treatment when such becomes available.

RECOMMENDATIONS:

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

2. The mental health unit should also continue to use its own case conferences to ensure consistency between staff members in developing measurable objectives toward marked improvement in those inmates followed by the mental health team. Such efforts are important in and of themselves, but they will also be important as the unit continues to develop its capacity to regularly access the overall quality and efficacy of the unit's efforts

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

ASSESSMENT: NONCOMPLIANCE

MENTAL HEALTH FINDINGS: As noted above, mental health programming has been expanded to include considerable non-pharmacologic therapeutic interventions, including the various group therapy sessions and the judicious use of individual sessions as needed. The addition of these interventions has been enormously helpful to many of the inmates who suffer from serious mental illness, and they have also been helpful to many of the 'less ill' but still unstable inmates, in that they have been helped to increase their capacity to remain more stable.

However, as also noted above, enhanced programming for seriously mentally ill inmates, especially those who are currently in isolation, continues to be a work in progress. There have been some notable gains with some of these inmates, despite the absence of a specifically developed enhanced program and despite the absence of renovated space where such an enhanced program could be provided. Staff must continue to find creative ways to offer as much programming as possible in the absence of the full facility to do so; staff must begin to plan for the development of a fuller enhanced program so such can put implemented once space is available; and, of course, staff must continue to advocate for the space that they require.

Finally, staff of the mental health unit continue to try to encourage those who have refused treatment to voluntarily accept treatment. Staff also appear to be clear about the fact that some subset of those who have refused treatment will never voluntarily accept treatment, and that some subset of those who will never voluntarily accept treatment meet the criteria for court intervention. However, the monitor continues to urge the mental health unit to distill all of this into a written and actionable policy/procedure. This is at least in part because having such a written policy/procedure that can be shared with other staff at the facility may help in efforts to address many of the problems noted above (such as the placement of seriously mentally ill in isolation/seclusion), and because the increased clarity that it would bring to the understanding of the management of seriously mentally ill individuals is so integral to addressing those problems.

RECOMMENDATIONS:

1. The mental health team will need to develop a global treatment menu designed to meet the needs of inmates at different levels of housing and treatment needs.

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

3. The facility should consider how it might create a special population housing unit that would provide a safe housing alternative to vulnerable mentally ill inmates and make the delivery of services more efficient to those who require enhanced mental health services.

4. Those who refuse needed treatment must be further assessed to determine if they are a danger to themselves or others. This assessment should be used to determine whether or not they require placement in isolation/segregation and whether or not a court intervention should

be obtained that would require them to undergo treatment; and all the while efforts should continue to convince such inmates to voluntarily accept treatment.

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

ASSESSMENT: PARTIAL COMPLIANCE

MENTAL HEALTH FINDINGS: Most of the issues related to this finding have been discussed in earlier sections of this report. However, one additional issue should be noted here, and that is that during medical/mental health chart reviews, this monitor did not always find documentation of informed consent for medication. Therefore, mental health staff should make sure to obtain informed consent and make sure that documentation of signed informed consent is included in the chart of all those who are currently taking psychotropic medications.

In addition, it remains the opinion of this monitor that all mental health staff and nursing staff should be trained to look for possible major medication adverse effects. There is no expectation here that mental health staff and nursing staff would begin to diagnose medication adverse effects. Instead, the expectation is that such training might help staff suspect adverse effects and report their concern to the psychiatrist, and upon doing so, the psychiatrist might see an inmate earlier than scheduled and thereby intervene more quickly. Rapid intervention would, of course, decrease the amount of suffering that an inmate might endure; it might decrease the likelihood that an inmate might stop complying with psychopharmacologic interventions because of concerns about/fears of unacceptable adverse effects; and it helps with inmate learning that if he/she participates in treatment, adjustments and changes in medication can be made in response to problems that the inmate reports, which in turn tends to enhance compliance.

RECOMMENDATIONS:

1. Continue to ensure communication between nursing staff and the psychiatrist with regard to inmate compliance with psychotropic medication orders.

2. Confirm the obtaining of 'informed consent' for medication in the medical records or consider a special form for this purpose.

3. Assure that medical and mental health staff are trained to suspect the presence of psychotropic medication adverse effects and report such a suspicion to the psychiatrist in a timely manner.

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

ASSESSMENT: NONCOMPLIANCE

MENTAL HEALTH FINDINGS: The mental health training that has been developed has been described and discussed in prior monitoring reports. That training is now underway, and it is expected to be completed in July 2016. Once the training has been completed, it will be important to evaluate the extent to which the training reached its goals, some of which are noted below.

As has been previously noted, the 'behavioral checklist' is the mechanism available to correctional staff that would allow staff to identify and report signs and symptoms of mental health needs of prisoners not previously assigned to the mental health caseload. Staff has been using the 'behavioral checklist', and it is expected that the mental health training that is currently underway will significantly improve their capacity to do so.

It is also hoped that the mental health training will help staff better understand the various ways that different types of mental illness can impact on an individual's ability to function, and thereby increase their appreciation for taking an inmate's mental health difficulties into consideration when making important decisions concerning the inmate. Such important decisions might include, for example, classification/placement, the planned use of force, the use of isolation/segregation, and disciplinary decisions.

