2013 Federal Court Settlement Agreement

In re: United States of America v. The Territory of the Virgin Islands (86/265)

Third Compliance Monitoring Report

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

Completed by:
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EXECUTIVE SUMMARY & ASSESSMENT OVERVIEW

This onsite compliance monitoring assessment was conducted by the monitoring team March 4 thru 7, 2014. The monitoring team consisted of Mr. Kenneth A. Ray, Monitor and correctional administration and operations expert; Dr. Ronald Shansky, MD, correctional medical expert; and Dr. Roberta Stellman, MD, correctional mental health and suicide prevention expert. Prior to this site visit, the Monitor coordinated communication between the Parties and monitoring team in preparation for the onsite assessment.

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

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

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

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

This assessment found 106 (88%) of the 120 substantive provisions (non X. Implementation) Noncompliance (second assessment: 108, 91%), 14 (12%) in Partial compliance (second assessment 7, 6%), none in Substantial Compliance. These compliance ratings show a slight improvement from the second assessment and two returned from Partial Compliance to Non-Compliance..

GGACF THIRD COMPLIANCE ASSESSMENT SCORE CARD				
Agreement Compliance Provision Topic Areas	Total Provisions	Non Compliance	Partial Compliance	Substantial Compliance
IV. Safety & Supervision	59	51	8	0
V. Medical & Mental Health Care	36	36	0	0
VI. Fire & Life Safety	10	10	0	0
VII. Environmental Health & Safety	11	5	6	0
VIII. Training	4	4	0	0
Total Substantive Provisions	120	106	14	0
	100%	88%	12%	0%

Additional Partial Compliance (PC) progress was demonstrated in areas of IV. Safety and Supervision (4 to 8 PC), VII. Environmental Health and Safety (3 to 6 PC).

Implementation (Section X) provisions were not measured using these standards but a narrative description of compliance is provided at this time; the required evaluation standards may be applied in evaluating these provisions in future reports once the Monitor has more clarity about doing so from the Parties.

This assessment found a paucity of progress despite the commendable efforts to purchase new radios, engage a major facility clean-up effort, observing many of the housing and external gates locked, hiring the new psychiatrist, and repairing perimeter fence lighting since the Findings of Fact Report (filed on 02/08/13), the September 2013 Baseline Assessment, and December 2013 second assessment. As such, and based on staff and inmate interviews; reviews of various official logs and records, and direct observations, GGACF remains a very dangerous, violent, unhealthy, under-supervised, under-maintained, and deleteriously understaffed correctional environment. Inmates and staff are unnecessarily exposed to real and potential psycho-social and physical violence, inmates cannot receive adequate levels of medical or mental health services and care, and the lack of an adequate fire suppression system places everyone working and incarcerated at GGACF at constant substantial risk. Substandard and inconsistent security practices i.e. consistently closing and locking security doors and gates are exacerbated by inoperable locking mechanisms. Housing units continue to flood during heavy rains and mold remains profuse throughout most inmate housing areas. The training program, based on documents provided, requires significant overhaul with focus on promulgation and evaluation of standardized curricula that emphasizes contemporary pre and in-service correctional subjects and practices as its priority. GGACF remains very penetrable for dangerous contraband (knives, shanks, cutting devices, impact tools, etc.) as well as cell phones and drugs, and a variety of the kinds of contraband according to evidence logs and incident reports. The inmate grievance process is not consistently managed and adequately documented according to grievance records review, and the inmate disciplinary process appears to deliver inconsistent consequences and fails to consistently administer due process hearings due to staffing shortages. Inmates continue to be allowed to keep in their cells used prescription needles and unused syringes, which is an extremely hazardous practice, especially considering the regularity that housing units are left with no or inadequate staffing levels. Inmates with mental illness, some with serious mental illness, are housing in segregation or locked in their cells (segregated) for long periods of time and without ongoing assessment and monitoring by mental health professionals. Housing unit logs also report that

inmates remain able to "pop" their cell door locks and gain unauthorized access to housing unit areas. Suicidal inmates continue to be placed on suicide watch by correctional officers without the knowledge or involvement by mental health staff, and housing unit logs report that officers either have difficulty summoning medical staff when needed for inmate medical issues or decide to respond to medical issues on their own without consulting medical staff. Events involving use of force against inmates is not reported consistently, and there have been delays in reporting to management potentially serious medical issues involving inmates assaulted by other inmates. These and similar other concerns will be further discussed and described in this report.

Territory officials must re-double their efforts and seriously consider revising recruiting policies in order to expeditiously fill all correctional and health care vacancies, and to hire all additional staff required following completion of the staffing analysis. Regarding deficient correctional staffing, housing unit logs for September 2013 thru March 2014 reported approximately 275 instances involving officer and supervisor staffing shortages including: 1) housing units being left locked or unlocked and unattended by staff, 2) officers showing up to work to find no officer on post, 3) officers leaving work or their post without authorization, 4) late to work, 5) no supervisor on duty, and 6) one officer responsible for monitoring two housing units. An examination of supervisor logs for August 2013 thru February 2014 found over 100 instances involving no unit staff, no supervisor, "extremely short staffed", staff call-offs, lateness, leaving work without authorization and refusing to work assignments as directed.

Equally vital is filling all health care vacancies including the medical director (MD) and nursing staff immediately. Until this is accomplished, inmate health services effectively functions without qualified leadership and clinical staffing levels necessary to provide and maintain constitutional levels of health care. Furthermore, the number of inmates with mental illness, many suffering from serious mental illness cannot be adequately assessed, treated, and monitored by a single mental health counselor and one psychiatrist; additional mental health staff is clearly warranted and necessary.

Finally, it is important to reiterate the need for the promulgation and implementation of adequate administrative and operational policies and procedures. Many of the problems and concerns discussed in this report are directly and in-directly related to a lack of effective and contemporary policies and procedures to govern facility leadership and staff duties and behavior. To date, the Monitor has not received any new or revised policies or procedures for review and approval.

PURPOSE

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

THIRD ASSESSMENT METHODOLOGY

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

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

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

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

   In general, compliance assessment will include the following activities:

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

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

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

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

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

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

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

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

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

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

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

Non-exclusive information required for the Baseline and subsequent visits and monitoring includes the following. Many of these documents were not provided at the Baseline and second visit as requested but more were provided during the second and third visits. Territory officials stated that they intend to continue to generate and provide the requested documents. It is important

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

A) Corrections Information:

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

24. Past 36 months of agency budgets.
25. List and contact information for any and all community vendors who provide services of any kind to GGACF and contracts or professional services agreement authorizing those services.
26. List and contact information for community regulatory agencies who inspect, review, approve, and/or provide consultation to the GGACF i.e., health inspections, fire inspections, etc., and any inter-local agreements involved in these services.

B) Medical and Mental Health Information:

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

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

C) Suicide Prevention Information:

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

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

It is important to note that Defendant made a reasonable effort to provide most of the information requested for this visit. Log books and other reports were ready for review on one the first day and throughout the visit. The balance of information listed above (in bold) in the Baseline and second reports is expected to be provided once it has been developed. Unfortunately, the Warden was not available throughout the visit due to serious illness. Because of this, the Monitor was unable to interview all command staff as a group or the Warden individually. Effective and productive onsite

monitoring requires the active presence of all command staff as needed to clarify information, observations, and findings. The Monitor looks forward to this process during the June 2014 and subsequent visits.

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

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

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

IV. SAFETY AND SUPERVISION

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

A. Supervision

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

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

ASSESSMENT: NONCOMPLIANCE

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

Examination of housing unit and supervisor logs, incident log and reports, and evidence log indicated that staff and inmates remain daily exposed to real and potential harm of physical violence.

Housing unit and supervisor logs report continue to reveal serious issues related to staffing and supervisory level deficiencies, verbal and physical violence against staff and inmates, inmate medical problems and unavailable medical staff to respond, no radios and inoperable telephones, other "equipment problems", and various other problems related to effective care and custody issues.

Examination, comparison, and categorical analysis of 12 housing areas logs provided at and since the Baseline visit. (9A,9B,9C,9D,G,H,I,J,K,L, R&D, and X), appear to show increases in certain events directly and indirectly related to safety and security. This assessment, however, must clarify that additional log books were provided during this visit and could, therefore, skew interpretations about increases in reported events because a similar volume of events could have been assessed from log books not previously provided.

Regarding likely increases in these events, for example, staff recorded approximately 50 times during September thru November 2013 that there were no officers on a housing unit when they arrived to work, officers departed before being properly relieved, being the only officer working a unit, there was no supervisor on duty, "serious staffing shortages," or other staffing problems. Reporting of these staffing problems more than doubled to 109 from December 2013 thru

February 2014. An examination of supervisor logs (December 2013 thru February 2014) found approximately 200 instances where supervisors reported officers calling in sick, leaving work before being relieved, refusing to work a post or assignment, officers being "AWOL", or late to work.

As stated above, housing unit log books were examined for event activity that seemed relevant to compliance with the Agreement. Recorded entries were categorized as shown below and counted. The chart below estimates the number of times staffing problems and other critical issues were reported in housing unit logs. Caution must be used in interpreting these data due to reporting inconsistencies and because additional log books were reviewed during the March 2014 visit. However, the information was recorded in the logs nonetheless.

Month / Year	No Unit Officer / Staffing Problem	No Supervisor	No Radio / Problem	No Flashlight / Problem	No Phones / Problem	No Equipment NOS	No Drinking Water / Problem	No Food / Problem	Escape / Attempt	Contraband	Medical Related / Event	Suicidal / Self Harm Related	Behavior Problem NOS	No Medical / Mental Health Staff Available	Assault on INM / Officer	Threat to Inmate / Officer	Locks Inoperable/Can't Secure	Unit Hygiene	Plumbing Problems	Electrical Problems	Leaking / Flooding	Fire / Fire Related	Modified / Full Lockdown	Inmate unauthorized action	Administrative/Problem
Sep-13	21	4	22	0	7	4	2	0	0	4	12	0	7	1	0	1	10	10	3	5	8	0	9	1	6
Oct-13	14	1	13	0	0	9	4	2	0	7	19	4	7	2	2	0	10	6	5	1	2	1	8	0	6
Nov-13	10	0	5	0	0	5	3	2	1	4	8	4	5	1	2	1	13	15	5	6	11	0	3	1	10
Dec-13	40	6	18	0	11	13	3	5	0	1	12	3	6	4	5	6	47	33	11	4	32	4	7	1	12
Jan-14	47	10	17	0	3	18	4	6	0	5	34	1	13	4	8	7	82	58	7	4	44	10	28	2	11
Feb-14	61	2	9	1	2	15	8	8	0	4	46	2	7	8	5	2	70	41	16	15	9	4	11	4	7
Mar-14 (3/1-17)	18	0	3	0	0	2	1	0	0	2	14	0	6	1	1	1	11	5	7	4	3	0	7	4	7
Total	211	23	87	1	23	66	25	23	1	27	145	14	51	21	23	18	243	168	54	39	109	19	73	13	59
Sep-Dec 2013	45	5	40	0	7	18	9	4	1	15	39	8	19	4	4	2	33	31	13	12	21	1	20	2	22
Dec 2013 - Feb 2014	148	18	44	1	16	46	15	19	0	10	92	6	26	16	18	15	199	132	34	23	85	18	46	7	30
Change	103	13	4	1	9	28	6	15	-1	-5	53	-2	7	12	14	13	166	101	21	11	64	17	26	5	8

It is safe to say that some of these issues are related to deficient inmate stratification and custody management deficiencies, but even the most effective system is rendered ineffective without consistent and adequate staffing levels.

RECOMMENDATIONS:

1. Revise/develop housing classification policies based on a current validated intake and review classification instrument. Submit document drafts as indicated in the Agreement before implementation.
2. Timely complete and submit a policy development plan that includes, at a minimum, the following elements:

A. Policy title with related procedure titles
B. Primary policy references
C. Person(s) responsible for document development
D. Expected dates to be forwarded to the Monitor and USDOJ for review and approval, date(s) of staff training, implementation date

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

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: An assessment of staffing needs has not been completed but the Territory has requested assistance from the National Institute of Corrections (NIC) for technical assistance in completing that assessment. The Monitor has been informed by NIC that the request is under review and should be approved soon.

Territory officials provided the Monitor several revised Post Orders for review but these orders cannot yet confirm "at least one officer per unit" until the staffing analysis is completed, approved, funded, and implemented. All housing unit posts toured had these post orders and staff seemed versed in information contained in them. However, these post orders do not effectively address the issue of minimum staffing levels as the housing unit logs continue to report units going unstaffed or understaffed.

Recommendations provided in the Baseline Report and second report remain appropriate.

RECOMMENDATIONS:

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

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

ASSESSMENT: PARTIAL COMPLIANCE

FINDINGS: Territory officials are to be commended for deploying approximately 45 new portable radios throughout the facility. During the tour, the Monitor observed every housing unit officer and supervisor with a portable radio, new or existing. However, the Monitor cannot objectively determine Substantial Compliance until adequate policies and procedures; relevant training curriculum; and, a full inventory of needed and assigned radios are assessed. It is unknown exactly how many radios are required to ensure full compliance and the Monitor requests a complete inventory of radios, radio deployment locations, and how many additional radios are needed.

RECOMMENDATIONS:

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

d. Supervision by corrections officers assigned to cellblocks, including any special management housing units (e.g., administrative or disciplinary segregation) and cells to which prisoners on suicide watch are assigned, including:
(i) conducting of adequate rounds by corrections officers and security supervisors in all cellblocks; and
(ii) conducting of adequate rounds by corrections officers and security supervisors in areas of the prison other than cellblocks.

ASSESSMENT: NONCOMPLIANCE

FINDINGS: **As previously described regarding housing and supervisor unit logs, there has been minimal improvement since the Baseline or Second Reports. Cell conditions continue to indicate that adequate and frequent rounds of cell block are not being conducted by officers or supervisors according to housing unit logs reporting a high frequency of staffing shortages and evidence logs reporting the continued presence of contraband.**

Although remarkable effort has been made to improve overall housing unit cleanliness, many of the cells were found to be cluttered with excessive personal items, some of which are combustible, and inmates were still allowed to keep dangerous and/or items that can be used to harm officers and other inmates. **For example, some of the cells still contain electric fans**

with exposed wiring and electrical mechanisms. Some of the cells still had sheets and/or towels draped across and over cell doors and/or hanging from the previously described clotheslines that fully or partially blocked viewing inside the cell. Some of the occupied cells were very dark making it impossible to perform inmate security / safety checks. R&D logs reported officers complaining about an inmate being housed in that area and their repeated inability to view in to the cell due to an obstruction over the window, yet no officer removed the obstruction.

Other log entries reported that certain inmates were placed on suicide watch or were acting such that officers were concerned about the inmates' welfare, but no further entries reported whether adequate security and safety rounds were made on those inmates. These records indicate that rounds were not conducted or the round was not recorded.

All cells must be kept reasonably lighted at all times and all visual obstructions into the cells must be removed. Staffing levels must provide for consistent and predictable supervision of inmates and housing areas.

As previously stated, revised post orders regarding this subject were found in the housing units and provided to the Monitor. Unfortunately, however, inadequate staffing levels cause a lack of consistent adherence to these directives by officers and supervisors, rendering the documents virtually ineffective.

All post orders must be supported by well-developed and written policy and procedures, which have not yet been provided to the Monitor for review and approval.

Recommendations provided in the Baseline and Second Reports remain appropriate.

RECOMMENDATIONS:

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

B. Contraband

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

a. Clear definitions of what items constitute contraband;

ASSESSMENT: PARTIAL COMPLIANCE

FINDINGS: These policies, as stated in previous reports, remain outdated, under-developed, and incomplete. There was no appreciable improvement determined during this assessment. However, there continues to be an appreciable increase in contraband recovery as indicated in incident reports and contraband logs. GGACF and the GIST Team are commended for this additional attention to controlling contraband but existence of dangerous items continues. Part of the problem is that the GIST program is inadequately staffed to maintain regular and consistent contraband searches; inadequate housing unit staffing levels severely impairs any productive contraband control by those officers. Consequently, housing units and the facility remain very dangerous environments for staff and inmates due to the ongoing high levels of dangerous contraband. This issue will be discussed in more detail in 1b below. Although exiting policies and statutory regulations provide definitions that constitute contraband, the definitions should be reviewed to ensure that staff apply the definitions accurately.

New or revised contraband control policies or procedures have not been provided to the Monitor for review and approval.

RECOMMENDATIONS:

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

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: As previously stated, GGACF officials are commended for their efforts to control contraband as evidenced in contraband and evidence logs. However, the facility remains very permeable to all sorts of contraband, some of which is very dangerous to inmates and staff.

An examination of evidence logs shows an overall decline in number of contraband items seized between two reporting periods – seven months before and after approval of the Agreement in July 2013. 343 items were collected between November 2012 and June 2013, 287 during July 2013 thru February 2014. However, this decline cannot be reliably interpreted as a decrease in the existence of contraband, but only as a decrease in what was found. What can be reliably

interpreted from these findings is that specific items posing considerable risk to staff, inmates, and facility security remain ever present throughout the facility as estimated in the chart below for the two reporting periods. What is most alarming is the exceedingly high volume of weapons being found. The fact that these dangerous items were found and removed is commendable.

Contraband	Nov 2012 - June 2013	July 2013 - Feb 2014
Cell Phone	74	52
Knife	12	9
Shank	25	114
Machette	1	3
Cutting Device	4	4
Alcohol	3	2
Marijuana / Leafy Subs	52	24
Drugs	3	1
Total Items	343	287
Cell Phones	74	52
Weapons	42	130
Intoxicatns / Drugs	58	27
Weapons	12%	45%
Intoxicants	17%	9%
Cell Phones	22%	18%

The chart below compares all contraband reported on evidence logs for the two reporting periods:

Contraband Seized	Nov 2012 - June 2013	July 2013 - Feb 2014
Cell Phone	74	52
Phone Charger	15	7
DVD / CD / TV	13	6
Other Electonic Device	36	6
Sewing Machine	1	0
Curency	11	13
Knife	12	9
Shank	25	114
Machette	1	3
Other Weapon	0	0
Cutting Device	4	4
Tattoo Device	2	0
Handcuff key	0	0
Tools	4	2
Alcohol	3	2
Marijuana / Leafy Subs	52	24
Tobacco / Papers	0	1
Cig Lighter / Burning Device	16	11
Toxic Chemical	4	1
Drugs	3	1
Medication	13	9
Scales	0	3
Food Items	2	0
Contraband	4	0
Clolthing	4	0
Jewelry	12	2
Personal Hygiene Product/Device	3	2
Wire / Rope	5	9
ID/BADGE/PATCH	1	0
Papers / Books/ Writing Materials	4	0
Keys	3	0
Eating Utencils / Pots / Pans	10	3
Bottles	1	0
Diaphram	4	1
ETC	1	2
Total Items	343	287
Cell Phones	74	52
Weapons	42	130
Intoxicatns / Drugs	58	27

GGACF officials are encouraged to continue with improvements to policies and procedures. Previous recommendations remain appropriate.

RECOMMENDATIONS:

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

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

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

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

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

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

(i) supervision of prisoners in common areas, the kitchen, shops, laundry, clinic, and other areas of Golden Grove to which prisoners may have access;

(ii) pat-down, metal detector, and other appropriate searches of prisoners coming from areas where they may have had access to contraband, such as at intake, returning from visitation or returning from the kitchen, shops, laundry, or clinic;

(iii) regular and random searches of physical areas in which contraband may be hidden or placed, such as cells and common areas where prisoners have access (e.g., clinic, kitchen, dayrooms, storage areas, showers);

ASSESSMENT: NONCOMPLIANCE

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

Additionally, the Monitor did not observe any inmate searches during this visit while touring the yard, housing units, or other areas observed. Inmate searches must become a routine practice to help control inmate clandestine motivations and contraband.

