IN THE DISTRICT COURT OF THE VIRGIN ISLANDS

DIVISION OF ST. THOMAS AND ST. JOHN

CARTY, ET AL.,)) Plaintiffs,)) vs.)) GOVERNOR DEJONGH, ET AL.,)) Defendants.) _____)	CASE NO. 94-78 **REPORT OF PLAINTIFFS' EXPERT STEVE J. MARTIN** March 23, 2009

I. INTRODUCTION

I have been asked by plaintiffs' counsel to provide testimony as an expert witness on behalf of prisoners confined to the Criminal Justice Complex (CJC) and the CJC Annex, St. Thomas, Virgin Islands. Specifically, I have been asked to render observations and opinions regarding security and corrections conditions at the CJC and the Annex.

II. QUALIFICATIONS OF THE EXPERT

My general qualifications as an expert in the field of corrections are set forth in my *Curriculum Vitae,* attached hereto as Exhibit 1. I began my career as a correctional officer in 1972 at a maximum security prison (Ellis Unit) operated by the Texas Department of Corrections (TDC). I also worked as a correctional officer at the single TDC prison for female felony offenders (Goree Unit). I subsequently served as a casework intern with the Federal Bureau of Prisons at the Federal Correctional Institution, Ft. Worth, Texas. While employed as a Federal Probation and Parole Officer in McAllen, Texas (1975-1977) I served on a jail planning commission for Hidalgo County, Texas. During my employment in the Tulsa County District Attorney's Office (1980) I was assigned

the Civil Division to assist the county attorneys defending the Tulsa County Sheriff on matters related to the operation of the county jail, including a class action jail conditions lawsuit.

In 1981 I rejoined the TDC in the Legal Counsel's Office and ultimately served as General Counsel and chief of staff operations for the Director. In my service with the TDC, I was involved in the development of policies and procedures in the areas of classification, administrative and punitive segregation, inmate disciplinary procedures, use of force, special needs prisoners and other operational issues. Much of this work related to compliance with court orders in *Ruiz v. Estelle*, a system wide conditions lawsuit brought by the prisoners and the U.S. Department of Justice. In my capacity as General Counsel, I was directly responsible for formulating and coordinating TDC's response to all compliance monitoring reports filed with the court by the Special Master. During the course of this work, I routinely conducted site inspections and conferred with facility and central office managers regarding implementation of the remedial plans.

As an independent corrections consultant (1987 to present), I have been retained on many occasions as a corrections expert by the U. S. Department of Justice, Civil Rights Division, related to a wide variety of correctional management issues; by both defendants' and plaintiffs'' counsel in numerous cases; by federal courts; and by a variety of state and local governmental entities. I have made well over 500 site inspections to jails and prisons in more than 35 states, Puerto Rico, Guam, Saipan, Jamaica, and Northern Ireland. I am currently serving as a court monitor for litigation related to crowding in the Mississippi Department of Corrections, and as a court appointed expert involving conditions of confinement in the Broward County, Florida jail system. I recently completed service on the Travis County, Texas Citizen Bond Advisory Committee and chaired the Sub-Committee on Jails in which we made recommendations adopted by the Travis County Board of

Supervisors on the expansion of jail beds for the county jail system. I have served as a federal court monitor in cases involving two other state prison systems (Arizona & Montana) and two large metropolitan jail systems in New York (New York City and Long Island). I am also presently involved in jail litigation in Illinois, New York, Georgia, Washington, Oklahoma, Michigan and California. Over the years of my work, I have been involved in jail conditions cases in well over half of the twenty largest jails in the U.S.

I have been qualified as an expert in the field of corrections and have testified as such on more than fifty occasions, mostly in federal courts. I am co-author of Texas Prisons: The Walls Came Tumbling Down, (Texas Monthly Press, 1987); and contributed to Courts, Corrections, and the Constitution (Oxford University Press, 1990) and Building Violence: How America's Rush to Incarcerate Creates More Violence (Sage Publications, 2000). I have published numerous articles related to correctional issues in law reviews and professional journals. I have also served on the adjunct or visiting faculties of six universities, including the University of Texas School of Law.