RECOMMENDATIONS:

1. Continue to utilize the Behavioral Checklist process.

2. Finalize and present mental health training for security staff.

3. Improve the incorporation of information obtainable from mental health assessments into security decision-making and review regarding disciplinary matters, the review of situations where there was use of force, the use of isolation/segregation, and the classification of inmates.

4. Consider a more formal process for providing feedback to security staff who complete a behavioral Checklist, regarding how helpful their effort to complete the checklist has been and also regarding any suggestions mental health might have that would help security staff better manage and otherwise interact with the individual.

5. 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 lockdown as a substitute for mental health treatment.

ASSESSMENT: NONCOMPLIANCE

MENTAL HEALTH FINDINGS: Most of the issues related to this provision have been discussed in previous sections of this report. However, it should be noted that the point most specifically related to this provision is the placement of seriously mentally ill inmates in isolation/segregation reportedly for their protection, instead of placing them on a special unit where they can receive the enhanced mental health programming that they require.

RECOMMENDATIONS:

1. GGACF must cease to place seriously mentally ill prisoners in segregated housing or lockdown as a substitute for mental health treatment.
2. The Health Services Administrator needs to coordinate regular monthly Medical Administration Committee (MAC) and Quality Improvement meetings, documented by minutes and attendance sign-in sheets. This issue should be an important agenda item for such meetings. These meetings should include the Warden or the Warden's designee in order to assure that plans for addressing this issue take all aspects of the problem into consideration.

VI. FIRE AND LIFE SAFETY

Compliance Summary: As discussed herein, this assessment found not factual basis on which to change any of the Monitor's compliance ratings of the 11 provisions in this section of the Agreement. As shown in the scorecard below, all provisions remain in NonCompliance. This scorecard is expected to substantively improve upon full implementation of these provisions.

VI. Fire & Life Safety		1	2	3	4	5	6	7	8	9	10	11
1	V.1a: Adequate Fire Safety Program/Plan/Fire Marshall Review	0	0	0	0	0	0	0	0	0	0	0
2	V.1b: Adequate Fire Safety Steps / Fireload Maintenance/Equipment Inspections/Alarms/Smoke Detection in all Housing Units	0	0	0	0	0	0	0	0	0	0	0
3	V.1c: Defined Comprehensive/Documented Fire Drills/Staff Competency	0	0	0	0	0	0	0	0	0	0	0
4	V.1d(i): Regular Housing Unit Inspections/Lock Functioning/Repair	0	0	0	0	0	0	0	0	0	0	0
5	V.1d(ii): Regular Housing Unit Inspections/All Remote Locking Mechanisms Functional	0	0	0	0	0	0	0	0	0	0	0
6	V.1e: All Staff Tested on Fire Safety Procedures	0	0	0	0	0	0	0	0	0	0	0
7	V.1f: Reporting/Notification of Fires/Audible Alarms	0	0	0	0	0	0	0	0	0	0	0
8	V.1g: Prisoner Evacuation as Indicated	0	0	0	0	0	0	0	0	0	0	0
9	V.1h: Fire Suppression	0	0	0	0	0	0	0	0	0	0	0
10	V.1i: Medical TX of Persons Injured from Fires	0	0	0	0	0	0	0	0	0	0	0
11	V.1j: Control of Highly Flammable Materials	0	0	0	0	0	0	0	0	0	0	0
	# NonCompliance	11	11	11	11	11	11	11	11	11	11	11
	# Partial Compliance	0	0	0	0	0	0	0	0	0	0	0
	# Substantial Compliance	0	0	0	0	0	0	0	0	0	0	0
	# Sustain Compliance	0	0	0	0	0	0	0	0	0	0	0
	Progress Points	0	0	0	0	0	0	0	0	0	0	0
	Percent Out of Noncompliance	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%

Substantive Provisions:

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

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

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: No substantive improvement from the previous assessment. However, with the continued assignment of a full-time fire safety officer and the proposed assignment of a fire safety coordinator, we are encouraged that the fire safety program at GGACF will improve. The new fire safety coordinator will be responsible for the fire safety programs at GGACF and St. Thomas. We interviewed and reviewed the CV of the proposed fire safety coordinator, Mr. Charlemagne Davidson, and we determined that he is highly qualified to serve in the capacity of Fire Safety Coordinator. Mr. Davidson has intimate knowledge of the fire safety program at GGACF as well

as the many challenges that remain in coming into compliance with fire safety provisions of the SA.

We continue to see incremental improvement in the conducting of monthly fire safety inspections of all areas of the facility. The monthly fire safety inspections are conducted in a consistent manner and deficiencies are being identified. However, corrective action on noted deficiencies needs to be addressed. We continue to note fire and life safety discrepancies dating back to May 2015 that have not yet been corrected.

The GGACF Fire and Safety policies and procedures have been finalized and approved by this Monitor. Next steps are for GGACF staff to start training on the policies and to commence a comprehensive implementation process of the fire safety program. 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 March 2016 inspection of the housing units. During these inspections I continue to observe the smell of smoke in several housing units.