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

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

ASSESSMENT: PARTIAL COMPLIANCE

FINDINGS: No change since previous assessment. The evidence confiscation log evidences reasonable efforts to comply with this provision. Previous recommendations remain appropriate.

RECOMMENDATIONS:

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

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

ASSESSMENT: PARTIAL COMPLIANCE

FINDINGS: Security staff posted at the main entrance conducted a reasonable search of the Monitoring team and other visitors during this visit. The Monitoring team was appropriately escorted throughout the campus, but did not witness escorts of visitors.

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

C. General Security

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

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

ASSESSMENT: NONCOMPLIANCE

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

RECOMMENDATIONS:

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

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: As reported in the previous report, none of the inmates were observed wearing correctional identification that was to be implemented. On March 21, 2014, the Warden issued a memorandum to staff that provides instructions regarding inmates wearing identification cards. Although it the Monitor has been provided a memorandum issued by the Warden that the cards are now in use, compliance will be assessed further during the next visit.

As previously reported, visitor identification cards and clips were not consistently issued to the monitoring team during this visit due to supply shortages. Neither the Monitor nor USDOJ were issued visitor badges during this visit.

RECOMMENDATIONS:

1. Ensure staff compliance with this provision.
2. Ensure appropriate policies and procedures are in place and made available to staff.

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

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: All internal housing unit gates and officer stations were found to be locked upon entry during this visit. However, none of the exterior security slider-doors were locked but standing open or unlocked upon entry into the units; we were advised that the electronic locking mechanisms are inoperable. Despite the security gates being locked upon entry, they were not locked when the monitoring team toured the housing units. These observations clearly support a lax security culture that demonstrates the need for additional training, monitoring, and supervision by GGACF leadership. GGACF staff must consistently practice good security habits by keeping security doors and gates closed and locked. Officers report that inadequate staffing levels require them to not lock security gates upon entry into the housing units for safety reasons. Housing unit logs report that fire escape doors and locks are inoperable. There was improvement found in yard-gate security but some of the locking mechanisms remain inoperable and prevent the gates from being locked.

Despite some progress to fixing locks, there are still delays and many non-functioning locks. Logbook entries continue to report key door/lock issues not being timely addressed. For example, the logbook for Detention R&D has almost daily entries from January 13 to March 4 from different C/O's complaining about the sally port door. The door must be operated manually, keys don't work, a metal pipe must be placed behind the outer sally port door to provide security to the area, etc. It appears that the lock work report does not mention this door.

Another example is X Pod, which is the housing unit for sentenced and un-sentenced female inmates that is monitored by one officer, but has gone for hours with no officers assigned according to unit log books. This building is divided into two housing units with a door separating the two populations. This door is not always locked, according to the unit officer, but must be to ensure secure separation between these populations.

Previous recommendations remain appropriate.

RECOMMENDATIONS:

1. Review, revise, develop, train, implement, evaluation policies and procedures related to facility security pertaining to locking and unlocking access points, units and cell doors, and other locations requiring consistent access controls.
2. Repair/replace all broken locks and keys.
3. Develop, revise, implement, audit lock/key inventory.
4. Regularly inspect keys, locks, and electronic locking systems to ensure reliable functionality, detection of tampering, and timely repair/replacement.

5. Ensure staff are adequately trained in the proper use of mechanical and/or electronic locking systems according to their post assignments.
6. Consistently sanction inmates for attempting or manipulating any security locking system or device.
7. Secure access to keys and electronic locking control panels.
8. Keep security doors locked!
9. Consider replacing or upgrading existing unit control panels to provide for remote electronic locking and unlocking of unit and cell doors.
10. Increase video surveillance of internal and external access points to ensure rapid detection of attempts to disable or damage locking devices/systems.
11. Increase perimeter and internal lighting to improve detection of sabotage to locking devices and mechanisms.
12. Supervisor should inspect all locking systems during each shift and report for investigation and/or repair any signs of lock disrepair, malfunctioning, or manipulations.
13. Consistently enforce security locking policies and procedures with staff and inmates.

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: The Monitor met with the facility maintenance director and examined existing and revised locking mechanism repair logs. This interview and document examination reveal positive effort for ongoing lock repair and maintenance. Several housing cell locks have been repaired or replaced, it appears that cell pad locks have been replaced with standard security locks, and efforts are being made to repair or replace inoperable electronic locks located at housing unit entrance and yard gates. However, an "all-locks" maintenance plan has not been provided as previously requested. **Additionally, it is the Monitor's opinion, based on interviews with the maintenance director and facility conditions, that the maintenance program is inadequately staffed to provide the level of attention to facility up-keep needed to comply with this Agreement.**

Previously provided recommendations remain appropriate. Additionally, additional maintenance staff should be hired.

RECOMMENDATIONS:

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

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: Documents provided to the Monitor and discussions with the HR/Training director during this assessment confirm that pre-employment background checks are conducted for all GGACF applications. A review of documents shows a requirement to self-report histories of arrests and convictions. However, personnel records for all GGACF staff were not provided for inspection and verification. Additionally, there remains no centralized tracking and periodic supervisory review process for early staff intervention purpose. These records are reportedly maintained off-campus and available for review by supervisors.

Previously provided recommendations remain appropriate.

RECOMMENDATIONS:

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

D. Security Staffing

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

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: Territory officials formally requested technical assistance from the National Institute of Corrections (NIC) to assist in completing a comprehensive staffing analysis. It is expected that this assistance will occur sometime in April or early May of this year. It is important to remind the Territory that this technical assistance will not fulfill this requirement but will only assist in the successful completion of the staffing analysis following that assistance. Completion of this analysis and rapid hiring of all additional security staff should be considered of utmost importance due to the ongoing and pervasive health, safety and security deficiencies. Territory officials must reconsider its hiring process to expedite the hiring of all staff allocated to this facility.

Examination and analysis of housing unit logs demonstrated a pervasive practice of allowing housing units to go without staff for long time periods and operate with only one officer to cover two housing units during a shift. These logs also reported several instances where no supervisors were on-duty or available. Logs document approximately 275 instances of staffing shortages including: 1) no officer on a housing unit, 2) only one officer to cover two housing unit, 3) no supervisor on-duty or available, 4) officers late to work or leaving work without authorization, and 5) officers arriving to work to find no officer in a unit with inmates either out of their cells or locked-in. There were many other examples reported in the log books. This is a deleterious practice that MUST be stopped.

During this visit the Monitor met with the HR/Director and BOC Director regarding the Territory's hiring process. It was learned that it typically takes one year before a correctional officer applicant is hired and working in the facility. Six-months of this time is spent in the VI Police Academy mostly learning subjects not related to correctional practices or operations. Requiring correctional recruits to attend a full police academy is an unusual practice in the Monitor's experience as a law enforcement and corrections academy director, and significantly contributes to the current staffing problems. This time period can and should be significantly shortened due to facility safety and security needs combined with ongoing staff attrition.

RECOMMENDATIONS:

1. Complete a comprehensive staffing study using the Staffing Analysis process of the National Institute of Corrections.
2. Appropriate funding to hire sufficient numbers of staff to establish and maintain adequate levels of facility safety and security in accordance with staffing analysis results.
3. Make all reasonable efforts to shorten the time required to hire staff to no more than 90 days, not including basic correctional officer training.

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: No change since the previous report. The required security staffing plan would be based on the pending staffing analysis.

Previously provided recommendations remain appropriate.

RECOMMENDATIONS:

1. Update existing security staffing plans for review with the Monitor during the December site visit.
2. Identify current and anticipated security staffing deficiencies.
3. Complete the required staffing analysis and based this plan on that analysis.

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: Refer to the above findings.

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

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

ASSESSMENT: NONCOMPLIANCE

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

RECOMMENDATIONS: Refer to previous recommendations.

E. Sexual Abuse of Prisoners.

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

ASSESSMENT: NONCOMPLIANCE

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

Previously provided recommendations remain appropriate.

RECOMMENDATIONS:

1. GGACF should take advantage of the National PREA Resource Center at http://www.prearesourcecenter.org/, and the National Institute of Corrections at http://nicic.gov/ for qualified information about PREA compliance, training, and other related resources.
2. Review PREA and develop an action plan for the implementation of PREA requirements.
3. Appoint a PREA Compliance Coordinator as soon as possible.
4. Complete the PREA Self-Audit.
5. Review, revise, develop, train, evaluate policies and procedures that include, at a minimum, the following PREA topics:

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

F. Classification and Housing of Prisoners

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

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

ASSESSMENT: NONCOMPLIANCE

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

From the Second Compliance Report:

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

The current admission and review classification instruments are outdated and cannot, therefore, reliably reflect actual classification levels and housing decisions. The current classification is inadequate because: 1) classification decision making is not based on a current and empirically-validated classification tool, and 2) the high levels of institutional violence and

contraband reporting in incident logs strongly are indicative of the absence of a valid and reliable classification system.

RECOMMENDATIONS:

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

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

ASSESSMENT: NONCOMPLIANCE

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

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

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

RECOMMENDATIONS:

1. Inmates should be housed and separated according to reliable classification process as previously discussed.
2. Pending completion of a reliable classification process, GGACF officials should use the Incident Log Report and other reliable information sources to target population cohorts for housing and separation that is more consistent with behavioral risks, and needs.

3. Comply with the Order's prohibition against housing seriously mentally ill inmates in an isolation cell or housing unit.

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: As reported previously in this report, positive improvements were observed in locking the housing unit security gates. However, this system remains flawed because officers continue to leave these gates unlocked when inside the housing area. Current staffing levels and gate locking practices impair GGACFs ability to comply with this Provision. Additionally, a lack of security cameras and monitoring capabilities provides no ability to monitor inmates effectively to detect and potentially prevent them from obtaining unauthorized access to each other. Furthermore, and until all locking systems are repaired and maintained consistently, inmates will be able to disable their cell locks for access to each other.

RECOMMENDATIONS:

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

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

ASSESSMENT: PARTIAL COMPLIANCE

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

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

RECOMMENDATIONS:

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

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

ASSESSMENT: PARTIAL COMPLIANCE

FINDINGS: Implementation of a new Incident Reporting Log was described in the Baseline Report and remains in effect. However, and as previously reported, a review of this log shows it is often incomplete and often illegible. This log cannot provide an accurate account for incidents because it contains multiple entries for the same incidents using the same or different incident numbers. This makes using this log for compliance with this provision virtually impossible and its uses should be revised.

The GIST (Gang Intelligence and Search Team) program is inadequately staffed to provide the level of evaluation and intervention needed to meet the apparent high volume of incident activity reported in the incident report, supervisor, and housing unit logs. Staff should be added to this program and a comprehensive evaluation and intervention program developed.

RECOMMENDATIONS:

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

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: As reported previously, there continues to be no formal mechanism or process for regularly reviewing status and conditions of inmates housed in segregation. **Additionally, the Monitor was provided no evidence that GGACF tracks and monitors inmate lengths of stay in segregation or why inmates are segregated. When viewed in combination with the flawed disciplinary process and the incomplete grievance tracking process, it is clear that segregated inmates are not provided adequate levels of due process, monitoring, and review. This practice is very serious and in direct violation of the Agreement.**

Additionally, virtually all other housing unit logs are placed on "modified" or "full" lockdown frequently due to staffing shortages. This practice, though apparently necessary for security purposes, effectively creates facility-wide segregation conditions that must be corrected.

RECOMMENDATIONS:

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

G. Incidents and Referrals

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

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: These policies have not been submitted as required.

It appears that not all incidents are being reported, and when they are reported, many reports are inaccurate, indicating that they are not reviewed closely. There are logbook entries regarding multiple assaults/attacks that have no corresponding incident reports. Only two Use of Force Reports were provided, despite the fact that many more incident reports or log book entries indicated that force was used to break up an altercation or subdue an aggressive or problematic prisoner. This indicates that staff were never trained on when to use different forms, what to include in those forms, and how those forms should be reviewed by upper level management. The result is that these forms are essentially meaningless – incidents are written up, but nothing is done with the reports. In addition, it will be impossible for the Warden or other leadership to evaluate whether the level of force used was excessive if use of force reports are simply not created.

RECOMMENDATIONS:

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

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

ASSESSMENT: PARTIAL COMPLIANCE

FINDINGS: As previously reported, senior staff now participate in GIST meetings to review incident activity, but additional work is needed for compliance. However, there are no policies or procedures governing or directing this process and the group does not meet regularly. Furthermore, and as previously discussed, the incident reporting system requires revision before it is a valid and reliable document for incident evaluation purposes.

RECOMMENDATIONS:

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

c. Requirements for preservation of evidence; and.

ASSESSMENT: NONCOMPLIANCE

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

RECOMMENDATIONS:

1. Refer to similar recommendations regarding contraband.

d. Central tracking of the above incidents.

ASSESSMENT: NONCOMPLIANCE

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

RECOMMENDATIONS:

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

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: Such a policy has not been provided.

RECOMMENDATIONS:

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

H. Use of Force by Staff on Prisoners

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

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: There has been no change since the Baseline or second visits. The policies and procedures provided to the Monitor are outdated and missing several standard elements. Additionally, the documents do not articulate decision-making protocols for staff when using force involving mentally ill inmates. A review of incident reports provides questionable examples of use of force practices:

Date and Type of Documentation	Incident Number (if any)	Description of Incident	Problem with Report and/or Result
12/16/13 (Incident Report)	GGACF-12-0339-13-IR	Officer reported that Inmate assaulted him/hit him in the face; C/Os went to investigate and inmate became hostile; inmate had a knife with him. C/Os had to restrain inmate	Multiple incident reports were written, some of which stated that officers restrained the inmate and forced him into a cell. However, no Use of Force report was every completed and the officers' use of force was never evaluated.

		to get him back in his cell	
12/18/13 (Incident Report) 1/14/14 (HDC Dismissal Form)	GGACF-12-0388-13-IR	Detainee attacked Detainee with a broomstick in 9C	Assistance was called, but the incident report does not indicate how the incident concluded. 12 officers responded. A second incident report notes that a behavioral checklist for Detainee was completed and forwarded to medical, but it is unclear if there was any follow up. Detainee did not receive any discipline for this incident because the disciplinary process resulted in a due process violation. Hearing Committee paperwork indicates that no disciplinary hearing was held due to a staff shortage and "security concerns"
12/25/13 (Incident Report)	GGACF-12-0344-13-IR	Inmate hit C/O in the back of the head on K Unit. Backup was called and inmate refused to go back in his cell. Officers used a baton to strike inmate until he stopped resisting and could be placed back in his cell.	Use of force was clearly used, but no Use of Force report was completed. Also, under "description of incident" at the top of the incident form, C/O wrote "Disorderly conduct, murder, attempted murder, assault" – clearly the "murder" and "attempted murder" categories are inappropriate. Yet, the reviewer who signed the back of the form approved the report on 12/25/13.
1/11/14 (Incident Report)	GGACF-01-0358-14-IR (this number was a little hard to read)	C/O "lightly pushed" Detainee "away from entering a fight" in 9D.	No Use of Force report accompanies this Incident Report Also Incident Report found regarding the underlying fight
1/17/14 (Incident Reports) 1/17/14 (Use of Force Reports)	GGACF-01-0355-14-IR	C/O was escorting inmate back to cell from medical building; inmate wouldn't go back in his cell, and punched C/O; C/O "responded with a one two combination to the facial area" and applied an "arm bear technique"	Use of Force report completed, but incomplete/not well done. The report says that a video recorded interview with the inmate was conducted – is that true? Where is the video? The person who completed the Use of Force report also notes that the inmate had injuries "but appeared to be ok"
2/13/14 (Incident Report) 2/13/14 (Use of Force Report)	GGACF-02-0378-14-IR	When distributing meds at Det. C/O noticed detainees tampering with the golf cart. When C/O approached the	A Use of Force report was completed following this incident, which was signed off on by Acting Chief. The reports are incomplete, however – the detainee was sent to the hospital to receive medical care for injuries

		detainees, Detainee tried to punch him. C/O "preceed [sic] to defend [him]self" and a "strugel ensued" [sic].	sustained during C/O use of force. This doesn't appear to be a full review of the use of force, and it is not indicated whether C/O conduct was appropriate or how he was instructed following the incident. Additionally, at the bottom of the Use of Force report, there is a "note" that a detainee attempted to run away during the incident because the door to the classification office was unlocked. The reviewer notes that this was a "situation waiting to happen" and that the door to classification "should be locked or equip with a buzzer."
1/29/14 (Incident Report) 2/18/14 (HDC Findings Letter)	GGACF-01-368-14-IR	Detainee assaulted Detainee. C/O on unit tried to break up the fight and restrain Detainee with the help of another C/O.	Force was clearly used to break up this fight, but no Use of Force Report was ever submitted. The Detainee was punished with 260 days of lockdown.

RECOMMENDATIONS:

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

V. Photographing, videotaping, recording of planned force events;
W. Other.

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: See above.

RECOMMENDATIONS:

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

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: See above findings.

RECOMMENDATIONS:

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

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: Refer to findings in H.a. above, and findings and recommendations for Training Provisions.

RECOMMENDATIONS:

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

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: Documents were provided that show the names of several officers who participated in weapons qualifications. However, these documents do not clarify whether all officers currently authorized to carry weapons are trained in accordance with the Agreement. The term

"weapon" should include any device issued to staff in the use of force against an inmate. This includes, but is not limited to: firearms, batons, impact weapons, chemical weapons, etc.

RECOMMENDATIONS:

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

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: The chart above evidences inconsistent reporting practices in the use of force that will need to be corrected before this compliance score can be returned to Partial Compliance.

RECOMMENDATIONS:

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

g. Supervision and videotaping of planned uses of force;

ASSESSMENT: NONCOMPLIANCE

FINDINGS: No change since previous reports. Policies and procedures regarding supervision and videotaping of planned for events were not provided to the Monitor.

RECOMMENDATIONS:

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

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: No change since previous reports. Security towers remain inconsistently operational due to staffing and problems rendering them an unreliable security control post.

RECOMMENDATIONS:

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

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: No change since previous reports. As noted in the incident report charts provided in this section, it appears that one inmate received medical attention following involvement in a use of force event with officers. However, the report does not refer to whether photographic documentation was completed and submitted for an administrative review of the event.

RECOMMENDATIONS:

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

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

ASSESSMENT: PARTIAL COMPLIANCE

FINDINGS: As stated in the previous report, the Warden stated that, although there are few incidents of force being used against inmates, that all incidents and reports are reviewed for accuracy and justification in a timely manner by supervisors and management officials. However, a review of reports indicated that some remain incomplete and/or do not effectively articulate what is being reported.

A review of incident reports involving use of force events, as described and listed previously, does not clarify timeliness of the review process but does indicate process flaws evidenced by the problems discussed.

No revised policy or procedure has been provided to the Monitor for review as indicated in the

RECOMMENDATIONS:

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

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: To its credit, the Territory has filled the vacant Chief Investigator position. Records provided for review indicate ongoing problems with the administrative review process that make clear assessment of this provision unreliable. Additionally, problems discussed regarding the inmate grievance process and tracking system further evidence systematic deficiencies in this review process. There does not appear to be any clear criteria guiding the review or referral process.

RECOMMENDATIONS:

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

l. Administrative investigation of uses of force;

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

ASSESSMENT: NONCOMPLIANCE

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

RECOMMENDATIONS:

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

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

ASSESSMENT: NONCOMPLIANCE

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

RECOMMENDATIONS:

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

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

ASSESSMENT: NONCOMPLIANCE

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

RECOMMENDATIONS:

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

I. Use of Physical Restraints on Prisoners

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

a. Permissible and unauthorized types of use of restraints;

ASSESSMENT: NONCOMPLIANCE

FINDINGS: No records, policies, or procedure were provided to prove compliance with this provision. Recommendations provided in the Baseline Report remain appropriate.