III. PUBLICATIONS AUTHORED BY THE EXPERT WITNESS

A listing of publications I have authored/co-authored may be found at pages 11-12 of my *Curriculum Vitae*, attached hereto as Exhibit 1.

IV. TESTIMONY AS AN EXPERT WITNESS AT TRIAL OR DEPOSITION

A listing of cases in which I have testified at trial or deposition within the preceding four years is attached hereto as Exhibit 2.

V. COMPENSATION

I am being compensated at a rate of $175 per hour for in-office work and $1500 per day for work performed on-site.

VI. DATA AND OTHER INFORMATION CONSIDERED IN FORMING OPINIONS

In preparation for a site inspection of the CJC and the Annex, I received and reviewed the following documents: 1) *Carty v. Farrelly,* Settlement Agreement and related remedial orders; 2) *Carty v. DeJongh,* Hearing on Motions, June 2, 2008 (with attachments); 3) *U.S.A. v. Territory of Virgin Islands,* Defendant's Status Reports, August 2008 thru October 2008; 4) "Monthly Population Report," CJC & Annex, May 2007; 5) Bureau of Corrections (BOC) "Detainee Policy Handbook," March 2004; 6) Jeffrey L. Metzner reports, October 31, 2007 and May 15, 2006; 7) James J. Balsamo report, February 9, 2005; 8) correspondence of Benjamin A. Currence, March 13, 2006 (with attachments); 9) correspondence and grievances of Burton Fahie, 2007-08; 10) Virgin Islands Detension [sic] and Correctional Facilities, "Initial Custody Assessment Scale"; 11) various news articles re Bureau of Corrections, 2006-2008. From November 17-20, 2008, I conducted site inspections of the CJC and the Annex. During the four days of site work I was given access to all areas of both institutions. I was allowed to interview both staff and inmates during the course of my inspection work. Moreover, I was given access to both facility and inmate records. I met with a variety of BOC officials including the acting Director and acting Assistant Director, acting CJC Warden, CJC Chief of Security, CJC Chief of Programs and the nursing administrator.

My observations and opinions in this matter are based on my study of the above materials; the site inspections; my thirty-seven years experience in the field of corrections, national and state standards, guidelines and regulations; policies and procedures related to the confinement of incarcerated persons; and professional/legal/scholarly literature on conditions of confinement.

Should I receive further documents and materials related to this matter, I reserve the opportunity to supplement this report accordingly.

VII. OBSERVATIONS AND OPINIONS

The following observations and opinions are presented under five topical headings as follows: A) Facilities Overview; B) Departmental and Facilities Management; C) Staffing/ Training; D) Facilities Security; and E) Prisoner File Reviews. I refer to provisions of the Settlement Agreement and remedial orders, as well as the Court's contempt decisions, where applicable.

A. Facilities Overview.

1. CJC Facility. The CJC is located on the third floor of the Alexander Farrelly Criminal Justice Complex building in St. Thomas. The jail has a rated capacity of 97 prisoners. The majority of prisoners at the CJC are pre-trial detainees. The prisoners are housed in seven "clusters" ranging in capacity from ten-twenty per cluster. There are dedicated clusters for female prisoners, mentally ill prisoners and new admissions. One of the clusters also serves as housing for prisoners in administrative or disciplinary segregation, although prisoners can be placed in segregation in any housing unit. Prisoners are typically housed two per cell including those housed in administrative or disciplinary segregation. The facility does not have/utilize dedicated single cells for special needs prisoners such as suicide risks, mental health observation, or the immediately assaultive. As of November 17, 2008, the population was 81 prisoners. As will be discussed below, physical plant security deficiencies are prevalent throughout the facility.