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

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

During our inspection, I also observed exposed electrical wiring in various areas of the facility, including the kitchen and housing units. 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 previous reports. These findings, in addition to previous findings, reveal the urgent need to develop and implement a comprehensive fire safety program at GGACF.

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 still do not outline the appropriate route. On a positive note, Officer Samuel has continued to conduct systematic inspections of fire safety needs for the facility. A comprehensive fire evacuation plan that would incorporate all areas and buildings within the confines of GGACF and the contents of the overall fire safety program, such as the finalized and approved fire safety policies and procedures, needs to be provided to the VI Fire Marshal for review. It is also expected that with the assignment of the Fire Safety Coordinator, the fire safety program will be advanced towards compliance.

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, that they be provided to the Fire Marshal along with a copy to the Monitor and USDOJ.

1. Implement the approved fire safety policies.

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 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.

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: Almost identical to previous Monitor's reports, we found that the Housing unit fire control panels remain inoperable, the primary fire suppression system remains broken, and cell and housing unit sprinklers are non-functional. We noted an improvement in the housing units whereby inmates were not using the fire sprinklers to support personal clotheslines; however, we did note that some inmates were using makeshift clotheslines in other areas of their cells. 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 handheld 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 and medical unit. 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 continues to be a positive step in improving fire safety. However, as the approved fire and life safety policies and procedures are implemented, GGACF staff must start taking deliberate steps in addressing discrepancies that are identified by the Fire Safety Officer and Fire Safety Coordinator.

As noted in previous reports, if GGACF plans to continue to house individuals in the "older" buildings with no plans to update or install fire suppression equipment in those buildings, GGACF will never come into compliance with these provisions.

Although it is 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 months of January and February 2016 continue to identify missing or non-functional smoke alarms and inoperable emergency lights dating back to May 2015; 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 the NFPA and/or the American Correctional Association to assist in program development and monitoring.

3. Continue to support fire safety officer.

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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 reporting, GGACF staff indicated that fire drills have not been conducted on a regular basis. The Fire Safety Officer had commenced a process for conducting fire drills; however, documents evidencing this process were not made available during this reporting period.

During this site visit it appeared that security staff continue to have a better awareness of emergency key management. With a few exceptions, staff were able to identify emergency keys.

In the housing units we inspected, we found emergency keys to be available. We conducted a random check of the emergency exit doors in Housing Unit 9-D and noted that security staff were unable to open one these doors. It appeared that the locking mechanism had been sabotaged. 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 and procedures. In future site visits we will continue to inspect this area of fire safety. The Fire Safety Officer and security management should conduct drills to see how promptly cell doors can be manually unlocked.

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

RECOMMENDATIONS:

1. Develop and implement a valid and reliable emergency key system as described above. Train and drill staff as discussed on system use.

2. Develop emergency key and locking mechanism inspection and reporting system as discussed above.

3. Implement competency-based staff training as discussed.

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.

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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. It should be noted that the Maintenance Department has addressed a number of locking mechanisms in various areas of the facility, but a more systemic approach needs to be implemented in the housing units whereby the inspection of the locking mechanisms become routine.

The Maintenance policy has been approved. However, 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 is there a system for ensuring that all facility remote locking cell mechanisms are functional. During this monitoring visit

we were pleased to again observe little evidence of inmates compromising the cell locks by inserting various materials in the locking mechanisms. We did, however continue to observe housing unit grills whereby the security grills were left open. We also noted improvement in other housing units where the entry door locks and doors had been repaired and were functional.

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.

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: No records have been provided to verify that all staff have been trained and tested on safety procedures. The Settlement Agreement requires testing of all staff regarding fire and life safety procedures. The fire safety policies and procedures have been approved and now staff need to be trained on them.

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.

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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 handheld 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 Monitoring 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.

RECOMMENDATIONS:

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

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: The fire evacuation policies and procedures have been approved and now staff must be trained on them and implemented to include full scale evacuation drills.

RECOMMENDATIONS:

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

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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.

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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 final and approved Fire and Life Safety policies and procedures. The next step is to ensure that staff are trained on them and they need to be fully implemented.

RECOMMENDATIONS:

1. Implement approved 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.

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j. Control of highly flammable materials.

ASSESSMENT: NONCOMPLIANCE

FINDINGS: Many inmate cells still contain considerable personal property, thus creating a fire and safety risk. The project of providing bins to all prisoners to store their personal belongings will help alleviate this problem. Identical to previous reporting, flammable storage areas/cabinets in the Carpentry shops do not appear to be properly vented; however, the fire safety staff reported that they will be addressing this issue as they systematically implement the approved Fire and Life Safety policies and procedures.

RECOMMENDATIONS:

1. It is anticipated that staff will be trained on the approved policies and procedures concerning the control of highly flammable materials as well as implementing them.

VII. ENVIRONMENTAL HEALTH AND SAFETY

Compliance Summary: As discussed herein, this assessment found not factual basis on which to change any of the Monitor's compliance ratings of the 11 provisions in this section of the Agreement. As shown in the scorecard below, the Territory has maintained six (6) provisions (55%) out of NonCompliance since the 7th assessment. This scorecard is expected to substantively improve upon full implementation of these provisions.