RECOMMENDATIONS:

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

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

ASSESSMENT: NONCOMPLIANCE

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

RECOMMENDATIONS:

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

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

ASSESSMENT: NONCOMPLIANCE

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

RECOMMENDATIONS:

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

d. Required observation of prisoners placed in restraints;

ASSESSMENT: NONCOMPLIANCE

FINDINGS: No change from the Baseline or second visits. Recommendations provided in the Baseline Report remain appropriate.

RECOMMENDATIONS:

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

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: No change from the Baseline or second visits. Recommendations provided in the Baseline Report remain appropriate.

RECOMMENDATIONS:

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

f. Required termination of the use of restraints.

ASSESSMENT: NONCOMPLIANCE

FINDINGS: No change from the Baseline or second visits. Recommendations provided in the Baseline Report remain appropriate.

RECOMMENDATIONS:

1. Same as above.

2. Ensure the policy includes restrictions on restraint use duration and termination requirements.

J. Prisoner Complaints

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

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: No change from the Baseline or second visits. Recommendations provided in the Baseline Report remain appropriate.

As stated in the previous report:

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

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

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

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

RECOMMENDATIONS:

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

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

ASSESSMENT: NONCOMPLIANCE

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

RECOMMENDATIONS:

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

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

ASSESSMENT: NONCOMPLIANCE

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

RECOMMENDATIONS:

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

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

ASSESSMENT: NONCOMPLIANCE

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

RECOMMENDATIONS:

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

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: No change from Baseline or second visits. Recommendations provided in the Baseline Report remain appropriate.

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

RECOMMENDATIONS:

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

K. Administrative Investigations

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

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

ASSESSMENT: NONCOMPLIANCE

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

RECOMMENDATIONS:

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

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: No change from Baseline or second visits. Recommendations provided in the Baseline Report remain appropriate.

RECOMMENDATIONS:

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

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: Little change from Baseline or second visits. Additionally as previously discussed, even if an investigation determines that an inmate deserves some form of punishment for a disciplinary infraction, that punishment is often not determined or enforced because due process proceedings often do not occur. A review of prisoner disciplinary files from the last three months shows that some prisoners had disciplinary action taken against him or her; disciplinary charges were dismissed because there were not enough staff to conduct the due process hearings. Recommendations provided in the Baseline Report remain appropriate.

RECOMMENDATIONS:

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

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: No change from Baseline visit. Recommendations provided in the Baseline Report remain appropriate. Training documents related to this provision were not provided nor are there policies and procedures promulgated on this subject. Although the Monitor did not review qualification documents of the new Chief Investigator, he seems qualified for the position based on the Monitor's interview.

RECOMMENDATIONS:

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

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: Documents and reports provided during this assessment, combined with previously such documents, cause this provision to return to Noncompliance; they more clearly evidence the absence of an effective and consistent inmate disciplinary system or process.

A review incident reports and related disciplinary hearing committee documents, including forms indicating dismissal of charges due to lack of due process and forms relaying the results of the hearing committee, show that there is no meaningful, consistent system in place. It appears that hearings occur randomly, and the punishments assigned are equally random. We have yet to see any policy governing when a prisoner receives a hearing, the process for that hearing, and what appropriate punishments should be. See the chart below for examples of the wide disparity in punishments for different rule infractions.

Moreover, the disciplinary sergeant wrote a "monthly report" for January 2014 of all the disciplinary hearing committee (HDC) activities for this month. The report notes several flaws in the disciplinary process at GGACF: 1) it is difficult to hold HDC meetings without adequate staff; 2) officers and supervisors need to attend a "report writing class" and 3) security staff don't know when to use disciplinary reports and incident report forms, evidencing the lack of any formal policy or guidance for this process. Moreover, the Monitor would like to know whether similar reports been created for previous months. If not, why not? If so, why have they not been produced to the Monitor?

The chart below provides examples of these problems with the inmate disciplinary system:

12/18/13 (Incident Report) 1/14/14 (HDC Dismissal Form)	GGACF-12-0388-13-IR	Detainee attacked Detainee with a broomstick in 9C	Assistance was called, but the incident report does not indicate how the incident concluded. 12 officers responded. A second incident report notes that a behavioral checklist for Detainee was completed and forwarded to medical, but it is unclear if there was any follow up. Detainee did not receive any discipline for this incident because the disciplinary process resulted in a due process violation. Hearing Committee paperwork indicates that no disciplinary hearing was held due to a staff shortage and "security concerns"
12/25/13 (Incident Report)	GGACF-12-0345-13-IR	GIST team received a call to search inmate, who may have a knife; GIST conducted the search and a knife was recovered	The incident report indicates that the inmate was placed in lockdown "pending his hearing," but no Disciplinary Committee Hearing paperwork was submitted along with this incident report. It is unclear if the inmate ever received a hearing, or if he is still on lockdown for this incident without a hearing.
1/2/14 (Incident Report)		On 9D unit, Detainee beating up with a piece of broomstick;	Detainee received 90 days lockdown for this incident, but other Detainee received 150 days. It is unclear from the

1/23/14 (HDC Findings Letter)		Detainee then attacked Detainee with another piece of broomstick.	paperwork why there is a 60 day discrepancy between the two punishments.
2/4/14 (Incident Report) 2/12/14 (HDC unable to continue disciplinary hearing notice)	GGACF-02-0371-14-IR	In 9C, Detainee began fighting with another. A third detainee joined in.	All three detainees were written up in incident reports and each received notice on 2/12/14 that the incident reports were not investigated and the charges were deemed a due process violation. Why this fight was never investigated?
1/20/14 (Incident Report) 2/18/14 (HDC Findings Letter)	GGACF-01-0359-14-IR	Detainee disobeyed order to stand by cell door during headcount	The HRC findings letter indicates that the Detainee received **100 days in lockdown** for this violation. Nothing in the findings letter or HDC disposition form indicates why such a severe punishment was given for this offense.
1/24/14 (Disciplinary reports) 2/18/14 (HDC Findings Letter)	GGACF-01-3064-14-IR (but no formal incident report attached; just disciplinary report)	Detainee was out of his cell after lockdown; apparently he was able to get out of his cell after the officer locked the door.	The detainee was charged with tampering with a locking device and being in an unauthorized area (i.e., out of his cell and in the common area). He was also convicted of "attempted or planned escape." He was disciplined with 290 days of lockdown. First, there is nothing in the disciplinary report indicating that he actually tampered with lock – the report reads more like the lock just didn't work. Second, the report does not indicate that he attempted to escape the housing unit – just that he was out of his cell. Finally, there just seems to be a complete lack of justification for placing this detainee in lockdown for 240 days. Why is the detainee being punished so harshly for a faulty lock?
02/09/14 (Disciplinary reports) 2/18/14 (HDC Findings Letter)	GGACF-02-0323-14-IR (but no formal incident report attached; just disciplinary report)	Detainee was told to go back to his cell during lockdown, but instead he went to talk to another detainee. The detainee then threw his water bottle, and was then secured in his cell.	See above. The same detainee was charged with another instance of being in an unauthorized area, disobeying an order, and attempting to commit any category II offense. This time, he was given another 100 days of lockdown as punishment, to run consecutive to the above punishment. Together, this inmate was placed in lockdown for almost a year simply for disobeying an order. This seems extreme

			and there is no justification in the paperwork submitted.

RECOMMENDATIONS:

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

V. MEDICAL AND MENTAL HEALTH CARE

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

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

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

ASSESSMENT: NONCOMPLIANCE

MEDICAL FINDINGS: For this visit, the Health Care Administrator and her team had clearly done a significant amount of work with regard to several of the policies that we had highlighted as priorities. Those include receiving screening, initial health assessment, nonemergency health care requests and services, emergency services, continuity of care during incarceration and chronic disease services. We have indicated that the quality improvement program policy can be delayed until the other policies are in place. In addition, we also indicated that until there is a Medical Director committed to the program, the intoxication and withdrawal policy cannot be drafted, since it will include clinical guidelines which must be drafted by the physician Medical Director. Of the policies, the chronic disease policy appears closest to being approved by the Monitoring team. There were a few minor elements that we discussed. With regard to the receiving screening policy, unfortunately a consultant not really familiar with the work we have been doing modified the draft that the Health Care Administrator had prepared and these modifications are unacceptable. We achieved agreement with the Director of Corrections that this consultant will not address either medical or mental health policies. Once again, we reviewed with the Health Care Administrator the elements in the receiving screening policy, which will enable the removal of the officers from the process, even when there is coverage only 16 hours per day, seven days per week onsite. This is because for people who enter the booking process after midnight but before 8:00 a.m., they can be screened for stability by a nurse over the telephone. If any questions suggest instability, then the Medical Director must be called. If, on the other hand, none of the questions suggest instability, the patient must be seen and provided the standard comprehensive intake screening at 8:00 a.m. when the dayshift begins. Also, we provided to the Health Care Administrator acuity scales utilized by two other jails which can be used to guide the nurse doing the comprehensive screen as to the urgency for the scheduling of the initial health assessment, such as on Day 1, Day 2, Day 3 or, where more monitoring is needed, Day 7. These acuity scales need to be figuratively attached to the screening so that based on the data collected and comparing that to the selected acuity scale, the health assessment will be scheduled. We also suggested some changes to the comprehensive screening tool itself, all of which can be accomplished prior to our next visit. Additionally, we had some suggestions regarding the form utilized for the initial health assessments and we will work closely with the Health Care Administrator in her efforts to refine those forms.

With regard to the policy on nonemergency health care requests (sick call), we also suggested some minor revisions. With regard to the emergency services policy, it dealt almost exclusively with disasters and disaster planning, which is important. However, we discussed an urgent/emergent policy which will have a much greater operational impact, both for how to respond to emergencies or urgent verbal requests as well as the requirements for follow up. One important clarification is that nonemergency requests as perceived by the patients should be submitted in writing on a sick call request form. On the other hand, if the patient perceives an urgent problem, this is to be addressed to the nearest officer verbally. The policy must indicate that the officer's obligation is to contact the medical staff and inform them of the request. When medical staff receive this request from an officer, they should document it in an urgent care services logbook and then arrange for an assessment to be performed as soon as possible. Most of these assessments should be performed in the clinic area; however, there are rooms in the housing units which can be fixed up and equipped to function as exam rooms and some assessments can be performed in those newly equipped exam rooms when they are fully equipped. We were informed that there are now locks available for all of the sick call boxes and therefore requests should be placed directly into these boxes by the inmates. We were also informed that the morning medication administration nurse does collect the slips and returns them to the health care unit for triaging by a registered nurse on a daily basis. This is consistent with our plans for this policy. On the other hand, the additional nursing staff have not been hired and the one full-time RN is now on vacation, creating problems for both sick call request triaging and for the performance of face-to-face assessments, which require an RN. The Monitoring team reviewed some evidence indicating that triaging of sick call slips is not occurring on the schedule reported.

With regard to continuity of care, we focused on continuity with regard to intake as well as after both scheduled and unscheduled offsite services. This policy and the policies for each of those services must indicate that patients being returned from offsite services must be brought to the medical area so that any documentation can be reviewed by a nurse and, if needed, the patient queried.

Finally, we reviewed the discharge planning policy, which in the way it was written, was applicable only to sentenced detainees. Although clearly it is much more difficult to provide successful reentry planning and implementation for patients who are in a pretrial detainee status because their release is frequently not known to the program before the court makes a determination, an effort must be made for these detainees. However, we discussed strategies that can be employed, which should provide at least some success in connecting patients with services that can assure continuity upon release.

We discussed a host of new policies that can be promulgated prior to our next visit. When some policies are approved and have begun to be implemented, partial compliance status will be achieved.

RECOMMENDATIONS:

1. Remove the consultant from involvement with the medical policies.
2. Incorporate an acuity scale for the determination of urgency by the screening nurse and schedule the health assessments on the basis of that acuity scale.
3. Continue to improve both the screening tool and the health assessment tool.

4. With regard to the ability to remove officers from any involvement in the medical screening process, develop a list of questions geared to determine whether the patient can wait up to eight hours in order to be screened. If those questions suggest instability, the nurse performing those screening questions must contact the physician. If the questions reveal no instability, the patient can wait until screened in the morning at 8:00 a.m.
5. Hire the additional nursing staff so that both the intake screens as well as the non-emergency health care request policies can be consistently implemented without any disruptions due to vacations.
6. Complete the policies that address both scheduled and unscheduled offsite services so that the follow up after the service has been provided is improved.
7. Make the changes on the chronic disease service policy in order for implementation to begin. It is especially important for the clinicians to utilize both the initial chronic care visit form and subsequently the follow up visit chronic care form.
8. The following policies are to be drafted:

    i. Hospital and specialty care
    ii. Urgent/emergent services
    iii. Access to care
    iv. Responsible health authority
    v. Medical autonomy
    vi. Segregated inmates
    vii. Patient safety
    viii. Infection control
    ix. Right to refuse
    x. Grievance mechanisms
    xi. Clinical performance enhancement reviews
    xii. Health training for correctional officers
    xiii. Medication administration training

MENTAL HEALTH FINDINGS: SECOND REPORT: December 2013: The intake process remains flawed with no change in the process or tools. As noted in September 2013 "even when incoming inmates are identified through the screening tool or the officer's observations as having mental health problems, referrals often do not occur, resulting in misidentification and lack of services for those individuals." Medical screenings are frequently delayed significantly and at least in one case, medications have been administered to an inmate for several months with no clinician's order or follow-up visit. Regarding the development of mental health policies and procedures specific to the facility, no new policies have been developed since the time of our initial visit. Staffing remains unchanged and is still considered inadequate in quantity and composition to meet the needs of those seriously mentally ill and acutely symptomatic inmates housed at GGACF.

THIRD REPORT March 2014: A new policy was distributed at the time of the site visit on intake screening. Medical has also drafted a detailed screening form which represents a significant improvement over the prior highly abbreviated and inadequate tool.
Dr. Sang, the newly hired psychiatrist, plans on developing mental health policies but has focused on seeing every inmate on the caseload and wants to organize the mental health charts first.
Several of the detainee intake screens reviewed this visit revealed a lack of vital signs noted to be due to the unavailability of the proper instruments.

RECOMMENDATIONS:

1. A more effective intake process should be developed so that medical staff has access to new detainees and prisoners within 24 hours. The initial security screening tool is not robust enough to provide good identification of medically and psychiatrically ill people. Security staff conducting these interviews will require additional training by health services (medical and mental health) and a quality assurance tool should be developed to monitor the completeness of their documentation and the accuracy of their triage two medical and mental health staff.
2. Medication bridging is problematic with evidence of medications being prescribed and administered but not ordered by a clinician. A review method needs to be developed to oversee the reliability of this process.
3. All of the medical policies need to be reviewed and modified as applicable to this facility.
4. The facility needs to purchase sufficient stethoscopes and sphygmomanometers to ensure availability of more than one of the latter on site. There should be sufficient instrumentation, at a minimum, for the treatment building, reception/suicide watch area, and the emergency response bag.

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

ASSESSMENT: NONCOMPLIANCE

MEDICAL FINDINGS: With the exception of a physician assistant who is onsite Saturday and Sunday, there has been no advanced level clinician presence at the facility. This makes it impossible to perform timely health assessments. We reviewed the records of five patients who had entered the facility in the last two months.

The first patient, a male with a prior history of treatment for mental health issues. He arrived on 1/8/14. He had no vital signs performed until 1/14. He had a TB skin test which was planted and read, but there were no results in the chart; instead, the results were in a notebook maintained by the nurses. In addition, despite his history, there was no mental health referral.

The next patient is a male who arrived on 1/29/14. He was not seen by an LPN until 1/31 and even then, no vital signs were performed. He also had a TB skin test completed but there were no results in the record.

Another patient who arrived on 1/19/14 who is being treated for mental health problems. He was seen by an LPN three days later, on 1/22, at which time he had a TB skin test planted. The skin test was read on 1/25 and he was sent for a chest x-ray over two weeks later, on 2/14. This patient could have had active disease and yet was allowed in population and there was an extraordinary delay in obtaining the chest x-ray. The chest x-ray was performed and it was abnormal, indicating a density in the left chest. This was reviewed and on 3/4, a request for a CT was made and apparently it was done, but there is no result yet available.

The last record is a male who arrived on 2/6/14 with a history of hypertension and asthma and also sciatica. He was seen by an LPN one day later and had a TB skin test which was planted and read

three days later as negative. We noticed that there were sections of the new screening form which appeared blank and we were informed that this was because the way the form is drafted, there is no allowance for negative responses. We discussed this with the Health Care Administrator, who will make the appropriate changes. Despite this patient's multiple chronic problems, there has been no health assessment in over a month, nor has there been any referral for the chronic care program.

RECOMMENDATIONS:

1. Again, hire the Medical Director, who should be onsite at least three days per week and on call 365 days a year.
2. Fix the intake screening form and utilize it so that the urgency of the health assessment is connected to the acuity status determined by the collected data. If the Medical Director is onsite three days a week during Monday through Friday, and the PA is available onsite Saturday and Sunday, you will have five days per week of advanced level provider coverage, which should be sufficient to perform the assessments timely.
3. Insure that the health screen includes vital signs.
4. TB skin test results must be documented in the medical record, as there is a location on the comprehensive screening form.
5. Fill the vacant nurse positions so that there are a total of four registered nurses and three LPNs.
6. After the policies are finalized, provide training for both the advanced level providers and the nurses so that they understand that the data collection on intake, including a health assessment, must lead to identification of problems with a plan to address each problem and insure continuity for follow up in the process.

MENTAL HEALTH FINDINGS: SECOND REPORT December 2013: Intake medical screenings are often delayed by nearly a week following booking. All too frequently there is evidence of the failure to complete a 14 day history and physical assessment by medical staff. This is an essential process designed to allow the inmate a second opportunity to report signs and symptoms that they may have not wish to share with the security officer at the time of intake or may have been impaired at that time and not interested in participating in the process. In addition, failure to complete both of these steps in a timely manner delays or fails completely to provide for mental health referrals. These inmates then become lost to follow-up and current preadmission medications abruptly discontinued.

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

THIRD REPORT March 2014: As mentioned elsewhere the intake process remains inadequate in identifying potentially mentally ill inmates entering the facility. The mental health coordinator reported finding a file with a positive mental health screening on the nursing desk one month after an inmate was booked. This inmate reported depression and auditory hallucinations during the correctional officer's screening. The medical health assessment performed five days later by a registered nurse was completely negative for mental health and medical complaints. No comments were made concerning the discrepancy with the reports on the initial screening. The detainee was finally referred by nursing one month later when he reported that he was

experiencing something emotional for the past 16 months and needed to speak with someone. There was a six day delay in the mental health counselor's discovery of this referral. She saw him immediately and documented that he was depressed, delusional, not goal directed, had poor insight and judgment. He was referred to the psychiatrist who again noted psychotic symptoms and began him on medications. This latter case demonstrates a very flawed system in nursing assessment and referral that in this case resulted in an inmate entering the system in a psychotic state and remaining seriously mentally ill and untreated for six weeks.

While on site a review of 24 detainee intake records was completed. As mentioned elsewhere none of these files were organized into a chart but rather were paper clipped together. Of these 24, 3 (13%) had positive mental health screenings yet none of those inmates had been referred to mental health for an assessment. Names of these inmates were relayed to the mental health coordinator so that she could follow up on these cases.

Other critical deficiencies noted in this review of detainees arriving at this facility between October 2013 and the present time noted multiple charts in which no vital signs were completed at the time of intake with the notation that there was only one instrument to measure blood pressures in the facility and it could not leave the Medical Department in order for the nurse to take vital signs in the reception area. There are frequent delays between the time of booking and the medical intake most commonly 2 to 3 days after booking but in some cases as much as six days. One detainee with a history of hypertension and slow heart rate had no intake paperwork.