2. CJC Annex. The Annex, located approximately two miles from the CJC, is a free-standing multi-story complex with perimeter security fencing surrounding the entire complex. It contains a large outdoor recreation area immediately adjacent to prisoner housing. It has a rated capacity for 80 double-celled prisoners. It contains three main housing units, A thru C. Currently, only two of the three units (A&B) are occupied. Unit A is a two-tiered direct supervision cell block while Unit B

contains seven cells, each equipped with a shower inside the cell. Unit C is a multi-occupancy housing area which is furnished with spatially dense double bunks. According to facility officials, Unit C is designated for federal detainees. It has a fixed security observation post but observation sight lines are obscured by the spatially dense double bunks. As of November 17, 2008, the population of the Annex was 23. As will be discussed below, security deficiencies are prevalent throughout the facility.

B. Departmental and Facilities Management.

The BOC is a division of the Department of Justice. The director is a non-cabinet position subordinate to the Attorney General. However, a 2008 law signed by the Governor created a Department of Correction (DOC), whose cabinet-level director will report directly to the Governor. Pursuant to the law, the DOC will begin operations in October 2009. The new management structure is certainly more typical of those utilized by most state correctional systems in the U.S.

Currently, the BOC is headed by an acting director who assumed his office on October 1, 2008. The acting director, Julius Wilson, is a career corrections professional who was formerly employed by the Ohio Department of Rehabilitation and Correction (ODRC). He is an experienced corrections manager having worked in the ODRC in a wide variety of administrative positions including having served as a warden of ODRC facilities.

Despite the existence of a new management team, the lack of adequate management and leadership has contributed to the dangerous operations and conditions at the jail, as described throughout this report, that pose an unreasonable risk of harm to the prisoners.

In an interview with Director Wilson it was evident that he had begun a number of initiatives that while critical were not a product of an as yet developed set of organizational priorities. For

instance, he had started incremental development of badly needed policies and procedures for the department but had not yet initiated a staffing analysis for the CJC or Annex notwithstanding the serious staffing deficiencies in both facilities (see below). While this staffing issue looms as a serious problem for the current population, Director Wilson stated his intention to start transferring mentally ill prisoners to these facilities from other off-island facilities, an action that if taken prematurely could very well aggravate management of these facilities.

While we were on-site, we were provided a copy of a Memorandum (November 19, 2008) from the Director to the Warden (who manages both facilities) enumerating a list of tasks to be accomplished at both facilities by December 14, 2008. Aside from whether these tasks could be completed in less than thirty days, the list of tasks appeared to be haphazardly compiled, because it contained what appeared to be an almost random list of items. Some physical plant items on the list were cosmetic while others involved critical safety issues. For instance, the list treated similarly the need to purchase a flag post and the need to replace fire escapes. Some items involved significant management moves that implicate serious supervision issues, e.g., moving "executive staff to annex." Most importantly, the Memorandum didn't begin to capture deficiencies observed at both facilities during the site inspection that should have been given significant and more immediate priority than any number of the enumerated tasks set out in the memo. For example, any number of cellblock and central control panels at both facilities are not functioning properly while a cellblock in the Annex (Unit A) has two cells with inoperable locking mechanisms such that if the control panel became inoperable the doors simply could not be opened (see below, Facilities Security). In this same cellblock, officers who have no radios are supervising prisoners in a cellblock with inoperable phones, which creates the possibility that the officer(s) will be totally isolated in the event of an

emergency. The tasks compiled for the memo certainly were not the product of an orderly/systematic audit intended to identify on a priority basis emergent or critical management/physical plant deficiencies. Having spent over three days on-site observing a litany of security deficiencies, it is clear that a high priority should be given to conducting a comprehensive security audit of both facilities.

One of the most important responsibilities of the BOC director is to ensure that a facility management team is in place that is advancing departmental missions. A former lieutenant was recently named acting warden of the two facilities. He clearly is very much engaged in making improvements to the operation of the CJC and the Annex. However, he has yet to develop a set of organized priorities to begin to advance systematic and much needed improvements to the overall operation of the facilities. More importantly, he does not yet have in place a management team that can actively advance his mission objectives. It is evident that his Chief of Security, a critical management position, is openly resentful of the Warden having been promoted over him. I understand this Chief has resigned since my site visit, and I understand he has not yet been replaced. His current Chief of Programs was unable to describe her duties in any substantive detail, which may explain why there are virtually no program activities ongoing at either facility. Plaintiffs' counsel asked for an associated job description for this position, and the BOC was reportedly unable to produce one.