Agreement Section & Substantive Provisions		Compliance Assessment Report Number & Scores										
VII. Environmental Health & Safety		1	2	3	4	5	6	7	8	9	10	11
1	VII.1a: Housing Plans/Proper Cleaning/Preventative Maintenance Plan/Response to Routine/Emergency Needs	0	0	1	0	1	1	1	1	1	1	1
2	VII.1b: Adequate Ventilation Throughout Facility	0	0	0	0	0	0	0	0	0	0	0
3	VII.1c: Adequate Lighting/All Prisoner Housing/Work Areas	0	0	1	1	1	1	1	1	1	1	1
4	VII.1d: Adequate Pest Control for Housing Units, Medical Units/Food Storage	0	1	1	1	1	1	1	1	1	1	1
5	VII.1e: Prisoner/Clinical Staff Access to Hygiene/Cleaning Supplies	0	1	1	1	1	1	1	1	1	1	1
6	VII.1f: Cleaning/Handling/Storing/Disposal of Biohazardous Materials	0	0	1	1	1	1	0	0	0	0	0
7	VII.1g: Mattress Care/Cleaning	0	0	0	0	0	0	1	1	1	1	1
8	VII.1h: Chemical Control/Supervision of Prisoners Having Chemical Access	0	1	1	1	1	1	1	1	1	1	1
9	VII.1i: Laundry Services/Sanitation Providing Adequate Clean Clothing,Underclothing,Bedding at Appropriate Intervals	0	0	0	0	0	0	0	0	0	0	0
10	VII.1j: Defined Food Services Safety/ Hygiene/ Temps/ Storage/ Transportation	0	0	0	0	0	0	0	0	0	0	0
11	VII.1k: Sanitary/Adequate Drinking Water Supply	0	0	0	0	0	0	0	0	0	0	0
	# NonCompliance	11	8	5	6	5	5	5	5	5	5	5
	# Partial Compliance	0	3	6	5	6	6	6	6	6	6	6
	# Substantial Compliance	0	0	0	0	0	0	0	0	0	0	0
	# Sustain Compliance	0	0	0	0	0	0	0	0	0	0	0
	Progress Points	0	3	6	5	6	6	6	6	6	6	6
	Percent Out of Noncompliance	0%	27%	55%	45%	55%	55%	55%	55%	55%	55%	55%

Substantive Provisions:

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 continue to be

more readily available in the housing units. Some housing units and cells were cleaner than others and the need to consistently conduct routine and sustained cleaning of all facility areas remains a challenge to GGACF staff.

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

The Maintenance Supervisor maintains preventative maintenance schedules for various components of the GGACF physical plant, including the emergency generator. The emergency generator had been problematic for some time. However, the Maintenance Supervisor reported that the emergency generator has been repaired and is functional.

Non-functional drinking fountains in the housing units remain of serious concern and have negative implications on inmate health and safety.

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 showerheads and plumbing to provide reliable personal hygiene, adhere slip-resistance materials at shower entrance points to reduce fall risks, repair water draining to eliminate standing water in unit and cell floors.

5. Develop a mold control/mitigation plan that includes routine inspection and cleaning activities. Control access to related cleaning chemicals and train staff and inmates in the proper use and storage of those chemicals.

6. Develop and implement a sanitation management plan that monitors and mitigates sanitation problems and hazards.

7. Improve practices involving mattress cleaning and ensure inmates and staff involved in this program are trained in proper cleaning methods and use of materials and chemicals. Ensure mattress storage areas are sanitary at all times.

8. Repair all housing/cell windows to prevent penetration by insects.

b. Adequate ventilation throughout the facility;

ASSESSMENT: NONCOMPLIANCE

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

The Director of Corrections is prioritizing the project as part of the capital improvement program for 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 mediations that are adversely affected by high body temperatures and take appropriate steps to eliminate adverse effects.

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

ASSESSMENT: PARTIAL COMPLIANCE

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

RECOMMENDATIONS:

1. Develop a comprehensive campus/facility lighting plan that ensures constant illumination of all required internal and external perimeters, housing areas, support services, structures and areas.

2. Maintain an ongoing lighting repair log that evidences repair activities.

3. Ensure rapid repair and replacement of inoperable lighting, add additional external and internal illumination where indicated by a comprehensive security lighting needs assessment.

4. Provide for adequate staffing levels to support lighting plan and maintenance.

5. Increase illumination in all occupied cells for improved security and inmate wellness.

6. Prohibit inmates from blocking cell door windows and from erecting anything in their cells that impedes good visibility from the cell door window.

7. Ensure that all emergency lights in housing units (and other occupied areas in the facility) are reliably operational.

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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 significant 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. We also observed missing or broken screens on many facility windows.

The BOC has a contract with a private vendor (Oliver Exterminating of St. Croix) to provide pest control services at GGACF. It does not seem that the contract provides for individual cell extermination, but perhaps it should.

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.

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

ASSESSMENT: PARTIAL COMPLIANCE

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

RECOMMENDATIONS:

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

2. Continue to provide adequate supply of these personal care items in control pods or housing units to ensure timely exchange of use-for-new products.