RECOMMENDATIONS:

1. Despite significant improvements in the intake assessment form, there remain significant deficiencies in the nursing staff's capacity to identify inmates for referral to mental health services and the timeliness in delivering those referrals. Medical administration and the nursing director need to address these deficiencies and develop monitoring tools for quality improvement purposes to ensure that this process has been corrected.

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

ASSESSMENT: NONCOMPLIANCE

MEDICAL FINDINGS: This particular requirement we have utilized to address non-emergency sick call requests (sick call). We have identified the following problems. Although frequently requests are being deposited in the boxes, some of them are being given to officers to put in the box. This potentially violates the confidentiality goals. In addition, one of the housing units just received its lock, so that the box was unlocked until very recently. In addition, because of the absence of a physician, the nurse was frequently attempting to respond to issues which should have required a referral. Although we appreciate the commitment of the registered nurse, the appropriate services must be provided by appropriately credentialed clinicians. We also continue to learn that it is common for the nurse to perform a face-to-face triage through a solid door as opposed to performing a nursing assessment in an appropriate space. Frequently, the nurse is doing this because of custody availability issues. The custody problems must be resolved. We did identify that in each of the housing units there are rooms designed for the ability to perform exams in them; however,

frequently they are unclean and used for storage and lack the required equipment. When those rooms are properly cleaned and equipped, the custody requirements to move patients to the clinic for every examination will diminish. Many records that we reviewed reflect the fact that a nursing assessment was not performed and instead, through a face-to-face triage, the nurse was attempting to respond to medical concerns. This has to be rectified, by both hiring more nurses and creating the exam rooms in the housing units.

RECOMMENDATIONS:

1. Insure that the Medical Director position is filled and he is onsite at least three days, Monday through Friday.
2. Fix up the examination rooms, providing the necessary equipment, including an exam table, desk and chair, etc., along with the necessary medical equipment and supplies to insure appropriate sanitation.
3. Hire the remaining nursing staff so that the nurse staffing is four full-time RNs and at least three full-time LPNs.
4. Insure that the sick call process goes from request placed in the box by the patient to collection by health care staff to paper triage by the registered nurse and then nursing assessments in an appropriate environment by a registered nurse. The only alternative is if the paper triage makes it clear that the patient needs to be seen immediately by an advanced level provider, then the nurse should so schedule the patient.
5. Insure that the sick call log contains date of receipt, presenting complaint, date of nurse assessment and if a follow up is indicated, date of advanced level provider assessment.

MENTAL HEALTH FINDINGS: Seventeen sick call requests for behavioral checklists were provided by the mental health coordinator and reviewed for timeliness of response. Of these there were critical delays in receipt of the information by mental health. Examples of the circumstances are as follows:

1. A behavioral checklist was issued December 17, 2013 for behavior such as hiding, refusing to leave cell, poor hygiene, fighting with others, alarmed. The record was received by mental health on January 7, 2014.

2. A consultation was issued for an inmate with multiple abdominal complaints and the belief that food has cockroaches in it. This was issued on December 26, 2013 by the physician and was received by mental health on January 17, 2014.

3. A checklist for auditory and visual hallucinations was issued December 15, 2013 and received by mental health on January 7, 2014.

4. Most of the settlement documents were received with inmate a two to five day window however those with significant delays were for urgent problems.

Review of the records also revealed questionable decision-making regarding follow-up services as follows:

1. One man placed a sick call request on January 7, 2014 for the complaint that his depression and anger was worsened by his medication which he discontinued. He was seen January 13, 2014 and was noted to be handcuffed secondary to locked down. He was described as

severely depressed. There is inadequate documentation of the signs and symptoms of his condition and no indication that he has been seen since that time.

2. Another inmate was seen on February 2, 2014 and was described as mute and catatonic. A record of a follow-up appointment was not able to be found. If the individual was truly catatonic he should've been on an inpatient psychiatric unit and not maintained at this facility.

Currently there is one full-time mental health coordinator and a part-time psychiatrist who is at the facility a minimum of three days per week. Delays in access to care continue to focus on the insufficient number of officers available to provide escorts to the treatment building. Other obstacles in the provision of adequate mental health care continue to depend on the performance of an adequate staffing needs analysis and also the development of the vision of what a comprehensive mental health program at this facility should look like.

The treatment building's dedicated officer has recently had his shift changed from Monday through Friday to Sunday through Thursday. However according to the medical staff Friday has been the busiest clinic day. The first and second Friday since this change resulted in no officer being provided or an officer calling in sick.

RECOMMENDATIONS:

1. The elements in the above findings should be used to promulgate a policy and procedure related to access to care and sick call. A system for a confidential retrieval of sick call request by medical staff should be implemented and codified in policy.
2. Mental health staff with the support of the Health Services Division, the warden and the Bureau should design an adequate mental health delivery system for the facility and develop plans to staff and implement the required services.
3. The Monitor's team should be utilized for consultation and/or technical assistance.
4. The facility needs to define by policy the qualifications required for each clinical process as well as time frames to complete these processes and provide the clinically necessary follow-up.
5. Again, a staffing analysis needs to be completed to determine the required minimum number of psychiatric hours and counseling hours needed.
6. Mental health staff should perform, at a minimum, weekly segregation rounds and monthly well-being checks on all sentenced inmates on the mental health caseload.
7. Nursing transcription omissions should be addressed through education, supervision, and monitored by a Quality Assurance process.
8. GGACF needs to closely monitor shift changes and assignments of officers to ensure that access to medical services is not impeded.

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

ASSESSMENT: NONCOMPLIANCE

MEDICAL FINDINGS: Although the policy has not been finalized, there is significant progress to report. There is now a contract pharmacist responsible for overseeing both the storage and onsite management of the medications. She has reorganized the medication area and has insured, with the cooperation of nursing staff that all medications and especially controlled substances are appropriately secured in conformance with local law. Unfortunately, the progress with regard to storage, which includes involvement of the pharmacist in plans for renovating a new area that will provide more space to both store medications as well as to more appropriately package them in blister cards, is not reflective of improvements in the medication administration process. In fact, when we observed an evening medication administration in the detention facility, we observed a nurse literally handing medications to multiple patients during the course of the administration and then walking away without the detainees ever ingesting the medications, let alone participating in a mouth check, which should occur after the ingestion. This was a failing performance by the nurse; however, occasionally officers did ask to check the mouths of patients, who cooperated immediately. The nurses almost never requested to inspect the mouths or for the inmates to have their mouths inspected. Finally, the way the medication administration is set up, the documentation of the administration does not occur until the nurse returns to the medical unit, which could be 30-60 minutes after the start time. It is this delay without the use of any notes or prompts that makes it likely that the documentation in the medication administration records is susceptible to a significant error rate. One of the policies that we have encouraged deals with the training provided to nurses performing the medication administration duties. This, along with the completion of the medication administration and medication management policy, should assist in improving the performance. In addition, none of the inmates were asked to demonstrate an ID of any form. The nurses presumed that they knew all the inmates. This violates what is required of nurses performing the nursing administrative duty in all other facilities. To review, the nurse should first request the patient present an ID. The patient should also bring a container of water to the nurse or the door of his cell. The nurse should check the ID and the medication administration record and then provide the medications. Finally, after the patient ingests the medication and swallows the water, a mouth check should be completed, after which the nurse documents the administration on the medication administration record. In almost every way, the current procedure violates these basic rules.

RECOMMENDATIONS:

1. The medication management policy should be completed and presented to us for the next visit.
2. With regard to medication administration, the steps outlined above should be described in the procedure.
3. The lead nurse should develop a way for nurses to be able to carry the medication administration record with them when they perform the duty.
4. The inspection of the mouth should be performed by an officer and this should be written into the officer's post orders. It would be useful for a single officer, as does happen now sometimes, to accompany the nurse on these rounds. What is problematic is that when we observed the process, it was the officer who is stationed in the clinic who gets pulled away for up to an hour to accompany the nurse in the process. This potentially shuts down the clinic unless his post is relieved.

5. Work with administration and custody to develop strategies that facilitate the health care program making discharge medications available at the time of release, both to sentenced inmates and pretrial detainees.

MENTAL HEALTH FINDINGS: SECOND REPORT December 2013: GGACF has made strides to improve medication management. A consulting pharmacist has been hired and construction to create improved pharmacy facilities and security are underway. The pharmacist is also working with the territories Board of Pharmacy to obtain a facility pharmacy license.
… Indeed review of every MAR showed excellent medication administration with sparse refusals.

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

THIRD REPORT March 2014: During this visit by review of records and observation this auditor noted that nursing staff delivered medication to inmates but did not administer it, in that, the inmate or at times correctional officer received the medication and the nurse walked on to the next inmate where she again handed out doses to other inmates. This method of delivering medications but not administering them most likely explains why observation of the medication administration records during the second site visit revealed perfect records of administration with no refusals and no skip doses.

The current psychiatrist as well as the mental health professional continued to complain about significant difficulties in the accuracy and timeliness of transcription of medication orders, discontinuation orders, and laboratory study requests despite hand delivering the orders to the nursing person responsible. Dr. Sang has begun to insist that nursing staff obtained vital signs girth and weight on all inmates presenting for a psychiatric appointment. Staff also complained that once a laboratory study was ordered the results were not returned to the physician for review prior to being filed in the medical record.

RECOMMENDATIONS:

1. Nursing staff should be instructed as to the proper procedure when administering medications to all inmates.

2. Supervisory observation of performance should be periodic and unannounced to ensure the effectiveness of in-service training on medication administration.

3. Quality measures should be implemented to monitor the timeliness and accuracy of order transcriptions.

4. Laboratory studies and requested medical records should always be reviewed and dated and initialed by the clinician prior to being filed in the medical record. This process ensures that critical information will not be missed by the treating clinician.

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

ASSESSMENT: NONCOMPLIANCE

MEDICAL FINDINGS: Since there is no staff person responsible for pulling and filing documents in the records, there tends to be some disorder, particularly in records of patients who have more problems or who have been in the facility longer periods of time. There continue to be documents which are unfiled or filed incorrectly. Given the number of staff utilizing these records, including caseworkers, nursing, medical clinicians, mental health, etc., a person should have the filing, the pulling and the maintenance of these records as their primary responsibility.

RECOMMENDATIONS:

1. Provide a position for a medical records technician who is dedicated to the maintenance and timely provision of medical records.
2. The medical records policy, which was generally well written, should include timeframes for filing of documents and for reviewing, initialing and dating by clinicians.
3. Continue to utilize the monitor staff for input in modifying the medical record policy.

MENTAL HEALTH FINDINGS: SECOND REPORT December 2013: Medical records are stored in a separate room. They are alphabetized and do not have a Bureau of Corrections number. Name alerts are utilized when necessary.

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

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

THIRD REPORT March 2014: Significant difficulties continue to exist regarding the availability and organization of the medical record. During this visit charts were requested from a list of all current detainees housed in the facility in order to review the adequacy of the intake process regarding mental health. Of the 107 charts requested only 24 were able to be located and produced for review. Of these 24 detainees, their records were not filed in folders, but rather paper clipped together waiting to be placed into a chart. Two other inmate records were requested repeatedly but were never able to be located for review. The difficulties in organizing and locating medical records places inmates requiring health services at a significant risk since the clinical staff will not always have prior information available at the time of their encounters. Potential risks can include prescribing medications for which the inmate has an allergy, duplications of laboratory and x-ray studies, potential drug toxicities because serum blood level reports may not be available for clinical review, potential trials of medications that have been documented as ineffective in the past, etc.

RECOMMENDATIONS: Unchanged from the prior reports. Failure to maintain comprehensive and accurate medical records is a major deficiency that hampers provision of adequate medical services and should be addressed with great priority.

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

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

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

ASSESSMENT: NONCOMPLIANCE

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

RECOMMENDATIONS: See letter (c) findings and recommendations.

MENTAL HEALTH FINDINGS: The processes of ensuring that mental health receives sick call requests in a timely manner require significant improvement. Multiple examples of delays in delivery of these triaged documents from nursing to mental health were noted at the time of this site visit. Once these records were received by the mental health coordinator, inmates were seen in an extremely prompt manner with rapid referral to the psychiatrist when indicated. This will be commented on further in this report.

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

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

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

ASSESSMENT: NONCOMPLIANCE

MEDICAL FINDINGS: Although there is tracking of sick call, the program is in the process of developing a scheduled offsite service log and an unscheduled offsite service log as well as an intake processing log. We reviewed with the staff the fields to be created for each of these logs, which should be clearly described in their respective policies.

RECOMMENDATIONS:

1. Develop these policies with reference to the elements that are required to be tracked for each of the above referenced services.
2. Utilize the resources of the monitor to assist in developing these materials.

MENTAL HEALTH FINDINGS: There has been no change in the mental health caseload tracking form.

RECOMMENDATIONS:

1. The current log should be maintained in a sortable format such as a Word table or Excel worksheet for ease of maintenance of an accurate record.

2. Health services may consider developing an intake log that records the inmates name, number, date a sick call request or behavioral referral are received, the date the request was triaged, the date it is received by the service responsible to respond (medical, dental, mental health), the date the issue has been resolved and the initials of the responding staff person. Such a log would assist in the quality assurance efforts when studying timeliness and access to care.

3. It is also recommended that the date of the last mental health and psychiatric visit as well as housing location, and the follow-up date be entered. This will enable quick assessment as to whether someone has accidentally fallen off the schedule and whether they are in a special housing unit.

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

ASSESSMENT: NONCOMPLIANCE

MEDICAL FINDINGS: This section addresses the medical chronic and acute care program. We observed delays in both initiating chronic care enrollment and in receipt of medications. We also found medication continuity disruption attributable to inconsistent physician presence at the facility. Due to inconsistencies of physician presence this program has regressed. Patients with chronic problems are not adequately or timely monitored and treated. Medications are continued without assessments. With regard to acute care guidelines, policies and procedures do not exist for assessing and treating acute medical events.

RECOMMENDATIONS:

1. Ensure adequate Medical Director and advanced level provider hours onsite.
2. Ensure appropriate assessments and monitoring.
3. Promulgate chronic and acute assessment and treatment guideline as indicated, train and monitor staff in the application of those guidelines.

MENTAL HEALTH FINDINGS: SECOND REPORT December 2013: unchanged since the baseline assessment as follows:

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

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

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

THIRD REPORT March 2014: Since the time of our last visit, GGACF has hired a new psychiatrist who has diligently seen every inmate on the caseload except for two at the time of our visit. She and the mental health coordinator have formed a good working relationship and her availability to the facility exceeds that of the prior psychiatrist. I am optimistic that inmates will be seen at appropriate frequencies going forward.

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

1. Contact the Monitor and his staff for consultation and/or technical assistance.
2. A minor modification to the current case list log as recommended above would improve the tracking capabilities of the facility.
3. The list should contain both the BOC number and the inmates' date of birth.
4. Any inmate followed by mental health should be captured on a log, perhaps one for psychiatry and one for counseling.
5. As mentioned previously, a policy that would dictate required time frames for follow-up of people in the chronic care mental health clinic may improve the timeliness of return visits and allow for tracking when looking for quality outcomes.
6. All prison inmates on a mental health caseload should have at a minimum a monthly well-being check by a mental health professional. Minimum frequency of psychiatric visits should be outlined by policy not to exceed every 90 days.
7. The mental health caseload should be modified to track the date of the follow-up visit for easy identification of overlooked appointments and housing unit to identify those in segregation or special housing.

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

ASSESSMENT: NONCOMPLIANCE

GENERAL FINDING: Review of the logbooks reveal several instances where security staff did not appropriately respond to serious injuries or life-threatening conditions by contacting medical staff (as would be appropriate). Instead, officers attempted to address seizures or prisoners with mentally acute symptoms on their own.
MEDICAL FINDINGS: Although an emergency policy was drafted, its focus was exclusively on disaster planning. Although this is an important part of emergency policy, it does not address the operational needs and guidance needed for urgent onsite care issues as well as problems that require the services of an offsite institution. We worked with the HCUA to describe the elements needed in this policy. The problems with accessing a Medical Director have continued and the current person has resigned. We did participate in an interview for a replacement Medical Director. We clearly hope this recruitment is successful.

We reviewed four records of patients for whom emergent services were required. A consistent pattern was identified with regard to an absence of emergency room reports. In addition, some of the patients were never followed up onsite after returning from the emergency room.

The first patient is a male in his 20s who has been in the facility for two and a half years. On 6/28/13, he presented with shortness of breath. There were no vital signs done, he has never been referred to an asthma chronic care program. He was sent to the emergency room and after he returned, there was no follow up onsite. There is also no emergency room report.

The second case is male in his 30s with no chronic problems. He was sent out to the emergency room because he demonstrated uncontrolled vomiting. He was seen in the emergency room and then returned, where he was seen by the nurse who wrote a note requesting approval to provide Gatorade. There is also no emergency room report or physician follow up.

The third case is male. He has type 2 diabetes and was sent out on 2/24/14 since he stopped eating and taking insulin. This is a very difficult patient who has been intermittently cooperative with his treatment plan. This patient is still in the hospital after more than two weeks.

The fourth case is male in his 20s with a seizure disorder who was sent to the emergency room on 2/15/14 and returned. There is no emergency room note, no note at the time he returned and no monitoring of his ingestion of the anticonvulsant.

We did discuss the requirements that an emergency room report always be retrieved and the Health Care Administrator assign someone to do this. It is also necessary that when patients return from offsite health care services, they are brought back through a nurse who can talk with the patient and receive the paperwork and where indicated perform vital signs. Also, when that paper work is available, the person assigned to obtaining it can schedule a follow up visit with a primary care clinician. These elements should be found in the urgent/emergent policy and included in that policy

should be that during the clinician follow up visit, a discussion with the patient of the findings and plan is documented. Ultimately, your quality improvement program should be monitoring this entire process.

RECOMMENDATIONS:

1. Complete the urgent/emergent policy with the above referenced elements.
2. The person assigned to obtain emergency room reports should be providing reports with regard to the success or difficulties in obtaining them.
3. The emergency care policy should include requirements for training and certification in basic life support and first aid as well as the documentation of critiques of quarterly emergency drills.
4. Nurses should be trained that when patients return from unscheduled offsite services, they should document a note that describes the patient's condition and a set of vital signs and insure that the appropriate paperwork is available.
5. The QI program can begin monitoring these elements of the service.

MENTAL HEALTH FINDINGS: Similar to those of the September 2013 report as follows:

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

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

THIRD REPORT March 2014: Structural modifications are currently underway to create a medical observation area in the treatment building. The mental health staff is optimistic that the space may also be used to accommodate inmates in need of intensive psychiatric monitoring or suicidal ideation. Inmates continue to remain in the housing units on a variety of safety watches or in a completely empty cell in the intake area both without adequate mental health supervision. These issues will be discussed in greater detail under section I.i.

One detainee, diagnosis schizophrenia and diabetes was booked into the facility on December 8, 2013 with a positive intake screening for a serious illness, use of medications, a history of diabetes, mental health treatment and depression. The officer noted that the detainee would talk to himself and appeared to be "delusional". He was seen the next day by medical who did speak with the mental health coordinator and she referred the inmate to see the psychiatrist. However, he was released on December 10, 2013. The inmate was booked again December 23, 2013 and refused to sign or answer any items on the officer's intake screening. The nurse documented on that date that he planned to contact the psychiatrist for orders. The psychiatrist, on December 24, ordered Haldol decanoate 150 mg intramuscularly and Haldol 10 mg by mouth daily with a notation that it was okay if the inmate refused medication until he was seen by the psychiatrist. Medications were ordered for the inmate's delusional behavior. By December 25 the inmate was

transported emergently by the psychiatrist to the hospital for stabilization as he was "in imminent danger of getting seriously hurt at this facility". This case does demonstrate the use of a local hospital to manage acutely mentally ill inmates beyond the capability of the facility. However, it also documents the lack of immediate face-to-face evaluations of inmates reported to be acutely mentally ill, use of medications prior to a face-to-face evaluation, and raises the question, "Could this third booking have been avoided had his mental illness been adequately addressed by the jail and the community at the time of his initial arrest?"