Another critical departmental function is to ensure the development and implementation of a sound operations infra-structure. A comprehensive set of policies and procedures/operations manual is the touchstone for management of any confinement facility. The Agreement requires Defendants to establish policies and procedures, which must be available to all staff and reviewed annually and

updated as necessary.[1] As aforementioned, the facilities are operating without a comprehensive and updated operations manual. They operate without a sound inmate classification system. For all practical purposes, they operate without such critical components as functioning inmate disciplinary and grievance systems. There is virtually no in-service training for officers. They have no identifiable system for information management and do not even compile basic data such as monthly reports that capture key performance indicators. Such reports would provide data on staffing (vacancies, overtime, double-shifting), prisoner population (admissions/releases), prisoner classification (by custody category), prisoner assaults, staff use-of-force incidents, contraband, program participation, grievances, and medical care.

The BOC does not have a separate budget, or separate personnel or finance divisions. Rather, all recruitment and budgeting is handled by the Department of Justice's personnel and finance departments. This arrangement has caused serious problems in BOC operations. The lack of a working relationship between BOC management and the Department of Justice's personnel department has led to longstanding problems in recruiting and hiring personnel for the CJC and CJC Annex. Some of these problems are outlined in the expert reports prepared by Jeffrey Metzner, M.D., which I have reviewed. Both Mr. Wilson and Mr. Herman acknowledged that there continue to be problems in completing the hiring of staff through the Notice of Personnel Action (NOPA) process. They said they did not know exactly how many vacant, funded corrections positions they have for the CJC and CJC Annex.

Mr. Wilson told me he had not hired additional administrative staff or completed a written transition plan to guide the BOC as it becomes a separate, cabinet-level department. I would

[1] Agreement ¶VI.A.1.

strongly recommend that Mr. Wilson and BOC leadership devise such a plan, and hire all necessary administrative staff so that this transition can go smoothly.

Another essential element of appropriate management is a system to investigate potential officer misconduct and alleged incidents of excessive force against prisoners. There is no such system in place in the BOC. Defendants state in their response to Plaintiffs' September 10, 2008 document requests that no officers have been referred to the Virgin Islands Department of Justice for a misconduct investigation over the past three years, and only one officer has been disciplined.

I have described in the Prisoner File Review section several excessive force and improper restraint episodes where there was no documented investigation conducted. I have provided below some examples of other incidents of potential officer misconduct that did not result in a documented investigation or discipline:

> • On Mar. 15 2008 Sgt. Lettsome called Chief Donovan and told him that Dep. EJ was acting strangely. "She said that she told Chief Donovan that CO [EJ] is looking to hit inmates with plates . . .in Cluster 1. She said that Chief Dale Donovan's response was okay."
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> • On Apr. 23, 2008, Sgt. Warner told Lt. Bridget Todman that Dep. EJ slammed the cluster 3 & 4 door on him. Lt. Todman told Sgt. Warner to relieve Dep. EJ and have him "sit on the bench up front."
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> • On May 18, 2008, "CO [GR] reported to the control CO Julian Lettsome and said signed him out and rest[ed] down clusters 3 + 4 keys and left the institution, unbeknownst to supervisor Sgt. S. Green."

Contraband, such as cell phones, is rampant at the CJC. There are few recorded shakedowns, and no documented internal investigations that have attempted to determine how the contraband has entered the facility, and what involvement, if any, staff members have had in these incidents

C. Staffing/Training.

There are many provisions of the Settlement Agreement and the Court's remedial orders that are designed to ensure that the jail has adequate staff trained to provide security and supervision to its prisoner population. The Agreement requires that by November 1, 1994, housing officers conduct fifteen minute checks of the housing units, and record their checks in unit logs.[2] In 1997, the Court held Defendants in contempt of this provision of the Agreement, and found that the officers' failure to monitor the housing units through on-site rounds, the severe overcrowding at the CJC, and the Defendants' failure to implement an objective classification system had resulted in numerous violent assaults at the jail.