3. Prohibit inmates from bartering these supplies and from hoarding empty containers in their cells and living areas.

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: There is no formal sanitation plan or protocols covering compliance with this Provision, nor is there a formal training program for staff or inmates on this topic. Staff and inmates must be trained and demonstrate competence in handling biohazardous materials, provided and instructed on the proper use of bio-protective clothing and supplies, and supervisors must closely monitor biohazard clean-ups.

In Housing Unit 9, we observed evidence in prisoner's cell that had been transferred to the hospital as a result of an apparent altercation with another prisoner. Even though several days had transpired since the incident, the prisoner's cell was in a state of disarray, unsanitary and still contained blood splatter residue on the floor. This is a serious breach to staff and inmate health safety.

Remaining in noncompliance with this Provision can jeopardize the health of staff and inmates.

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

RECOMMENDATIONS:

1. Develop, as part of medical infection control policies and facility sanitation plans, a comprehensive biohazard 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 cleanup;

c. Staffing and inmate training on the plan and proper handling and disposal of biohazards;

d. Consistently maintain adequate supplies of feminine hygiene products and disposal bags for all biowaste;

e. Locate adequate supplies of biohazard disposal and cleanup supplies in or at all locations where biological waste and/or spills do and could occur;

f. Provide appropriate cleanup apparel and training in the use of that apparel.

2. 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.

3. Develop a biohazardous control program that involves regular inspections of all potential contamination areas.

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

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

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g. Mattress care and replacement;

ASSESSMENT: PARTIAL COMPLIANCE

FINDINGS: The related policy has been approved by the United States and the Monitor. 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, with few exceptions. 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.

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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 the approved policies and procedures, and a quality assurance tracking system will aid in advancing this provision to Substantial Compliance. Although chemical storage appears appropriate, there is no training program for staff or inmates responsible for handling and controlling these chemicals. Additionally, staff 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. As noted in our previous report, staff have developed Material Safety Data Sheets that are contained in notebooks and have been placed in various areas of the facility.

RECOMMENDATIONS:

1. Implement approved 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.

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: We found no substantive improvement in this area from our previous site visit. 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. We observed inmates drying these items in their cells using clotheslines anchored to walls, window frames, bunks, etc. We also continue to observe worn out linens and dirty linens in many inmate cells.

RECOMMENDATIONS:

1. Implement approved 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 makeshift 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. Consider replacing all wood laundry carts made of nonabsorbent materials that can be sanitized and completely cleaned. Discontinue the practice of moving laundry on carts that have not been cleaned and sanitized.

7. The initial issue of inmate supplies should include, at minimum: one (1) corrections issue shirt/pants, jumpsuit, undergarments, towel, bedding, mattress, sheet, and blanket. Clothing should be exchanged with clean items twice per week at a minimum, sheets and towels once per week at a minimum. Blankets should be exchanged monthly at a minimum. Any clothing, linens or bedding should be changed immediately if they appear damaged and/or unsanitary, or appear to present a risk to health.

8. Ensure that inmate handbooks provide clear rules and information about the laundry program, how to access clothing, linens, and bedding. Cease the practice of allowing inmates to wash clothing in housing unit or cell sinks and toilets.

9. Staff and inmates involved in the laundry work program should be properly trained and supervised.

10. Laundry equipment should be reliable and properly maintained.

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: The Director of Corrections reported that funding has been secured to refurbish the Kitchen and the bidding process was initiated. This is a very positive development. In addition, the food services policies and procedures have been finalized and approved.

The physical plant of the Kitchen remains in a state of substantial deterioration as does the food service equipment. Overall, the kitchen was clean. The dishwasher is still not working properly.

There is still an inoperable walk-in refrigerator that was cleaned from our previous site visits; however, there is still evidence of insect and rodent infestation that staff are trying to address. It appears that part of the scope for the kitchen refurbishing project will be the permanent removal of all inoperable and non-useable food service equipment.

The kitchen doors are not rodent-proof. We observed evidence of mold and rust in various areas of the Kitchen that staff is attempting to temporarily address; however, a permanent fix to the problem still needs to be made to the overall structure of the kitchen.

The kitchen officer is still working on finalizing a chit checkout system for the utensils and dangerous implements. This has been a lengthy project that requires completion.

RECOMMENDATIONS:

1. Implement approved policies.

2. GGACF officials should review food service requirements promulgated by the National Correctional Association and National Commission on Correctional Health Care.

3. Develop a food service training program that includes inmate and staff training records and ensure that all training is well-documented.

4. 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.

5. Timely complete planned renovations to the kitchen and food service support areas.

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k. Sanitary and adequate supplies of drinking water.

ASSESSMENT: NONCOMPLIANCE

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

The lack of constant reliable access to drinkable water further prevents GGACF from ensuring that inmates live in a healthy environment. Similar to previous reporting, many of the cell sinks were still inoperable and inmates rely on officers to provide water before and during lockdown. 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 lockdown. 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. During this visit there were still some complaints regarding contaminated ice with rust and particles. A long-term solution to the problem still needs to be addressed through the installation of refrigerated water fountains in the housing units.

In X-Dorm we had been reporting a consistent problem regarding the lack of drinking water for this unit. However, since our last four site visits, GGACF officials have addressed this problem by installing portable water bottles in the dorm. We did note that the assigned officer's portable drinking fountain was empty.