RECOMMENDATIONS:

1. Consider opportunities to improve coordination between GGACF staff and community case managers when dealing with these complex cases.

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

ASSESSMENT: NONCOMPLIANCE

MEDICAL FINDINGS: We reviewed eight cases of patients referred for specialty care. The biggest problems identified were the follow up upon return, which includes the availability of the offsite services report. Occasionally there were delays, but frequently these were due to lack of custody.

The first patient is female with hypertension and gynecologic problems. On 1/14/14, she was referred to the gyne clinic and this was scheduled for 2/13. The visit was cancelled due to lack of custody staff availability and could not be rescheduled until the month of March.

The second case is female with hypertension. On 1/6/14, there was an order for a gyne clinic and this was to be the same day as the previous patient, 2/13. This patient was also cancelled due to lack of custody and she will be seen in March.

The third case, a male who suffered a possible fracture of a finger, which was x-rayed on 1/27/14. The x-ray report was not reviewed until almost a month later, 2/22/14, and there has been no follow up visit with the patient.

The fourth case female with migraines and asthma. On 10/3/13, there was an order for a gyne clinic visit. On 10/13, the patient was found to have an abnormal Pap smear. There was a repeat Pap smear done in February of 2014 and the results were normal, but there has been no follow up with the patient to explain what was found and what needs to be done in the future.

RECOMMENDATIONS:

1. The Health Care Administrator has appointed a scheduled and unscheduled offsite service coordinator who will be responsible for scheduling the initial visits, retrieving the documents and scheduling any follow up visits with the primary care clinicians. This is very encouraging. This should be written into both the scheduled offsite services policy and the unscheduled offsite services policy.
2. For both services, when patients return they should be returned through a nurse who can inform the coordinator whether the reports are available and also who can see the patients and write a note as to the condition of the patients.

3. This scheduled offsite service program should be monitored for both timeliness of obtaining of service, timeliness of obtaining reports and timeliness of follow up encounters with the primary care clinician.

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

RECOMMENDATIONS: defer to Dr. Shansky's report

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

ASSESSMENT: NONCOMPLIANCE

MEDICAL FINDINGS: This has been discussed under number v.

RECOMMENDATIONS: See number v.

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

RECOMMENDATIONS: defer to Dr. Shansky's report

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

ASSESSMENT: NONCOMPLIANCE

MEDICAL FINDINGS: Without a Medical Director in place it is impossible to develop a guideline for the management of intoxication and detoxification, in addition to the appropriate policies and procedures that flow from the guidelines. The revised intake-screening tool does address the issues of substance use and potential withdrawal or intoxication issues. We look forward to working with a Medical Director on developing approaches to both alcohol, opiates and benzodiazepines that include both monitoring performed by nursing staff as well as treatment.

RECOMMENDATIONS:

1. Obtain an involved Medical Director who we can work with to develop the guidelines, policies and procedures for this issue.
2. When this happens, contact the monitor staff for technical assistance.

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

RECOMMENDATIONS: defer to Dr. Shansky's report

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

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

ASSESSMENT: NONCOMPLIANCE

In view of the fact that there is only one full-time registered nurse, it is understandable that they have not yet developed an organized infection control program. In the vast majority of facilities, a registered nurse, although sometimes a licensed practical nurse, is assigned this responsibility. The intake screen includes a TB skin test, which currently appears to be done, although there is a problem documenting the results in the medical record. It tends to be exclusively documented in a notebook which contains all of the test results. There is a space on the newly developed screening form which should be utilized in addition to the notebook. Review of the logbooks show instances where positive TB test results were noted by security staff , yet no particular actions were recorded that indicated that the prisoner was quarantined or otherwise segregated.

RECOMMENDATION:

1. Work through the monitor and his staff for consultation and/or technical assistance with regard to the key elements in an appropriate infection control program which includes not only screening for tuberculosis but also tracking of skin infections as well as instruction to inmates and officers regarding how to clean up after body fluid spills.

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

RECOMMENDATIONS: defer to Dr. Shansky's report

i. Adequate suicide prevention, including:

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

ASSESSMENT: NONCOMPLIANCE

MENTAL HEALTH FINDINGS: SECOND REPORT December 2013: GGACF Mental Health did not report placing anyone on suicide watch this last quarter. However, the security logs demonstrated an inmate placed on observation without his possessions for attempting to cut himself and being suicidal. Mental health was not notified and this was not called a suicide watch.

THIRD REPORT March 2014: Security log books continue to demonstrate placement of inmates on safety watches for behavioral health problems including suicidal and self-injurious behavior without notification and oversight by medical and mental health professionals. The mental health service was only aware of one inmate who placed on a mental health watch (by the mental health coordinator) although officer log books indicate other inmates were restricted since our last tour. It should also be pointed out that those instances can only be identified by examining every page in every unit's log book.

Despite Defendants' claim that they implemented a new suicide policy in February 2014, this instance demonstrates lack of compliance with the new policy's requirements pertaining to security as follows:

Section G.2. "The suicide watch and\or immobilizing restraint log shall be completed on all offenders placed on suicide watch by the correctional officer."

It is important to note, however, that proper implementation of new policies must follow the requirements of Settlement Agreement IX.3.

Even when appropriate behavioral referrals are issued there are significant delays in the actual notification of the mental health staff. For example, on February 21, 2014 there appears to be a reference in the security log that an inmate was placed on watch and the behavioral checklist was generated that same day. However, this critical document was not received by the mental health professional until March 3, 2014 which represents an unacceptable delay in notification. Inspection of the actual referral form does not indicate the date received by medical, only mental health, and therefore; the conclusion cannot be drawn regarding where the delay occurred. However, most of the delays seen are due to the lack of reliable transfer of referrals and sick call requests by nursing staff to the mental health coordinator. This conclusion was supported by a focused review, while on site, of intake screenings on detainees. Additional observations of other documents now dated when issued by the officer and received by the nurse, demonstrated an obvious delay in the receipt of the referral by mental health. The mental health professional did make appropriate and timely arrangements once she received the referrals.

RECOMMENDATIONS:

1. GGACF needs to develop a communication system that is timely and reliable for notification regarding inmates placed on suicide watch, behavioral referral requests, and intake referrals.
2. Medical Services needs to develop a reliable system to ensure that the mental health clinicians receive referrals in a timely manner.
   Sufficient training needs to be provided to all staff when new policies are developed and implemented.

(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: THIRD REPORT March 2014: While on site in March 2014 the monitoring team received a copy of a draft policy and procedure on suicide assessment and intervention and observation protocol revised January 2014 and effective February 2014. This policy calls for (B.2.) an offender being placed on continuous observation until appropriate medical, mental health or supervisory assistance is obtained.

Security log books entries beginning December 13, 2013 continue to document haphazard security checks even when the mental health service provided the warden with a memo instructing 15 minute checks for suicide watch on a particular inmate. Documentation of any watches occurred hours apart. Even when an officer clearly documented in the logbook that the mental health professional had called and stated and the inmate must be checked on every 15 minutes the next documented officer check occurred 45 minutes later. When notations are made they usually simply state a check was made and provide no descriptive material regarding the inmate's condition or behavior.

RECOMMENDATIONS: An assessment of noncompliance remains in place because, although a draft policy now exists, it clearly has not been adequately implemented. Until a qualified mental health professional assesses the inmate they should be placed on suicide precaution under direct observation and then the necessary level of observation recommended by the mental health professional should be implemented per the new policy and procedure.

1. Quality assurance measures need to be implemented to ensure that all components of the new policy are effectively carried out.

2. Evidence of adequate training of staff should be provided to the monitoring team when new policies are implemented.

3. In the future, all policy drafts should be distributed electronically to the monitoring team and the parties for review prior to acceptance and implementation. The current suicide prevention policy includes provisions that are not possible given the current structural constraints of the facility and the lack of 24 hour daily staffing patterns for health services. Observation status requirements of correctional officers are too infrequent compared to the customary requirements which impose a 30 minute rounds as opposed to the "not less than every hour" requirement in this policy. The policy also requires that the mental health counselor will observe the offender every shift which is not feasible given the staffing pattern of GGACF. The nature of this policy is such that the facility will perpetually be out of compliance with its own policy. This needs to be amended.

4. Please distribute any current mental health policies to the Monitor and USDOJ attorneys in an electronics format.

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

ASSESSMENT: NONCOMPLIANCE

MENTAL HEALTH FINDINGS: A standardized and validated risk assessment form has not yet been developed by the mental health service. Currently inmates referred for assessment received a face-to-face interview with a mental health professional. The advantage of a standardized form is that it allows for all components of suicide risk to be identified and for the professional to indicate the level of risk based on their professional opinion, be it low, moderate, or high.

RECOMMENDATIONS:

1. An after hour protocol should be considered as well to allow for notification of mental health staff by the next morning. This is a requirement of the new policy in section H.1. But no 24-hour emergency mental health plan was presented to the monitors at the time of the March site visit.

2. It is suggested that the service develop a standardized suicide assessment progress note that would include a suicide risk assessment and a suicide watch treatment plan.

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

ASSESSMENT: NONCOMPLIANCE

MENTAL HEALTH FINDINGS: SECOND REPORT December 2013: As indicated in the Monitor's previously discussed review, there is a lack of cut-down tools throughout the facility. Additionally, and as reported by the Monitor, some staff are not aware of the location of existing tools, tools are commonly reported as missing on the Officer's Log, and emergency drill training in the use of these tools is not regularly conducted.

THIRD REPORT March 2014: The Monitor found cut down tools in most housing units toured during this assessment; however, the A Dorm officer stated there was no cut-down tool for that unit and was not able to produce one. Many officers interviewed stated that they were not trained in the use of the tool or have participated in any emergency drills using the tools. Officers interviewed report that they have a basic understanding about how to use these tools but are not routinely assessed in demonstrating proficiency with the tools.

Recommendations provided in the previous report remain appropriate.

RECOMMENDATIONS:

1. Cut down tools should be available in all housing areas, and areas where inmates could have an opportunity to harm themselves i.e. kitchen, medical building, etc.
2. All staff required to use this tool should be well trained and emergency drills demonstrating proficient use of the tool should be conducted on a regular basis.
3. Supervisors should regularly inventory and audit tool location and make immediate provisions to replace missing or non-functioning tools when found.

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

ASSESSMENT: NONCOMPLIANCE

SECOND REPORT December 2013: During both site visits, September and December 2013, the training officer was unavailable and no one had access to her files. No proof of in-service training or disaster drills have been made available to the monitoring team.

THIRD REPORT March 2014: No training records verifying the existence of a qualified suicide prevention training program or whether staff have completed a qualified suicide prevention training program. A qualified suicide prevention training program should include, at a minimum, the following guidelines for revising suicide prevention protocols according to the National Center on Institutions and Alternatives.[1]

[1] http://www.ncianet.org/services/suicide-prevention-in-custody/publications/guide-to-developing-and-revising-suicide-prevention-protocols-within-jails-and-prisons/

Staff Training

The essential component to any suicide prevention program is properly trained staff, who form the backbone of any correctional facility. Very few suicides are actually prevented by mental health, medical or other professional staff because suicides are usually attempted in housing units, and often during late evening hours or on weekends when they are generally outside the purview of program staff. These incidents, therefore, must be thwarted by correctional staff who have been trained in suicide prevention and have developed an intuitive sense about suicidal inmates. Correctional staff are often the only personnel available 24 hours a day; thus, they form the front line of defense in preventing suicides.

All correctional, medical, and mental health personnel, as well as any staff who have regular contact with inmates, should receive eight (8) hours of initial suicide prevention training, followed by two (2) hours of refresher training each year. The initial training should include administrator/staff attitudes about suicide and how negative attitudes impede suicide prevention efforts, guiding principles to suicide prevention, inmate suicide research, why the environments of correctional facilities are conducive to suicidal behavior, potential predisposing factors to suicide, high-risk suicide periods, warning signs and symptoms, identifying suicidal inmates despite the denial of risk, components of the facility's suicide prevention policy, and liability issues associated with inmate suicide. The two-hour refresher training should include a review of administrator/staff attitudes about suicide and how negative attitudes impede suicide prevention efforts, predisposing risk factors, warning signs and symptoms, identifying suicidal inmates despite the denial of risk, and review of any changes to the facility's suicide prevention plan. The annual training should also include general discussion of any recent suicides and/or suicide attempts in the facility.
In addition, all staff who have routine contact with inmates should receive standard first aid and cardiopulmonary resuscitation (CPR) training. All staff should also be trained in the use of various emergency equipment located in each housing unit. In an effort to ensure an efficient emergency response to suicide attempts, "mock drills" should be incorporated into both initial and refresher training for all staff.

Identification/Referral/Evaluation

Intake screening and on-going assessment of all inmates is critical to a correctional facility's suicide prevention efforts. It should not be viewed as a single event, but as an on-going process because inmates can become suicidal at any point during their confinement, including the initial admission into the facility; after adjudication when the inmate is returned to the facility from court; following receipt of bad news or after suffering any type of humiliation or rejection; confinement in isolation or segregation; and following prolonged a stay in the facility.
In addition, although there is no single set of risk factors that mental health and medical communities agree can be used to predict suicide, there is little disagreement about the value of screening and assessment in preventing suicide. Research consistently reports that approximately two-thirds of all suicide victims communicate their intent some time before death, and that any individual with a history of one or more suicide attempts is at a much greater risk for suicide than those who have never made an attempt.

Intake screening for suicide risk may be contained within the medical screening form or as a separate form. The screening process should include inquiry regarding: past suicidal ideation and/or

attempts; current ideation, threat, plan; prior mental health treatment/hospitalization; recent significant loss (job, relationship, death of family member/close friend, etc.); history of suicidal behavior by family member/close friend; suicide risk during prior confinement; and arresting/transporting officer(s) belief that the inmate is currently at risk. Specifically, inquiry should determine the following:

- Was the inmate a medical, mental health or suicide risk during any prior contact and/or confinement within this facility?
- Does the arresting and/or transporting officer have any information (e.g., from observed behavior, documentation from sending agency or facility, conversation with family member) that indicates inmate is a medical, mental health or suicide risk now?
- Have you ever attempted suicide?
- Have you ever considered suicide?
- Are you now or have you ever been treated for mental health or emotional problems?
- Have you recently experienced a significant loss (relationship, death of family member/close friend, job, etc.)?
- Has a family member/close friend ever attempted or committed suicide?
- Do you feel there is nothing to look forward to in the immediate future (expressing helplessness and/or hopelessness)?
- Are you thinking of hurting and/or killing yourself?

Although an inmate's verbal responses during the intake screening process are critically important to assessing the risk of suicide, staff should not exclusively rely on an inmate's denial that they are suicidal and/or have a history of mental illness and suicidal behavior, particularly when their behavior and/or actions or even previous confinement in the facility suggest otherwise.
The process should also include referral procedures to mental health and/or medical personnel for a more thorough and complete assessment.

The intake screening process should be viewed as similar to taking your temperature, it can identify a current fever, but not a future cold. Therefore, following the intake screening process, should any staff hear an inmate verbalize a desire or intent to commit suicide, observe an inmate engaging in any self-harm, or otherwise believe an inmate is at risk for suicide, a procedure should be in place that requires staff to take immediate action to ensure that the individual is constantly observed until appropriate medical, mental health, and/or supervisory assistance is obtained.
Finally, given the strong association between inmate suicide and isolation/special management (e.g., disciplinary and/or administrative segregation) housing unit placement, any inmate assigned to such a special housing unit should receive a written assessment for suicide risk by medical or mental health staff upon admission to the placement.

The screening and assessment process is only one of several tools that increases the opportunity to identify suicide risk in inmates. This process, coupled with staff training, will only be successful if an effective method of communication is in place at the facility.

Communication

Certain behavioral signs exhibited by the inmate may be indicative of suicidal behavior and, if detected and communicated to others, can reduce the likelihood of suicide. In addition, most suicides can be prevented by correctional staff who establish trust and rapport with inmates, gather pertinent information, and take action. There are essentially three levels of communication in preventing inmate suicides: between the arresting/transporting officer and correctional staff; between and among facility staff (including correctional, medical and mental health personnel); and between facility staff and the suicidal inmate.

In many ways, suicide prevention begins at the point of arrest. At Level 1, what an arrestee says and how they behave during arrest, transport to the facility, and at intake are crucial in detecting suicidal behavior. The scene of arrest is often the most volatile and emotional time for the individual. Arresting officers should pay close attention to the arrestee during this time; suicidal behavior may be manifested by the anxiety or hopelessness of the situation, and previous behavior can be confirmed by onlookers such as family members and friends. Any pertinent information regarding the arrestee's well-being must be communicated by the arresting or transporting officer to correctional staff. It is also critically important for correctional staff to maintain open lines of communication with family members who often have pertinent information regarding the mental health status of inmates.

At Level 2, effective management of suicidal inmates is based on communication among correctional personnel and other professional staff in the facility. Because inmates can become suicidal at any point during confinement, correctional staff must maintain awareness, share information and make appropriate referrals to mental health and medical staff. At a minimum, the facility's shift supervisor should ensure that appropriate correctional staff are properly informed of the status of each inmate placed on suicide precautions. The shift supervisor should also be responsible for briefing the incoming shift supervisor regarding the status of all inmates on suicide precautions. Multidisciplinary team meetings (to include correctional, medical and mental health personnel) should occur on a regular basis to discuss the status of inmates on suicide precautions. Finally, the authorization for suicide precautions, any changes in suicide precautions, and observation of inmates placed on precautions should be documented on designated forms and distributed to appropriate staff.

At Level 3, facility staff must use various communication skills with the suicidal inmate, including active listening, staying with the inmate if they suspect immediate danger, and maintaining contact through conversation, eye contact, and body language. Correctional staff should trust their own judgment and observation of risk behavior, and avoid being misled by others (including mental health staff) into ignoring signs of suicidal behavior.
Poor communication between and among correctional, medical, and mental health personnel, as well as outside entities (e.g., arresting or referral agencies, family members) is a common factor found in the reviews of many custodial suicides. Communication problems are often caused by lack of respect, personality conflicts and boundary issues. Simply stated, facilities that maintain a multidisciplinary approach avoid preventable suicides.

Housing

In determining the most appropriate housing location for a suicidal inmates, correctional facility officials (with concurrence from medical and/or mental health staff) often tend to physically isolate (or segregate) and sometimes restrain the individual. These responses might be more convenient for all staff, but they are detrimental to the inmate since the use of isolation escalates the sense of alienation and further removes the individual from proper staff supervision. To every extent possible, suicidal inmates should be housed in the general population, mental health unit, or medical infirmary, located close to staff. Further, removal of an inmate's clothing (excluding belts and shoelaces) and the use of physical restraints (e.g., restraint chairs or boards, leather straps, handcuffs, and straitjackets) should be avoided whenever possible, and used only as a last resort when the inmate is physically engaging in self-destructive behavior. Housing assignments should be based on the ability to maximize staff interaction with the inmate, not on decisions that heighten depersonalizing aspects of confinement.

All cells designated to house suicidal inmates should be as suicide-resistant as is reasonably possible, free of all obvious protrusions, and provide full visibility. These cells should contain tamper-proof light fixtures, smoke detectors and ceiling/wall air vents that are protrusion-free. In addition, the cells should not contain any live electrical switches or outlets, bunks with open bottoms, any type of clothing hook, towel racks on desks and sinks, radiator vents, or any other object that provides an easy anchoring device for hanging. Each cell door should contain a heavy gauge Lexan (or equivalent grade) clear panel that is large enough to allow staff a full and unobstructed view of the cell interior. Finally, each housing unit in the facility should contain various emergency equipment, including a first aid kit, pocket mask or face shield, Ambu-bag, and rescue tool (to quickly cut through fibrous material). Correctional staff should ensure that such equipment is in working order on a daily basis.

Levels of Observation/Management

In regard to suicide attempts in correctional facilities, the promptness of the response is often driven by the level of supervision afforded the inmate. Medical evidence suggests that brain damage from strangulation caused by a suicide attempt can occur within 4 minutes, and death often within 5 to 6 minutes. Two levels of supervision are generally recommended for suicidal inmates: close observation and constant observation.

Close Observation is reserved for the inmate who is not actively suicidal, but expresses suicidal ideation (e.g., expressing a wish to die without a specific threat or plan) and/or has a recent prior history of self-destructive behavior. In addition, an inmate who denies suicidal ideation or does not threaten suicide, but demonstrates other concerning behavior (through actions, current circumstances, or recent history) indicating the potential for self-injury, should be placed under close observation. Staff should observe such an inmate in a protrusion-free cell at staggered intervals not to exceed every 10 minutes (e.g., 5, 10, 7 minutes).

Constant Observation is reserved for the inmate who is actively suicidal, either threatening or engaging in suicidal behavior. Staff should observe such an inmate on a continuous, uninterrupted basis. In some jurisdictions, an intermediate level of supervision is utilized with observation at staggered intervals that do not exceed every 5 minutes.

Other aids (e.g., closed-circuit television, cell mates) can be used as a supplement to, but never as a substitute for, these observation levels.

In addition, mental health staff should assess and interact with (not just observe) the suicidal inmate on a daily basis. The daily assessment should focus on the current behavior, as well as changes in thoughts and behavior during the past 24 hours (e.g., "What are your current feelings and thoughts?" "Have your feelings and thoughts changed over the past 24 hours?" "What are some of the things you have done or can do to change these thought and feelings?," etc.)

An individualized treatment plan (to include follow-up services) should be developed for each inmate on suicide precautions. The plan should be developed by qualified mental health staff in conjunction with not only the inmate, but medical and correctional personnel. The treatment plan should describe signs, symptoms, and the circumstances under which the risk for suicide is likely to recur, how recurrence of suicidal thoughts can be avoided, and actions the inmate and staff will take if suicidal ideation reoccurs.

Finally, due to the strong correlation between suicide and prior suicidal behavior, in order to safeguard the continuity of care for suicidal inmates, all inmates discharged from suicide precautions should remain on mental health caseloads and receive regularly scheduled follow-up assessments by mental health personnel until their release from custody. Although there is not any nationally-acceptable schedule for follow-up, a suggested assessment schedule following discharge from suicide precautions might be: 24 hours, 72 hours, 1 week, and periodically until release from custody.

Intervention

Following a suicide attempt, the degree and promptness of the staff's intervention often foretells whether the victim will survive. National correctional standards and practices generally acknowledge that a facility's policy regarding intervention should be threefold. First, all staff who come into contact with the inmate should be trained in standard first aid procedures and CPR. Second, any staff member who discovers an inmate engaging in self-harm should immediately survey the scene to assess the severity of the emergency, alert other staff to call for medical personnel if necessary, and begin standard first aid and/or CPR as necessary. If facility policy prohibits an officer from entering a cell without backup support, the first responding officer should, at a minimum, make the proper notification for backup support and medical personnel, secure the area outside the cell, and retrieve the housing unit's emergency response bag (that should include a first aid kit, pocket mask or face shield, Ambu-bag, and rescue tool). Third, correctional staff should never presume that the victim is dead, but rather should initiate and continue appropriate life-saving measures until relieved by arriving medical personnel. In addition, medical personnel should ensure that all equipment utilized in responding to an emergency within the facility is in working order on a daily basis.

Finally, although not all suicide attempts require emergency medical intervention, all suicide attempts should result in immediate intervention and assessment by mental health staff.

Reporting

In the event of a suicide attempt or suicide, all appropriate officials should be notified through the chain of command. Following the incident, the victim's family should be immediately notified, as well as appropriate outside authorities. All staff who came into contact with the victim before the incident should be required to submit a statement including their full knowledge of the inmate and incident.

Follow-Up/Mortality-Morbidity Review

An inmate suicide is extremely stressful for both staff and other inmates. Staff may also feel ostracized by fellow personnel and administration officials. Following a suicide, misplaced guilt is sometimes displayed by a correctional officer who wonders: "What if I had made my cell check earlier?" Inmates are often traumatized by critical events occurring within a facility. Such trauma may lead to suicide contagion. When crises occur in which staff and inmates are affected by the traumatic event, they should be offered immediate assistance. One form of assistance is Critical Incident Stress Debriefing (CISD). A CISD team, comprised of professionals trained in crisis intervention and traumatic stress awareness (e.g., police officers, paramedics, fire fighters, clergy, and mental health personnel), provides affected staff and inmates an opportunity to process their feelings about the incident, develop an understanding of critical stress symptoms, and seek ways of dealing with those symptoms. For maximum effectiveness, the CISD process or other appropriate support services should occur within 24 to 72 hours of the critical incident.

Every completed suicide, as well as serious suicide attempt (i.e., requiring medical treatment and/or hospitalization), should be examined through a mortality-morbidity review process. If resources permit, clinical review through a psychological autopsy is also recommended. Ideally, the mortality-morbidity review should be coordinated by an outside agency to ensure impartiality. The review, separate and apart from other formal investigations that may be required to determine the cause of death, should include a critical inquiry of: 1) the circumstances surrounding the incident; 2) facility procedures relevant to the incident; 3) all relevant training received by involved staff; 4) pertinent medical and mental health services/reports involving the victim; 5) possible precipitating factors leading to the suicide or serious suicide attempt; and 6) recommendations, if any, for changes in policy, training, physical plant, medical or mental health services, and operational procedures.

RECOMMENDATIONS:

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

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

ASSESSMENT: NONCOMPLIANCE

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

THIRD REPORT March 2014: Refer to Provision (v) above.

RECOMMENDATIONS:

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

(vii) availability of suicide resistant cells;

ASSESSMENT: NONCOMPLIANCE

MENTAL HEALTH FINDINGS: SECOND REPORT December 2013: There are no suicide resistant (safety) cells at GGACF. This was further verified in consultation with the Monitor.

THIRD REPORT March 2014: Security escorted an inmate to see mental health on December 6, 2013 and the correctional officer stated that he placed the inmate on a suicide watch after the inmate stated to the officer, "I don't want to live anymore." There is no way of knowing what property the inmate continued to have in his possession. The counselor evaluated the inmate and spoke with the psychiatrist and he was released back to his cell. Mental health did place a phone call to the correctional officer to follow-up regarding the inmate the next day but should have performed a face to face review. The inmate was seen four days later by the psychiatrist to whom he stated he was not suicidal. Three days later a behavioral checklist was appropriately initiated when he expressed feelings of wanting to kill himself and was crying. He was seen that same day by the mental health coordinator who placed him on a 24 hour suicide watch and ordered documentation every 15 minutes concerning his condition. As noted previously the 15 minute watches were not documented in any reliable format. The inmate was reevaluated two days later by the psychiatrist who discontinued the suicide watch.

Pertinent to this section, the inmate was moved to a cell in the intake area of the facility. This room had been observed during our baseline visit and was noted to be a completely empty concrete cell with a drain in the floor. Mental health staff related to the reviewer that inmates on suicide watch do not receive mattresses, suicide resistant blankets or garments. Rather, this inmate was on suicide watch with only his undershorts.

RECOMMENDATIONS:

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

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

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

   In older, antiquated facilities with cell fronts, walls and/or cell doors made of steel bars, Lexan paneling (or low-abrasion polycarbonate) or security screening (that has holes that are ideally 1/8 inches wide and no more than 3/16 inches wide or 16-mesh per square inch) should be installed from the *interior* of the cell.
   Solid cell fronts must be modified to include large-vision Lexan panels or security screens with small mesh;

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

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

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

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

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

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

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

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

9. CCTV monitoring does *not* prevent a suicide, it only identifies a suicide attempt in progress. If utilized, CCTV monitoring should *only* supplement the physical observation by staff. The camera should obviously be enclosed in a box that is tamper-proof and does not contain anchoring points. It should be placed in a high corner location of the cell and all edges around the housing should be caulked or grouted. Cells containing CCTV monitoring should be painted in pastel colors to allow for better visibility. To reduce camera glare and provide a contrast in monitoring, the headers above cell doors should be painted black or some other dark color.
   CCTV cameras should provide a clear and unobstructed view of the entire cell interior, including *all* four corners of the room. Camera lens should have the capacity for both night and low light level vision;

10. Cells should have a smoke detector mounted flush in the ceiling, with an audible alarm at the control desk. Some cells have a security screening mesh to protect the smoke detector from vandalism. The protective coverings should be high enough to be outside the reach of an inmate and far enough away from the toilet so that the fixture could not be used as a

ladder to access the smoke detector and screen. Ceiling height for new construction should be 10 feet to make such a reasonable accommodation. Existing facilities with lower ceilings should carefully select the protective device to make sure it cannot be tampered with, or have mesh openings large enough to thread a noose through. Water sprinkler heads should not be exposed. Some have protective cones; others are flush with the ceiling and drop down when set off; some are the breakaway type;

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

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

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

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

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

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

17. The mattress should be fire retardant and not produce toxic smoke. The seam should be tear-resistant so that it cannot be used as a ligature;
18. Given the fact that the risk of self-harm utilizing a laundry bag string outweighs its usefulness for holding dirty clothes off the floor, laundry bag strings should be removed from the cell;

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

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

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

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

ASSESSMENT: NONCOMPLIANCE

MENTAL HEALTH FINDINGS: SECOND REPORT December 2013: The facility needs to develop, train to, and implement a policy for suicide prevention. In addition, there does not appear to be any system by which security implements and maintains an adequate watch.

THIRD REPORT March 2014: This provision has been included in the current draft policy but no situations where constant observation has been ordered occurred and could therefore, not be reviewed to monitor compliance with the policy.

RECOMMENDATIONS:

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

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

ASSESSMENT: NONCOMPLIANCE

MENTAL HEALTH FINDINGS: SECOND REPORT December 2013: There have been no improvements regarding suicide prevention. Security does initiate Behavioral Referrals but these are not always responded to by Health Services/Mental Health Services as promptly as is necessary. It is unclear if the delay is due to delayed arrival of the referral to the clinic, a shortage of security staff to escort the inmate, a shortage of mental health staff, or all of the above plus other obstacles the facility may be aware of.

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

Security places people on lockdown status for self-injurious behavior without notifying mental health services. As a result there is absolutely no mental health review of the inmate. The decision to remove the person from watch is made by security not a psychiatrist or a mental health professional in consultation with a psychiatrist. Grossly inadequate levels of observation are documented in the security logs during the time this person was on lockdown.
Therefore, when medical informs the auditing team that there have been no instances of suicide watch in the facility their data and reports are unintentionally inaccurate.

THIRD REPORT March 2014: despite the draft suicide prevention policy, the requirements of this provision 1-3 have not been implemented in practice.

RECOMMENDATIONS:

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

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

MEDICAL FINDINGS: We have discussed in detail with the Territory that a Medical Director on call 365 days a year and onsite at least three days a week, Monday through Friday along with the two weekend days coverage by a PA is sufficient primary care coverage. We also have indicated that a total of four RN positions is also necessary, both for intake and sick call as well as eventually to cover the observation or infirmary area. The use of at least three licensed practical nurses to complete medication administration as well as assisting the advanced level clinicians is also required. Finally, it is our recommendation that a health information technician be provided to manage the medical records. With these elements in place, there will be extremely rapid progress.

RECOMMENDATIONS:

1. Provide a staffing document to the monitor along with the duties assigned to each staff member.
2. Complete the hiring of those positions already budgeted, which should certainly address most if not all of the nursing needs.

3. Bring on to the program a Medical Director who will provide three days onsite Monday through Friday as well as 365 day a year on call coverage.
4. Bring on board a health information technician position.
5. Address the medical records component.

MENTAL HEALTH FINDINGS: SECOND REPORT December 2013: No staffing analysis was presented to the monitor. Mental health staffing levels remain unchanged from the time of our last visit. Delays in follow-up care are frequently related to the lack of escort officers; however, if security staff was increased it is unlikely that the current mental health staff hours would be sufficient to meet the needs of the facility, particularly if sufficient services were provided to the seriously mentally ill inmates.

THIRD REPORT March 2014: As of the current time there has been no staffing analysis or development of what programs and services the facility will strive to implement.

1. RECOMMEDATIONS: Refer to the Monitor's assessment, findings and recommendations pertaining to staffing analysis recommendations. Provide the staffing document to the Monitor along with the duties assigned to each staff member.

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

GENERAL FINDINGS: Review of unit logbooks reveals serious deficiencies in security staff's ability to identify, refer, and supervise prisoners with serious medical and mental health needs.

MEDICAL FINDINGS: We were informed and the records demonstrated that lack of availability of officers compromises the availability of both onsite and offsite services.

RECOMMENDATIONS:

1. There should be a permanent medical transport post of at least one and possibly two officers.
2. In addition, there should be an officer assigned to assist nurses who are performing medication administration and at least one officer onsite in the medical clinic area.
3. All of these posts should be mandatory.
4. There should also be a medical van assigned to primarily provide medical transports offsite.
5. Leadership should complete and implement a comprehensive staffing analysis without delay.
6. All correctional officers and supervisors must be adequately trained as required in this provision before being assigned oversight of inmate housing units or duties involving contact with inmates.

MENTAL HEALTH FINDINGS: SECOND REPORT December 2013: Clearly, the consistent availability of offsite officers as well as a transport van has interfered with the ability to provide

follow up ordered lab and x-ray services. In addition, we are aware of access onsite that was either delayed or unavailable due to officer staffing.

THIRD REPORT March 2014: Based on observations and staff reporting there remains inadequate correctional officer staffing to ensure that all scheduled appointments occur and that there is the capacity for inmates with urgent issues to also be escorted to the clinic. In addition there can be no growth in the capacity to deliver clinical services until sufficient security staffing is available to support those measures.

RECOMMENDATIONS:

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

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

ASSESSMENT: NONCOMPLIANCE

MEDICAL FINDINGS: Until the policies and procedures have been finalized and implemented, there cannot be an effective, organized quality improvement program. This also requires an actively involved Medical Director to lead the professional performance review aspects of the program. Once the policies are finalized, the procedures will dictate what specific duties both nursing and clinician staff must perform. These elements can then be monitored by the quality improvement program. The creation of logs for intake processing, sick call, scheduled offsite services and unscheduled offsite services, will facilitate this review and monitoring.

RECOMMENDATIONS:

1. Obtain the Medical Director to work with the Health Care Unit Administrator and Chief Nurse to implement the policies and procedures such that performance can be monitored and improved.
2. Work with the monitor and his staff, who can provide technical assistance.

MENTAL HEALTH FINDINGS: March 2014: Health services did not provide the monitoring team with proof of an implemented quality improvement program. Once a medical director can be hired that person and the psychiatrist and dentist, in conjunction with the health services administrator in charge nurse, may begin to develop an agenda and the underpinnings of the quality management program.

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

RECOMMENDATIONS:

1. Complete development, training, and implementation of required medical, mental health, and suicide prevention policies
2. Include in each policy core measures, metrics, and methods for continuous quality improvement of these governing documents.
3. As the policies and procedures are finalized, staff are trained and the policies implemented, begin the monitoring of process performance with regard to intake, health assessments, TB screening, sick call, unscheduled onsite and offsite services, scheduled onsite and offsite services as well as chronic disease management and medication management.
4. Work with the monitor and his staff, who can provide technical assistance.

m. Adequate dental care;

ASSESSMENT: NONCOMPLIANCE

MEDICAL FINDINGS: We did have the opportunity to interview both the dentist and the dental assistant. We were told that the dentist is available on Wednesdays from 2:30 to 5:30; however, because of custody issues, including lockdown and the absence of out-counting, his time with patients is limited to between 3:30 and possibly 5:00. It is important that for the entire three hour period custody staff arranges for patients to be available. This can be accomplished by out-counting or if necessary changing meal times. We were aware that the medical assistant does some oral screening in the clinic and does sterilization of instruments. We were not able to review the records regarding sterilization and the biologic controls. We look forward to reviewing the remaining issues in the program for our next visit.

RECOMMENDATION:

1. The dental program should track the number of extractions and restorations performed each month and we will be able to review that data upon return.
2. Develop adequate dental care policies, procedures, and protocols.

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

RECOMMENDATIONS: defer to Dr. Shansky's report.

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

ASSESSMENT: NONCOMPLIANCE

MEDICAL FINDINGS: There was one death in October of 2013 and we did have the opportunity to review the record. There has been no site review or discussion of this case. During the record review of a male in his 60s with HIV disease and hepatitis C. In August 2012, the records showed that he had a CD4 count of 261 and his viral load was undetectable. This puts him in reasonable shape and certainly not suggestive of being near death. We learned that he was followed by the Department of Health HIV program; however, notes from the Department of Health clinic are not available. Also there were no recent laboratory notes in the record. On 8/17/13, he began complaining of musculoskeletal and digestive problems and he had stopped eating. On 8/22, he was found with red spots on his body and he was not breathing normally and he was sent to the hospital, where he stayed until his death two months later on 10/28/13. We do know that before he was sent out, the Department of Health clinic recommended that he be put on an antibiotic as prophylaxis, which is normally done when a patient's CD4 count drops below 200. This suggests that he may have been developing resistance to the medicines he was taking. If that was the case, the regimen might have been changed to medications to which his body was not resistant. In any event, it is clear that when any patients are followed in a Department of Health clinic either for HIV or hepatitis C or for OB/GYN, the records of their encounters in the offsite clinic must be made available so that appropriate follow up can be conducted onsite.

RECOMMENDATIONS:

1. Obtain the Medical Director position in place.
2. Arrange for clinic encounters to be made available at the prison for patients seen for infectious diseases or gynecologic problems or any other problems.
3. Consider utilizing the services of an offsite clinician to perform a death review on all deaths of patients incarcerated in the Department of Corrections.

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

RECOMMENDATIONS: defer to Dr. Shansky's report

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

ASSESSMENT: NONCOMPLIANCE

MEDICAL FINDINGS: We are still awaiting the drafting of the segregation round policy. It would make sense for both nursing and mental health to share this responsibility.

RECOMMENDATION:

1. Draft the policy and procedure for segregation rounds for our review.

MENTAL HEALTH FINDINGS: SECOND REPORT December 2013: Similar to the baseline assessment as follows:

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

THIRD REPORT March 2014: There continue to be no mental health rounds in segregation (Inmates on both the sentenced and detainee units directly reported that there are not medical rounds occurring either). The nursing function on this unit appears to be strictly limited to passing medications.

A striking example of why rounds are an essential process is demonstrated by the report that only a few days before our site visit the psychiatrist was requested to see an inmate who has been maintained in isolation for 10 years. This reviewer also had the opportunity to interview this man while on site. He clearly suffers from a serious and chronic psychotic illness with paranoid delusions. The monitor also reviewed his administrative record which demonstrated a history of repeated assaults on officers. His mental condition has never been treated while incarcerated at this facility. He has persisted in isolation with no awareness by the mental health staff of his presence in segregation and there has been, up until the very present time, no assessment as to whether this is an appropriate placement. In addition, there have been no attempts by security to develop accommodations that would enable trials in a less restrictive environment after years in isolation.