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

Compliance Summary: As discussed herein, this assessment found not factual basis on which to change any of the Monitor's compliance ratings of the four (4) provisions in this section of the Agreement. As shown in the scorecard below, all provisions remain in NonCompliance. This scorecard is expected to substantively improve upon full implementation of these provisions.

Agreement Section & Substantive Provisions		Compliance Assessment Report Number & Scores										
VIII. Training		1	2	3	4	5	6	7	8	9	10	11
1	VIII.1a: Defined Staff Training Curricula/Scheduling	0	0	0	0	0	0	0	0	0	0	0
2	VIII.1b: Pre-Service Training for all New Employees	0	0	0	0	0	0	0	0	0	0	0
3	VIII.1c: Periodic In-Service Training/Retraining of all Employees Following Pre-Service Training	0	0	0	0	0	0	0	0	0	0	0
4	VIII.1d: Documentation & Accountability Measures to Ensure Staff Completion of Required Training	0	0	0	0	0	0	0	0	0	0	0
	# NonCompliance	4	4	4	4	4	4	4	4	4	4	4
	# Partial Compliance	0	0	0	0	0	0	0	0	0	0	0
	# Substantial Compliance	0	0	0	0	0	0	0	0	0	0	0
	# Sustain Compliance	0	0	0	0	0	0	0	0	0	0	0
	Progress Points	0	0	0	0	0	0	0	0	0	0	0
	Percent Out of Noncompliance	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%

Substantive Provisions:

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: Policies and procedures required under this provision have been fully completed and approved by this Monitor, the United States, and the Territory.

Training and implementation for the approved medical and mental health policies and procedures is well underway. GGACF staff, in collaboration with the United States and the monitoring team, developed curricula for training health care and custody staff (as required) on these policies and procedures. A training plan for these policies and procedures was approved by the United States and this Monitor and file as D.E. 923-1 on June 16, 2015. This plan divides training into four groups with specified timelines for demonstrating completion of training for each group. Combined, the four groups comprise some 37 training topics. Training for groups 1-3 (26 topics) was completed as of September 14, 2015. The final 11 topics (group 4) is scheduled for completion by July 31, 2016.

On April 22, 2016, the Territory issued written notice the this Monitor and the United States that the weekly training schedule for completing grouping 4 training was not underway due to holidays that were not contemplated when developing the training schedule. Nonetheless, the Territory stated that it remains on track to complete all training by July 31, 2016. The Territory advised this Monitor they will file this information in their next status report.

The Territory has selected a contract-provider to develop and implement the training requirements of this Agreement; we had the opportunity to meet representatives from this company and review proposal documents while onsite. These interviews and review of documents seem to indicate that the contract-provider is well qualified and competent, and voiced a serious determination to ensure that their product complied with the conditions of the Agreement and produced required outcomes.

Briefly, the Territory and contract-training provider are developing training curricula for 1) policies and procedures and 2) other training topics contained in the training policy. This contractor stated that all components of the curricula will meet industry standards and include all lesson plans, learning materials, and pre and post-training assessments. Additionally, instructor development curriculum will be developed for preparing qualified GGACF staff to facilitate and instruct the new curricula, and onsite instructor monitoring and coaching by the contractor during the first 80 hours of staff training to ensure instructor fidelity to the prescribed training protocols. Training GGACF staff to train their own will be a major step toward the Territory demonstrating sustainable compliance during and beyond the term of this Agreement. Section F.2 of the Territory's approved training policy below specifies pre and in-service training requirements for unformed and civilian staff, and GGACF leadership. This robust list of basic and advanced topics on contemporary correctional science meets industry standards and is adequately comprehensive to meet compliance requirements and GGACF staff professional needs.

General Assignment	Pre-Service Training Requirement (Subject Areas)	Minimum Duration of Training
Civilian Staff (non-inmate/detainee contact, determined by job description)	1. Orientation to Corrections / BOC / GGACF 2. Facility Orientation 3. Emergency Procedures 4. Communication Systems / Uses 5. Sexual Abuse Prevention and Response (PREA), BOC-PREA-4000 6. Facility Access & General Security 7. Professionalism 8. Incident Reporting Policy, BOC-SEC-1003 9. Administrative Investigations/Staff Discipline Policy, BOC-SEC-1006 10. Searches Policy, BOC-SEC-1011 11. Fire and Life Safety Policy, BOC-EHS-3003 12. Training Policy, BOC-TRAIN-1000 13. OJT	20 Hrs. Total
Civilian (Qualified Medical/Mental Health Staff)	1. Same training as Civilian Staff (non Inmate/Detainee Contact) 2. Inmate/Detainee Complaints/Grievance Process, BOC-SEC-1007 3. Communicable Diseases 4. The following approved medical and mental health policies and procedures: a. Infection Control, P-B-01 b. Suicide Prevention and Observation, P-G-05 c. Informed Consent and Refusal of Care, P-I-05 d. Medical Records, P-H-01,3,4 e. Emergency Psychotropic Medications, P-I-02	1. 20 Hrs. 2-4- 20 Hrs.