RECOMMENDATIONS: Similar to the baseline assessment as follows:
It is recommended that:

1. A policy be developed that incorporates the requirements of national accrediting bodies such as the NCCHC or the ACA.
2. Medical and mental health segregation rounds be implemented following national guidelines.
3. Staff training regarding what are critical questions in areas to review during medical and mental health rounds on the segregation unit.
4. The facility will need to provide adequate security staffing and access in order for the medical staff to conduct the appropriate rounds and treatment services.

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: SECOND REPORT December 2013: Mental health staff provide no structured out of cell therapeutic programming for seriously mentally ill inmates in administrative segregation or the special needs housing unit adjacent to segregation. In general, it is recommended that the former, should they require a residential level of care, receive at least 10 hours per week of unstructured out of cell time and 10 hours of structured out of cell encounters per week (individual or group therapy) driven by their individual treatment needs. Those requiring only outpatient care should have more than five hours per week of unstructured

out of cell time and increased private contact with a counselor and a psychiatrist while housed in isolation.

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

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

THIRD REPORT March 2014: Staff reported that inmates on the mental health caseload are not screened prior to placement in segregation. In addition, the mental health staff is not notified of this placement until they see the patient at the time of his\her next appointment. There is no enhanced mental health programming offered to mentally ill inmates housed in segregation units.

The Monitor, an experienced licensed mental health clinician, observed inmates presenting symptoms of serious mental illness in segregation units having conditions that amount to an isolation environment. Many of these inmates were locked in their cells for most of the day. Many of the cells were very dark with virtual no social interaction other than inmates yelling.
These conditions, as reported by the Monitor, and this expert agrees, can seriously exacerbate mental health symptoms and adversely impair mental health recovery.

RECOMMENDATIONS:

1. This Provision mandates a strict prohibition on placing in isolation environment ANY inmate having or suspected of having a serious mental illness. Policies and procedures must articulate this mandate and be monitored by supervisors and mental health staff for compliance.

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

3. The facility should develop an outline for therapeutic residential level of treatment on these units, identify the staffing needs and coordinate with security to effectively initiated enhanced treatment designed to stabilize and improve inmate function with the goal of possibly moving some of these men into general population and an outpatient level of care.

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

ASSESSMENT: NONCOMPLIANCE

MENTAL HEALTH FINDINGS: As reported in the Second Report, there remains no formalized process by which a qualified mental health provider performs a pre-segregation assessment to determine whether the person is at risk of self-injury if placed in isolation and is at risk of an intensification of their mental illness if placed in isolation. Mental health also has no formalized

process to determine if there are mitigating factors that would lessen or eliminate the disciplinary sanction.

Similar to the baseline assessment as follows:

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

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

RECOMMENDATIONS: Similar to the baseline assessment as follows:

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

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

ASSESSMENT: NONCOMPLIANCE

MEDICAL FINDINGS: The potential examination rooms in the housing units have still not been reestablished as appropriate examination rooms. This would require cleaning, the provision of both a table and chairs, as well as an exam table and appropriate medical equipment. Supplies to insure sanitation should also be made available. We also looked at the space that is to be remodeled but no one has yet seen the official architectural plans even though some construction is occurring.

RECOMMENDATIONS:

1. Reestablish clinically appropriate examination rooms in each of the housing units.
2. During our next visit, provide us with the architectural drawings for the new health care unit renovation.

MENTAL HEALTH FINDINGS: There has been no change as reported in the previous assessment. The physical plant regarding the delivery of mental health services has not altered since our last visit. We did observe some confidential log material displayed in a manner that would have been readily visible to inmates being treated within that office space. The staff member was informed that this was a poor practice and immediately removed the materials.

Currently the Mental Health Coordinator is conducting 1 group therapy in an office that would not comfortably hold more than 4 inmates. The physical limitations, in addition to the shortage of escort officers and mental health staff, severely limit any additional programming opportunities at this time. No adequate programming space exists in or near the special needs unit or segregation for the programming of the seriously mentally ill inmates in these housing units. There is a small satellite medical clinic space that could be used for individual mental health encounters on the segregation pod.

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

RECOMMENDATIONS:

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

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

ASSESSMENT: NONCOMPLIANCE

MENTAL HEALTH FINDINGS: December 2013: During this visit we again found examples of inmates with delayed or absent psychiatric follow-up.

THIRD REPORT March 2014: New mental health medical record forms have been developed including a treatment plan form. Copies of these were provided during this visit. I did review these forms with the psychiatrist and recommended revision since these forms are better suited for an inpatient hospitalization than a detention/prison facility. It is too soon to be able to monitor the implementation of these components. The new facility psychiatrist employed as of a week and a half ago) is enthusiastic, knowledgeable and energetic. She is establishing relationships with the inmates currently on the caseload and will be a valuable asset to the health team.

RECOMMENDATIONS:

1. Continue to monitor the plans to implement the new forms, modifications to the tracking case list including housing area, past visit and date of return to clinic.
2. Consider developing quality improvement process to monitor outcomes from data collected via the treatment forms.

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

ASSESSMENT: NONCOMPLIANCE

MENTAL HEALTH FINDINGS: SECOND REPORT December 2013: Similar to the baseline assessment as follows:

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

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

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

THIRD REPORT March 2014: The mental health coordinator continues to offer one structured group activity per week with between five and six attendees. During the month of February 50% of those groups were canceled due to the lack of an escort officer. Ten inmates and detainees are also receiving individual counseling therapy as needed.

The current psychiatric case lists include 16 inmates and 18 detainees. Dr. Sang is committed to ensuring that inmates are seen within the necessary and appropriate clinical time frames.
There are no structured program services offered to segregated inmates other than psychiatric visits which may be monthly or quarterly and 1:1 counseling encounters. Currently there were five identified inmates in the prison segregation unit who have a serious mental illness (as prohibited by V.p as discussed above). Only one of those inmates is currently being seen in the mental health coordinator's weekly group. The others received no programming. Mentally ill inmates in segregation do not receive any additional out of cell time or, as a rule, increased mental health contact compared to the segregation and general populations.

No needs analysis has been performed yet.

RECOMMENDATIONS: Unchanged from the Baseline Assessment as follows:

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

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

ASSESSMENT: NONCOMPLIANCE

MENTAL HEALTH FINDINGS: SECOND REPORT December 2013: Unchanged since the Baseline Assessment based on chart review.

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

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

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

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

THIRD REPORT March 2014: Thus far there is little change from our previous visits. Dr. Sang has begun to make modifications in the medication treatment regimens but it is too soon to monitor the end results. One of the new forms may provide some indication that inmates are informed of medication risks and benefits.

RECOMMENDATIONS:

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

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

ASSESSMENT: NONCOMPLIANCE

MENTAL HEALTH FINDINGS SECOND REPORT December 2013: As mentioned previously, the training officer has not been available during our two site visits and no one else has access to her training records. Therefore there is no ability for the monitoring team to make any determinations regarding a level of compliance with this requirement. In addition case #9, indicates that security staff including supervisory level staff have little awareness and or training in the suicide prevention policy. This is demonstrated by security placing an inmate who was self-injurious on lockdown, failing to notify medical services and mental health services of that status, and failing to implement and document the watch requirements of the policy. In addition, security staff terminated the watch without any review by mental health.

THIRD REPORT March 2014: Based on chart review, it is evident that adequate training is not yet in place when new policies are implemented.

RECOMMENDATIONS:

1. GGACF should ensure the training officer or her records are available at the time of the next site visit for review by the monitoring team.
2. Develop, implement, and evaluate comprehensive training curricula to comply with Provision.

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

ASSESSMENT: NONCOMPLIANCE

MENTAL HEALTH FINDINGS: SECOND REPORT December 2013: Unchanged from the Baseline Assessment as follows:

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

THIRD REPORT March 2014: February 25 2014 GGACF relocated some inmates identified as mentally ill (previously housed in the unit next to long-term segregation) or vulnerable to an older housing unit, A unit. This transition is a positive step in attempting to create a physically more pleasant environment with greater potential for enhanced treatment services; however, the process by which this transition occurred indicates a lack of communication and coordination between the Bureau, security leadership, and health services. It is our understanding that Security requested a copy of the mental health caseload several weeks in advance of the move but no other information was communicated to the mental health team. Neither the psychiatrist nor the mental health coordinator was aware of a plan to re-locate inmates until they arrived at work the following Monday after the transition had been completed. Logbook entries reveal that the unit was unstaffed overnight after the inmates arrived. In addition, little has yet been done to alleviate

placement of mentally impaired inmates in segregation who may be in that placement because of their untreated or partially treated serious mental illness.

Inspection of A unit revealed a capacity of 22 inmates with a current census of 10. On entering the unit there is a small officer's station separated from the housing area by a solid door that has only a small window which does not enable visualization of the housing area by the officer. Plus, this opening currently is ¾'s sealed over by cardboard to keep the officer's station air-conditioned and is therefore useless as a security measure. Hazardous conditions exist in the housing areas. Many cells have shoelaces or wire knotted to the metal mash or door which the inmates and officer use as door handles. One positive compared to their prior housing circumstance, is the availability of air circulation and sunlight on this unit.

One man was sleeping on a totally shredded mattress which can no longer can be sanitized properly. Clotheslines were observed hanging in several cells. The dayroom area has a long strip of fabric from the padlock through a window in an external door. An easily reached electrical conduit is affixed to the wall that could secure a ligature. Cigarette butts were observed on the floor of the day room. Indeed, one man repeatedly sets fires in his cell despite this being a smoke free facility. There are stout metal grates above every cell which are open mesh where a ligature could be secured. When the inmates are in their cells or in the recreation area there is absolutely no visibility from the officer's station making this a dangerous environment for inmates and especially mentally ill inmates who may become aggressive or suicidal. Inmates in this unit are currently receiving no structured therapeutic activities.

We also walked to and inspected RSAT unit which currently houses detainees who cannot mingle with the other inmates in detention. This classification of inmate has been housed here for the last 3 to 4 years thereby eliminating the residential substance-abuse treatment program which was initially housed here. The officer who observes the inmates on A Unit also monitors inmates in this housing unit. Thus, when the officer is on one unit the inmates on the other unit have absolutely no security supervision. When we arrived at RSAT Unit there was no officer on the unit. An office is being renovated there. The door was unsecured and there were bundles of plastic coated electrical wires on the floor and readily available to the inmates. Inmates interviewed on this unit stated they were locked down in the evening after 6 or 7 PM. They were only able to recall security doing rounds on the unit 1 to 2 times a week between lockdown and 7 AM. An inmate on this unit easily became highly agitated and verbally threatening towards the mental health coordinator when speaking with the U.S. Department of Justice attorneys. Given his level of agitation, it seems particularly unsafe for him to be housed on a unit with this little supervision.
It was also brought to our attention that the facility has been on a modified lockdown since December as a security measure due to both increased inmate violence and officer sick call. 2 to 3 weeks prior to our visit we were told that an inmate was stabbed in the face. Only a few skilled inmates are allowed out to staff the kitchen or perform essential grounds activities.

The clearest example of the failure to comply with this element of the settlement agreement is the example detailed above of a mentally ill inmate who has been housed in isolation for 10 years unbeknownst to the mental health treatment team. Comprehensive assessment has begun, by the psychiatrist, with the hopes of determining whether this man can be stepped off of segregation into less restrictive housing.

Both segregation units were inspected and both had the odor of marijuana smoke. Both units were filthy, small expanded metal grates block openings in the door too small to make observation of the inmate adequate. These grates often were blocked from the inside with cardboard and other makeshift materials. The grates were covered with accumulated dust. Inmates controlled the lighting from inside their cells also hampering security observation. Most cells were further obscured by sheets hanging from the ceilings creating multiple layers of visual privacy from the officers. Considering that most suicides occur in segregation units, the presence of so much contraband and layers of concealment in these housing units is concerning. It is also unclear how inmates can continue to smoke openly in units manned by officers 24 hours per day.

RECOMMENDATIONS:

1. GGACF should develop a plan to introduce adequate programming for this population.
2. Increased out-of-cell-time and life skills activities should be considered.
3. It is also recommended that all inmates with a serious mental illness should be seen in a confidential setting at a minimum of at least monthly by a psychiatrist and also monthly by a mental health counselor.
4. Weekly mental health rounds are also required for this population to identify mentally ill inmates housed in segregation who have not been referred for mental health services by sick call request or by officer referral.
5. GGACF is a facility that demonstrates fragmented communication and lack of inclusion at the table of critical professional staff when designing and attempting to implement new housing areas and programming. This seems to be a pervasive difficulty at all levels. Even when looking at the organizational chart for health services division, it is clear that the health services administrator does not have centralized authority for the management of the health services department. Rather, all functions and employees are placed beneath the medical director. This structure is problematic in several regards.
   a. Effectively, there has been no medical director at this facility. Staff reported that Dr. Williams Hendricks is rarely, if ever, on site.
   b. Having the medical director be responsible for all personnel activities and administrative decisions for the service is a highly cost ineffective structure. The medical director should be responsible for the quality improvement program, policy and procedure development, and management and supervision of the clinical staff.
   c. The health services administrator should be responsible, at a minimum, for all personnel decisions not based on clinical performance and interface with the facility administration regularly. This would include the authority to dismiss personnel based on repetitive absenteeism, inability to follow facility policies, inappropriate behavior with inmates were staff, etc. In addition, they should oversee compliance with policy and procedure, supervise medical records, oversee pharmaceutical, equipment, and supplies availability and ordering. A directors (Medical, Nursing, Pharmacy, Dental, Mental Health) should administratively report to the HSA.
   6. These units need to be sanitized, wire grates should be replaced or removed since many are torn and have ragged metal edges. Sheets and other impediments to inmate observation should be removed.

VI. FIRE AND LIFE SAFETY

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

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

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: No change since the Baseline or second visits, previous recommendations remain appropriate. Although the Fire Marshall is involved in fire safety program planning and inspections, the fire safety program lacks the following minimum elements:

- Policies and procedures
- An adequate fire suppression system for occupied buildings
- An adequate, policy-driven and competency-based training policies, procedures or curriculum
- Quarterly fire drills for all staff
- Multiple and easily accessible fire escape doors and pathways
- Fire response breathing apparatus for officers

The lack of an adequate fire safety program is particularly troubling considering reported fire incidents. Housing unit logs examined for this reporting period found approximately 18 entries related to arson or fire related events, some duplicate entries. This is an extremely dangerous condition considering the fact that inmates continue to cause fires in their cells and housing units, are allowed to possess cigarette lighters and electrical devices with damaged electrical wires, and maintain high quantities of combustible items.

RECOMMENDATIONS:

1. Develop, train, implement, and evaluate a comprehensive life-fire safety program that includes all policy, procedure, resources, equipment, training, monitoring, and system/programming testing components.
2. Repair/replace/install fire detection and suppression systems throughout the entire campus and structures.
3. Train all staff on this plan.
4. Install SCBAs or an appropriate alternatives at all locations where staff would need to search for or evacuate people.
5. Conduct and document quarterly fire drills for all shifts and document those activities.

6. Officials must continue to critically review staffing levels to ensure adequate inmate supervision and flammable contraband control in the housing units, fire detection, response, suppression, evacuation, and incident security.
7. Additional part-time fire safety officers should be selected from the officer corps, trained, and participate in the administration of a comprehensive fire safety program. It is unrealistic to expect one expert to develop and oversee such a complex program.
8. Supervisors should conduct routine, schedule and unscheduled physical inspections of occupied structures taking particular note of fire risks and hazards, document and report those findings to administration for timely and appropriate corrective action.
9. The fire inspection program must be clearly detailed in fire safety policies and procedures, and become a fundamental element of pre-and in-service training.

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: No change since the Baseline visit, previous recommendations remain appropriate. Housing unit fire control panels remain inoperable, the primary fire suppression system remains broken, cell and housing unit sprinklers are non-functional and regularly used by inmates to support personal clotheslines.

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

RECOMMENDATIONS:

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

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: No change since the Baseline or second visits, previous recommendations remain appropriate.

RECOMMENDATIONS:

1. Refer to previous recommendations for this provision.
2. Develop and implement a valid and reliable emergency key system as described above. Train and drill staff as discussed on system use.

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

d. Regular security inspections of all housing units that 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: No change since the Baseline visit, previous recommendations remain appropriate. During this inspection, as previously described some of the Housing Unit locks were found non-functional.

RECOMMENDATIONS:

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

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

ASSESSMENT: NONCOMPLIANCE

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

RECOMMENDATIONS:

1. Refer to previous recommendations for this provision.

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: No change since the Baseline or second visit, previous recommendations remain appropriate. The fire reporting and notification system remains operable.

RECOMMENDATIONS:

1. Refer to previous recommendations for this provision.

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

ASSESSMENT: NONCOMPLIANCE

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

RECOMMENDATIONS:

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

h. Fire suppression;

ASSESSMENT: NONCOMPLIANCE

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

RECOMMENDATIONS:

1. Refer to previous recommendations for this provision.
2. Develop and implement an annual full scale evacuation exercise that involves community emergency, health, and social services responders.
3. Ensure that the fire suppression system is fully operational, regularly tested, and maintained.

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: No change since the Baseline or second visits, previous recommendations remain appropriate.

RECOMMENDATIONS:

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

should participate in the development of training related to critical incident recovery and emotional injury and recovery.

j. Control of highly flammable materials.

ASSESSMENT: NONCOMPLIANCE

FINDINGS: Inmates continue to be allowed to possess large quantities of combustible products in their cells. Although some of these items might be acceptable in a facility having adequate fire detection, response, and suppression systems and programming, GGACF conditions should not allow inmates to maintain large quantities of these items in their cells.

RECOMMENDATIONS:

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

VII. ENVIRONMENTAL HEALTH AND SAFETY

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

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

GENERAL COMMENT: Policies and procedures required under this Provision have not been provided to the Monitor or USDOJ for review and approval. However, it is important to note positive efforts made by the Territory to improve certain environmental conditions that were observed during this assessment.

In general, the housing units and most of the cells appeared cleaner; inmates and staff reported a "major effort" to steam clean housing areas. Notwithstanding other environmental improvement required in the kitchen area (broken tiles, deep cleaning of floors; equipment; vent hoods, etc.), the kitchen looked much cleaner and the tool/utensil cage was locked. Most of the housing units previously reported in need of repair were repaired, some with fresh paint. Efforts were made to provide hot water in the housing units but the water felt just above room temperature to the touch but may simply require thermostat changes. A review of the maintenance logs evidence timely inspection of generators, Greece-traps, and some lock repairs. These findings show positive effort to develop a strategic approach to improving environmental conditions and should be expanded to all facility areas and promulgated into well written policies and procedures.

1. There is no hot water in the housing units, which creates serious health and sanitation risks for staff and inmates. Take necessary steps to ensure units are provided with sanitary hot water.
2. Many sinks in the cells were inoperable.
3. Some of the toilets did not flush properly.
4. Inmates are allowed to wash their clothes and linens in the toilets and/or sinks, then hang them to dry on clothes lines anchored to inoperable fire sprinklers in their cells.
5. Standing water was found in housing units and cells. Inmates and staff state that housing units will flood during heavy rains.
6. A few shower heads remain broken, some shower stalls remain covered with mold, as were ceilings and cell-block walls.
7. Mold remains on housing unit ceilings, maintenance closets, pipe chases, recreation areas, some areas in the kitchen.
8. Housing unit temperatures will rise in the hotter season which, combined with high humidity can promote and spread infectious diseases, exacerbate certain chronic medical and mental illness, promote inmate frustration and violence, and dissuade correctional staff from leaving air-conditioned control rooms to conduct housing unit inspections, rounds, and security checks. High temperatures also pose very serious health risks to inmates on certain psychotropic medications current being administered to inmates.
9. Food trays being filled in the kitchen with food were still drying after being washed. Overall sanitation in the kitchen has improved some but remains in need of regular deep cleaning.

10. Housing unit water is essentially undrinkable and inmates are unable to access water when locked in their cells without the assistance of the housing unit officer. I was told by inmates that there are times when officers will not respond to requests for water or are away from control rooms for extended periods. This is evidenced by officer logs where officers have recorded leaving their units completely unattended to take breaks and/or where no relief officer was available. Unit logs also report a practice of "last call for water". This practice evidences that inmates do not have consistent access to potable drinking water.
11. Many of the inmate mattresses appeared old, tattered, and filthy but the Territory has purchased new mattress for distribution. Inmates and staff stated that mattresses are not routinely cleaned or disinfected during and between uses. Linens are allowed to be washed in toilets and hung to dry as previously described.
12. There is no written formal sanitation inspection and/or infection control program.
13. The facility appears inadequately staffed to provide adequate monitoring, oversight, and response to routine or emergency sanitation conditions or maintenance issues.

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

ASSESSMENT: PARTIAL COMPLIANCE

FINDINGS: The Monitor met with the GGACF maintenance director and reviewed revised sanitation and maintenance records. Although formal housing keeping and sanitation plans remain under development, this interview and records review indicated positive progress since the previous inspection. Formal plans should be completed and issued in the form of policies and post orders. The monitoring team was also pleasantly pleased to observe significant improvements in facility cleanliness. GGACF leadership report the implementation of a planned and coordinated facility hygiene program that included high-pressure washing of housing units, painting, kitchen deep cleaning, and making inmates more accountable for personal and cell hygiene. Additionally, it appeared that most of the broken shower plumbing was repaired and housing unit should seem much cleaner. These observations and reports show determined and positive effort by GGACF officials to comply with this provision and should be consistently monitored and maintained.

Most of the housing areas and cells were cleaner; fewer occupied cells were cluttered with empty food cartons, excessive personal items, and there was a noticeable decrease in the number of cell clotheslines as previously report. GGACF staff are commended for this progress and the effort involved to improve these conditions. This effort should be consistently maintained and include other housing and cells areas found unacceptable.

A tour of the juvenile housing area found vegetation growing through cell windows, dirty sinks, and rubbish about the floors. The one juvenile inmate being housing in this unit complained of "constant mosquitos" coming through the torn window screens and biting him "day and night."

The RSAT unit was in similar condition as the juvenile unit. The day room appear reasonably organized but tables were filled with unattended trash bags, Ajax cleaning power, used latex gloves. A small bathroom near the officer's stated was dirty and in need of a deep cleaning. Cells, overall, appeared reasonably organized and free of clutter but many of the sinks and

toilets were dirty. Inmates in this unit also complained of mosquito problems due to torn window screens. Shower areas were also dirty with some mold.

A Unit is now being used to housing inmates with serious mental illness but does is not an appropriate environment for this population. There is only one officer assigned to it and the RSAT who is unable to provide adequate supervision and monitoring of inmates in either units. A unit sanitation was poor overall. There was mold on ceilings, showers areas, some of the cell walls near the floor, missing exhaust fans, exposed electrical wires, and broken tile. The floor in the janitor's closet was dirty with muddy water. One occupied cell had words written on the wall with what the Monitor and the unit officer believe was human feces. Another cell emitted a strong order of something burnt. Some of the cells did not have clean mattresses, one had no mattress. Overall, this unit requires deep cleaning and repair as indicated.

RECOMMENDATIONS: Correct the following, and continue the new facility hygiene program:

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

b. Adequate ventilation throughout the facility;

ASSESSMENT: NONCOMPLIANCE

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

RECOMMENDATIONS:

1. Timely complete an air quality assessment performed by a qualified provider. Implement necessary improvements that reduce housing area temperatures and increase air flow.
2. Ensure inmates have constant access to drinkable water.

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

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

ASSESSMENT: PARTIAL COMPLIANCE

FINDINGS: The Monitor was pleased to see that all but one of the external perimeter security lights were functioning. However, many of the occupied cells remain very dark.

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.

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

ASSESSMENT: PARTIAL COMPLIANCE

FINDINGS: There has been no change since previous inspections. Additionally, inmates housed in RSAT and Intake units reported "constant" mosquito problems. An inspection of these cell areas found broken and missing cell window screens that should be replaced.

RECOMMENDATIONS:

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

2. Ensure that inmates involved in pest control activities are properly trained, equipped, and clothed for requirements of those activities.
3. Replace all missing and broken unit and cell window screens to prevent access by insects.

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

ASSESSMENT: PARTIAL COMPLIANCE

FINDINGS: Inspection of housing units, cells, kitchen, and medical areas show consistent presence to personal hygiene and cleaning supplies.

RECOMMENDATIONS: Continue to implement these recommendations:

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

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

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

ASSESSMENT: PARTIAL COMPLIANCE

FINDINGS: No change since the Baseline or second visits, previous recommendations remain appropriate.

RECOMMENDATIONS:

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

H. Develop a bio-hazardous control program that involves regular inspections of all potential contamination areas.

2. GGACF officials should consult an environmental specialist to assess these conditions and assist them in developing appropriate mitigation plans and policies.
3. This provision can advance to Substantial Compliance once related policies and procedures have been approved and implemented according to the Agreement.

g. Mattress care and replacement;

ASSESSMENT: NONCOMPLIANCE

FINDINGS: No change since the Baseline or second visits, previous recommendations remain appropriate.

RECOMMENDATIONS:

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

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

ASSESSMENT: PARTIAL COMPLIANCE

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

RECOMMENDATIONS:

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

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: An inspection of inmate cells and inmate interviews revealed no substantive improvement. Inmates continue to wash personal and issued clothing in sinks and toilets, and dry these items in their cells using make-shift clotheslines anchored to fire sprinkler heads, walls, window frames, bunks, etc. Additionally, several occupied cells revealed soiled bed linens, no linens, tattered and dirty mattress, and mattresses with no covers. This compliance score is move back to Noncompliance unit specific corrective action is accomplished:

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

RECOMMENDATIONS:

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

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: Inspection of kitchen areas found many of those areas much cleaner. Decomposing food particles observed during previous visits were removed, sink and floor cleanliness was improved, and food preparation tables appeared cleaner. Food storage areas appeared better organized and clean. However, food transport carts appeared dirty. Cold storage temperatures were within acceptable ranges. Water problems previously reported at the main kitchen door from the work side and reported electrical wire concerns were repaired.

No food temperature logs were provided to the Monitor to assess food temperatures between the kitchen and distribution. Inmates interviewed report hot meats as cold by the time they receive them, unit logs report instances of missing meals. Kitchen staff remained in their office, which is located in the kitchen area, and not involved in supervising inmates. However, there was one officer actively observing the inmate workers.

The meal menu appears to provide for adequate nutritional requirements for this population. However, inmates interviewed indicated that they sometimes don't receive medically-required special diets. The following needed improvements found during the previous inspection were similarly observed during this visit.

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

2. The male bathroom is in similar condition as the female bathroom and requires a deep cleaning. There is a dirty wall urinal, the light over the toilet area was not working, and there is cold water but no hot water. The frame separating the toilet areas is rotting at the base. There was toilet paper but no hand sanitizer found.

3. The kitchen has two large internal cooler/freezers; one of them is operational and one appears to be broken. The broken cooler has no external temperature gauge and appears to be used for non-food storage.

4. The working cooler has an external temperature gauge showing an appropriate temperature of about 47 degrees, and contains various properly stored food products.

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

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

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

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

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

RECOMMENDATIONS:

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

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

k. Sanitary and adequate supplies of drinking water.

ASSESSMENT: NONCOMPLIANCE

FINDINGS: No change since the Baseline or second visits, previous recommendations remain appropriate. Additionally, housing unit logs report instances when water was unavailable, and many of the occupied cells inoperable sinks.

RECOMMENDATIONS:

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

VIII. TRAINING

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

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

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: There has been no change since the Baseline or Second assessment reports.

The Monitor was provided several official documents during this and the December and March visits that listed current training topics, invoices for training, partial and staff attendance, a few training materials, and multiple copies of four correctional basic training topic lesson plans. Additionally, Territory officials provided copies of certain training course materials used for recruit officer training. No curricula documents were provided for review, nor any documents that allow for objective and meaningful assessment of compliance.

During this visit, the HR/Training Director was present to discuss this provision and other provisions. She indicated that the training records system remains incomplete and that assessment of topic or staff training files would not evidence compliance with this provision. She was unable to confirm when complete and accurate training program or staff training records would be available but stated that she understood that was a priority and was working hard to complete the work.

However, the Monitor has not been provided any revised policies or procedures to review; it would be impossible, impractical, and non-efficient utilization of resources to re-build the entire training curricula, if required, until all required policies and procedures are approved per the Agreement for implementation. This is not to suggest that certain critical training curriculum should not be immediately reviewed and revised to respond to certain urgent conditions. Territory officials are encouraged to determine those critical topics – focusing on security and health/life safety, and immediately begin reviewing those training plans.

Training curriculum is a total package of learning activities designed to achieve the objectives of the training program. In a competency-based system, the objective, or desired end, is that trainees will acquire the specific knowledge and skills (competencies) they need to do their jobs. There are three primary components to be examined when evaluating any training curriculum. They are:

1. the content or information to be transmitted
2. the organization of the curriculum which includes
3. structure, format, and sequencing
4. the training methods used

Training Content

Compliance requires that content include specific information, facts, attitudes, and skills to be transmitted by the training program. In a competency-based system, which is defined as "Training" in the Agreement, these are formalized in the competency statements containing measurable training outcomes. The following principles relate to training content:

1. The scope and depth of the content of any curriculum are determined by the competencies the curriculum is designed to teach.
2. Content should transmit a theoretical framework and conceptual rationale for the training.
3. Content should reflect best standards of practice.
4. Content should communicate a values orientation.
5. In an in-service training program, the content must be applicable to direct practice.
6. The content of a curriculum must be congruent and complementary both within and between sections.
7. Content must clearly distinguish knowledge competencies and knowledge application competencies.

Structure and Format

This refers to the construction of individual sections, and the organizations of the parts of the curriculum into an integrated whole. It includes the design of each section to achieve objectives, the sequencing of sections and activities, establishing time frames, and designing linkages between sections.

The sequence of activities within each section and within the curriculum as a whole should be concordant with the natural learning process and measureable learning outcomes.

Knowledge and skills that are conceptually related, or that are performed together on the job, should be taught together.

Providing a broad overview of the content early in the sequence provides a conceptual framework within which trainees can organize the parts. This facilitates retention and understanding.

Principles of sequencing are: from simple to complex, from the universal to the exception, and from fundamental to more refined applications:

1. Repeating key concepts in different contexts facilitates understanding.
2. Relating sections within a curriculum helps develop logical linkages between previous and current training content, and identify different situations in which similar knowledge and skills are applied, which helps to reinforce retention and promote generalization.

Planning adequate time to cover the content to the desired level of depth is essential. Compression of content into an unrealistic time segment limits the effectiveness of the training. It can't be done faster than it can be done.

Training Methods

Training methods are the strategies used to transmit the content and to promote learning and retention. In an in-service training curriculum, the training methods must be appropriate for use with adult learners in an applied setting. The method that is best suited to achieve the objective of the section should be selected:

1. Use presentation to quickly transmit factual information.
2. Use discussion to promote greater exploration of the information and to develop understanding.
3. Ask questions of trainees or use exercises that feed information back to the trainer to determine how well trainees understand the content.
4. Use experiential exercises to develop self-awareness.
5. When trainees have prior knowledge or preconceived ideas about the content, use an activity that challenges mindsets and motivates trainees to rethink their own beliefs.
6. Use exercises and simulations to promote application of the content to job tasks, and to develop trainee skills.
7. Use activities that identify solutions to potential barriers in the workplace and action planning to promote TOL from the workshop back to the job setting.
8. Present the same concepts using a variety of learning strategies to help ensure that trainees with different learning styles can assimilate the knowledge. Hearing, seeing, modeling, and then practicing the training content also reinforces learning for individual trainees.
9. As determined appropriate, training should be conducted in housing units or other locations where the information is applicable.

Ultimately, this provision asks for a/the training "curriculum," which has not been provided as required and possibly does not exist based on the training documents provided. The documents provided, as stated above, would not qualify as curriculum by and definition. The training materials provided appear to be outdated reading materials involving a blend of some basic and special topics. The materials provided are considered "canned" resources purchased off the internet from Lockup USA, a company that specializes in producing correctional training videos that includes study reading materials. A review of that website (http://www.lockupusa.com/). The Monitored accessed and reviewed several training videos for corrections and non-corrections staff. Although the website allowed only partial viewing of training videos, their content appeared to provide meaningful training information for basic and in-service training purposes. However, the videos nor supplemental reading materials qualify as curriculum but are considered training supplements that would support a written curriculum if it exists. The Monitor has provided Territory officials curriculum document samples for review and consideration.

Training Materials

Training materials must support the overall curriculum and expected learning outcomes. This can be achieve:

1. Ensure that training materials include all updated policies, procedures, regulations, forms and documents.
2. Ensure that training materials are current and related to subject outcomes.

3. Ensure that the materials appropriate for adult learners and support trainee learning styles and abilities.
4. Ensure that training materials support Agreement requirements and Provisions.

RECOMMENDATIONS:

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

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

Y. Training topics, content, proficiency, and hours/weeks of training is established for pre-service, in-service, and specialized training;

Z. Firearms training covers use, safety, and care of firearms and the legal and ethical constraints on their use. Training includes knowledge and performance, and is assignment specific (e.g. use of weapon in various settings, conditions, areas);

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

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

CC. Access the American Jail Association, American Corrections Association, and National Institute of Corrections training libraries for more resources for designing, developing, implementing, and evaluating policy driving training curriculum for adult learners.

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

b. Pre-service training for all new employees;

ASSESSMENT: NONCOMPLIANCE

FINDINGS: Similar findings as discussed above.

RECOMMENDATIONS:

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

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: Similar findings as discussed above. Training-related documents provided by Territory officials do not provide sufficient information and clarity to assess compliance.

RECOMMENDATIONS:

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

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: Similar findings as discussed above.

RECOMMENDATIONS:

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

IX. IMPLEMENTATION

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

FINDINGS: Territory officials have completed and submitted to the Monitor and USDOJ on April 15, 2014 a more detailed plan and schedule for policy development, training, and implementation. This newly issued plan is currently under review by the Monitor and USDOJ.

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: As stated above, a revised plan has been submitted to the Monitor and USDOJ for review and comment.

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

FINDINGS: As discussed throughout this assessment report, the Territory provided no evidence that any policies or procedures are in revision. Policies or procedures that comply with the conditions of this Agreement been not provided to the Monitor or USDOJ.

Territory officials recently submitted to the Monitor three documents intended to comply with this requirement. The documents were labeled as "memorandum" to staff regarding important security requirements. Although these documents seem to be valuable for directing staff performance, none of the documents qualify as a policy or procedure, in this Monitor's opinion.

The Monitor submitted a written objection to the Territory within the required time period and the Territory quickly responded and is currently reviewing that objection. The following objection was submitted to the Territory on April 3, 2014:

"I am providing the following "written objection" to these documents qualifying as policies or procedures per section IX 3 of the Agreement as both documents are written in similar form. As you know, section IX 3 of the Agreement states

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

Basis of Objection:

Agreement Intent and Requirements:

The Agreement was based, in part, on the stipulated Findings of Fact document that assessed several deficiencies in GGACF policies and procedures including content and format. I, therefore, interpret the requirement for "policies and procedures" in the Agreement to be documents that address and resolved related FOF findings, and would meet correctional industry standards. I do not believe these documents accomplish the intent or requirements of the Agreement for the following reasons:

1) The documents are issued as "Memoranda." Memorandums are directives that are not policy or procedure documents according to correctional industry standards. Memorandums are simply that – "memos" that advise, clarify, direct, inform, etc." Policies and procedures are specific documents having a specific format, are coded (codified), and use standard titles and verbiage. Please see the attached document regarding this industry standard from the National Institute of Corrections for the development of policies and procedures I previously emailed to Territory officials on August 12, 2013.
2) Per the Agreement, there must be training involved in the implementation of policies and procedures. Even if these documents did qualify as policies or procedures, there are no training statements described, which is a standard policy element. Have staff and supervisors been trained on the implementation of these documents? If so, what "…means to instruct (staff) in the skills addressed to a level at which the trainee has demonstrated proficiency to implement those skills as, and when called for, in the training (Section III Definitions)" were used? If staff were trained, I have not received for my "…review and approval" (VIII 1) any curricula regarding that training per Provision VIII 1 (a-d).
3) Implementation of these documents as policy or procedures also appears in conflict with the definition in Section III: **"To 'Implement' a policy means: the policy has been drafted and disseminated to all staff responsible for following or applying the policy; <u>all relevant staff have been trained on the policy</u>; <u>compliance with the policy is monitored and tracked through audit tools</u>; <u>the policy is consistently applied, as demonstrated by audit tools approved by the Monitor; and there are corrective action measures to address lapses in application of the policy</u>."** I have not received or approved any audit tools for this policy/procedure, nor have I received from the Territory any information regarding compliance or corrective action for non-compliance.

The memoranda you provided **does** show meaningful and necessary effort by the Warden to move compliance in a positive direction; the documents should be followed by official policies and procedures meeting industry standards that are implemented according to the terms of the Agreement.

Thank you. Ken"

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: The Monitor received the first semi-annual impact evaluation on January 15, 2014 as agreed. This evaluation, being the first, shows some but little progress toward complying with this requirement and is expected to improve as more progress is made. The Monitor believes that this evaluation is welded to the implementation schedule; evaluation contents should be supportive and reflective of the implementation schedule, which has not yet been adopted.

The Monitor has provided the Territory verbal and written technical assistance as required above; Territory officials and the Monitor continue to maintain a positive and collaborative relation on this matter.

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 not submitted to the Monitor any requests, proposals or recommendations to modify policies, procedures or the plan. The Monitor looks forward to reviewing proposed changes and provided requested technical assistance if requested. It is believed, however, that the creation of a better development implementation plan will greatly facilitate the Territories compliance with this requirement.

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

FINDINGS: The first four-month report was timely filed on January 15, 2014 as mutually agreed by the Monitor and the Parties.

Report format is adequate and easy to read. It appears to include all substantive provisions and progress statements were applicable, but does not include progress statements for the requirements

in Section IX Implementation but should. This requirement uses the term "provision" versus Substantive Provision. Therefore, the Monitor interprets IX.6 to require the four-month progress report to include actions taken to report progress for all requirements provided in the Agreement.

Despite the fact that the deadline has passed, the Monitor has not received the second four-month report and did not find it filed in PACER ECF.

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: Territory counsel notified the Monitor and DOJ officials of two such incidents via email during the monitoring period:

1) Inmate stabbing (01/10/2014), incident reports emailed on 01/16/2014, health and investigative reports were not provided to the Monitor.
2) Suspected assault of and inmate report (01/12/2014), incident reports, logs, and medical records were provided to the Monitor on January 28, 2014. This notification states that this event occurred on 01/08/2014 and that delay in notification was because it was not timely reported to the Warden or the Director, but was under investigation.

An examination of housing unit, supervisor, and incident report logs for this reporting period indicate several events that may have needed to be reported under this requirement. For example, housing unit logs for this reporting period report an estimated 59 medical-related events, 6 suicidal or self-harm events, and 7 inmate assaults.

Inconsistent reporting methods, lack of continuity between these logs, and lack of clarity in GGACF reporting practices make it very difficult to verify which events should have been reported.

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

FINDINGS: Territory officials appear to be making reasonable, albeit slow, progress in meeting this requirement.

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

FINDINGS: Territory officials provided reasonable access to the facility and staff during the baseline visit. Several log books and other documents were ready for review by the Monitor and USDOJ on the first day of visit and during its duration.

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

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