	f. Terminally Ill Inmates/Detainees, P-G-11 g. Pregnant Care, P-G-09 h. Alcohol and Drugs Detoxification and Intoxication, P-G-06&07 i. Basic Mental Health Services, P-G-04 j. Infirmary Care, P-G-03 k. Medical Diets, P-F-02 l. Chronic Disease Management, P-G-01 m. Discharge Planning, P-E-13 n. Contraception, P-G-09 o. Restraints and Seclusion, P-I-01 p. Continuity of Care, P-E-12 q. Nursing Assessment Protocols, P-E-11 r. Emergency Services, P-E-08 s. Hospital and Specialty Care, P-D-05 t. Oral Care, P-E-06 u. Basic Health Assessment v. Receiving Screening, P-E-02 w. Nonemergency Health Services/Sick Call, P-E-07 x. Aids to Impairment, P-G-10 y. Psychotropic Medication, P-D-02B z. Medication Services, P-D-02 aa. Pharmaceutical Operations, P-D-01 bb. Patient Safety, P-B-02 cc. Grievance Mechanism for Health Complaints, P-A-11 dd. Notification of Serious Illness or Injury and Procedure in the Event of Death, P-A-10 ee. Privacy of Care, P-A-09 ff. Continuous Quality Improvement, P-A-06 gg. Access to Care, P-A-02 hh. Transfer Screening, P-E-03 ii. Segregated Inmates/Detainees, P-E-09 jj. Patient Escort, P-E-10	
Civilian Staff (inmate/detainee contact, determined by job description)	1. Same as civilian staff with no inmate/detainee contact, and: 2. Radio Communications 3. Personal Safety/Security 4. Effectively Communicating with Inmates/Detainees 5. Detection and Reporting of Prisoner Medical, Mental Health, and Suicide Risk Detection & Reporting 6. Training on the following policies based on job responsibilities: a. Classification and Housing Review, BOC-CLAS-2000 b. Special Housing Management, BOC-CLAS-2001 c. Inmate/Detainee Complaints/Grievance Process, BOC-SEC-1007 d. Inmate/Detainee Discipline, BOC-SEC-1005 e. Environmental Health and Safety, BOC-EHS-3000 f. Environmental Health and Safety-Food Service, Sanitation and Hygiene, BOC-EHS-3006 g. Environmental Health and Safety -Control of Chemicals, Flammables, Toxic and Caustic Materials, BOC-EHS-3004 h. Environmental Health and Safety-Inmate/Detainee Clothing, Bedding, and Linen Supplies, BOC-SEC-3002	2-6. 40 Hrs. Total
Custody Staff	1. Same as Civilian staff with inmate/detainee contact 2. Legal & Constitutional Aspects of Pre-Trial Confinement and Convicted Imprisonment 3. Security Methods and Practices 4. Inmate/Detainee Supervision 5. Contraband Prevention, Identification, Detection, Removal, Processing & Reporting 6. Use of Force, BOC-SEC-1004	1. 40 hrs. 2.-26. 120 Hrs. Classroom 27. 480 Hrs. OJT

	7. Verbal Escalation Methods & Techniques 8. Weapon Retention 9. Interpersonal Communications 10. Crisis Intervention & Resolution 11. Inmate/Detainee Rules, Regulations, Rights, Privileges 12. Detection, Identification, Response, and Referral of medical and mental health emergencies 13. Basic First Aid/CPR/AED 14. Communicable Disease Awareness & Prevention 15. Emergency Response & Management 16. Key Control 17. Social / Cultural Aspects of Prisoner Populations and Correctional Operations 18. Counseling Techniques 19. Inmate/Detainee and Workplace Cultural Diversity 20. Self-Defense 21. All approved security policies, procedures, post orders, and protocols 22. The following medical and mental health policies and procedures: a. Discharge Planning, P-E-13 b. Suicide Prevention and Observation, P-G-05 c. Intoxication and Detoxication of Alcohol & Drugs, P-G-06 &07 d. Emergency Psychotropic Medications, P-I-02 e. Medication Services, P-D-02 f. Restraints and Seclusion, P-I-01 g. Hospital and Specialty Care, P-D-05 h. Segregated Inmates/Detainees, P-E-09 i. Patient Escort, P-E-10 j. Receiving Screening, P-E-02 23. OJT	Probationary Training
Mid-Level Custody Supervisor (Sergeants and Lieutenants)	1. Pre-service training for custody officer 2. Effective Supervision of Line Staff (Custody/Civilian) 3. Resource Management & Control 4. Leading Supervisors 5. Counseling & Discipline of Supervisors 6. Techniques of Instruction and Training 7. Staff / Resource Allocation & Management 8. Program Supervision, Management & Evaluation 9. Legal Aspects of Employee Discipline 10. Administrative Investigations and Documentation 11. Leadership in Supervision 12. Professionalism and Human Relations 13. Problem Solving & Decision Making 14. On-Scene Event Control & Management 15. Incident & Administrative Investigation 16. Shift Management 17. Staff Counseling & Discipline 18. Staff Performance Assessment & Evaluation 19. Collaboration 20. Conflict Intervention & Resolution 21. Monitoring & Enforcing Policy Compliance 22. Effective Documentation 23. OJT / Probationary Period: Student First-Line Supervisor consistently demonstrates proficiency and application of 80 hr. classroom topic areas under the mentorship of a qualified supervisor(s).	1. same as above 2.-22. 80 Hrs. 23. 480 Hrs. OJT Probationary
Upper-Management Custody Supervisor (Chiefs of	Has completed all training for Mid-Level Custody Supervisor, and: 1. Executive Leadership, Command & Control 2. Leading and Supervising Mid-Level Managers 3. OJT	1.-2. 80 Hrs. 3. 120 Hrs. OJT Probationary

Security, Assistant Warden, Warden)		

This contractor's presentation of this training program development plan was very positive and promising. The selection of this vendor and the training plan seems to indicate deliberate intentions by the Territory to comply with the Agreement while improving the overall quality of GGACF staff performance. Draft curricula remains under development and will be forwarded to this Monitor and the United States for review and approval once completed, according to the BOC Director.

Train the trainer instruction on the approved PREA policy is tentatively scheduled with the National PREA Resource Center for June 28-29.

RECOMMENDATIONS: Previous recommendations remain appropriate.

1. Implement training policies and curricula once approved.

2. Provide this Monitor and United States all requested training documents.

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b. Pre-service training for all new employees;

ASSESSMENT: NONCOMPLIANCE

FINDINGS: Unformed staff continue to receive basic preservice training as discussed in previous reports. The BOC Director understands the limitations of this training and has including an overhaul of all preservice training with the assistance of the new training program contractor. Topics for pre and in-service training are clearly delineated in the approved training policy and the training contractor will develop the requisite curricula needed to meet the requirements of this provisions, according to the BOC Director. Draft training materials will be forwarded to this Monitor and the United States as they are completed.

RECOMMENDATIONS:

1. Implement training policies and curricula once approved.

2. Provide this Monitor and United States all requested training documents.

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: As discussed previously in this section of the Agreement.

RECOMMENDATIONS: Same as above.

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: As discussed previously in this section of the Agreement.

RECOMMENDATIONS: As stated in previous provisions of this section.

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: Implementation of this agreement remains somewhat slow but steady. New BOC and GGACF leadership seem positive and determined to ensure ongoing implementation of the agreement.

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 has adopted and will continue to adopt all implementation schedules agreed to by the Parities or ordered by the court. This Monitor has and will continue to make all reasonable efforts to resolve disagreements between the parties about implementation schedules and support either parties' right to seek dispute resolution from the court.

3. Defendants will implement every policy, procedure, plan, training, system, and other items 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: The development of final policies, procedures, and training curriculum has become a positive and collaborative process involving this Monitor and monitoring team members, and the parties. There are no outstanding standing disputes currently.

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: As previously reported, the semiannual impact evaluation documents submitted by the Territory only describe, but do not evaluate, compliance progress. This Monitor has provided the Territory consultation and documents to assist it in the development of methods for completing qualitative and quantitative evaluations. However, it is important to note that only medical and

mental health policies and training have been fully implement and ready for empirical evaluation. Such evaluation of non-health care policies, procedures, and training will come once those requirements are fully implemented. This Monitor will provide additional and ongoing assistance to the Territory.

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 become much more timely and proactive in involving this Monitor and the United States in proposed changes to policies, procedures, and/or compliance plans. This improvement has helped to improve the pace of programs and reduce unresolvable disputes.

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

FINDINGS: The Territory continues to timely file required status reports. Descriptions of actions taken to comply with the agreement are improving.

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

FINDINGS: The Territory has become more proactive in notifying this Monitor and the United States of such incidents. The Territory monthly provides documents listing all prisoners who were provided emergency medical attention for the prior month. Also, the Territory provides notification and documentation of such incidents before submitting that monthly report where required by this agreement.

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

FINDINGS: This Monitor is not aware of any recent deviations from this requirement by the Territory.

10. Excluding onsite 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: Responses have been generally received within this 30-day requirement.

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 requirement has and continues to be met by this Monitor. Both parties have demonstrated positive support to this Monitor in carry-out these responsibilities.

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 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: Generally speaking, there has been improvement in the Territory's efforts to facility compliance with this requirement. However, this Monitor continues to experience delays in receiving complete monthly monitoring documents, and responses to requests for information where reasonable advance requests are provided. That said, then Territory seems to be making better efforts to ensure timely and complete responses to this Monitor's request for information and records.

APPENDIX A – ASSESSMENT METHODOLOGY

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

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

Pursuant to Section X.D.1 of the 2013 Settlement Agreement, the Monitor provided the following information to the Territory and U.S. Department of Justice officials for review and comment. This information intended to provide to the Parties: 1) the description of how compliance with the Agreement will be assessed; 2) how information necessary for on and offsite 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. Onsite 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. Onsite 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, 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 and assessment and management. Additionally, specific measures articulated in the Order of the Court dated May 14, 2014 [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 offsite assessment work will be gathered.

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

- Communications with Territory and U.S. Department of Justice Officials as authorized in the Order
- Onsite 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 previous

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 workday.
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 26 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 offsite for hospitalization listing where applicable name, date of service, diagnosis and services 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 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, 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 any suicide occurring within the past year.
52. List of all persons on warfarin, Plavix, digoxin.

C) Suicide Prevention Information:

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