In January 2001, the Court ordered Defendants to hire and retain sufficient custody staff to provide for the health, security and safety of all prisoners; to respond to emergencies; to appropriately monitor prisoners; and to permit for foreseeable illness, vacation, attrition, and training.[3] The Order also required Defendants by April 5, 2001, to hire an additional twelve officers to work at the CJC and Annex.[4]

In 2003, the Court again found Defendants in contempt of the Agreement's supervision provision and of its 2001 staffing order, finding that "the jail remains dangerously under-staffed, despite this Court's Order."[5] The Court cited Mr. Balsamo's testimony that during his most recent site visit "[c]orrectional officers were seen moving from one cluster to cover in another cluster and

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[2] Agreement, ¶VI.A.3.

[3] *See Carty* Jan 31, 2001 Order.

[4] The Agreement likewise requires Defendants to provide documentation on staffing and recruitment. *See* Agreement ¶XI.F.

[5] *Carty*, slip op. at 44.

there were not enough officers to properly man the cluster control room," and that prisoners continued to be "left unattended, either locked in their cells or in housing unit day rooms with other prisoners."[6]

The jail remains seriously understaffed, which endangers the lives and safety of its prisoners. During the site work, I observed any number of clusters with no assigned officer present either in the unit or the control office, leaving the prisoners in these units unsupervised. This extremely dangerous security breach puts the lives and safety of prisoners at risk. Because there are too few officers to provide utility support (escorting, visitation, recreation, etc.) cluster officers often perform tasks other than cellblock supervision, which take them away from their assigned posts, leaving prisoners in those clusters unsupervised. Also, two officers are routinely assigned to manage four clusters (3&4 and 5&6). This also creates an unacceptable security risk, particularly when the cluster officer must leave the control office unattended. For example, the following May 11, 2008 incident is described in the Main Control log:

> • Inmate KR came out of cluster #4 after CO Clarke was leaving with the food cart and got in an altercation with officer Clarke. CO Clarke went to clusters 5 & 6 control to get assistance from officer John Aymer when inmate KR went into the officers control and hit the cluster #4 doors and all the inmates came out and started to fight with the officers.

The dangers of leaving mentally ill Cluster 3 prisoners unattended is particularly acute. Nevertheless, the officer assigned to that cluster is not only also responsible for Cluster 4 prisoners, he also has duties that require him to leave the control office, leaving the Cluster 3 prisoners periodically unsupervised and unobserved.

The dangers from the under staffing in Cluster 3 is also exacerbated by the periodic

[6] *Carty*, slip op. at 44-45.

overcrowding and triple-celling in that unit, which has been documented by the Court and by mental health expert Jeffrey Metzner, M.D.

In his October 2007 report, Dr. Metzner documented one particular episode involving inmate CP, a seriously mentally ill prisoner with a long institutional history of assaulting fellow prisoners and staff. Inmate CP was able to open his locked cell door after evening lockdown and enter the day room while the assigned officer was absent from the control office.

Given the understaffing, officers are routinely required to work double shifts. A review of cluster logs revealed the following examples:

The following deputies worked 16-hour shifts in Clusters 5&6, April 1-14, 2008:
Deputy Nibbs worked a 16-hour shift on April 1, 2008
Deputy James worked a 16-hour shift on April 2, 2008
Deputy Brooks worked 16-hour shifts on April 15-16, 2008
Deputy Blyden worked 16-hour shifts on April 16, 24, 2008
Deputy Clarke worked a 16-hour shift on April 18, 2008
Deputy Kennings worked a 16-hour shift on April 21, 2008

The following deputies worked 16-hour shifts in Cluster 1, June-August 2008:
Deputy Clarke worked 16-hour shifts on June 26-28, July 5,20,25, 2008
Deputy Foy worked a 16-hour shift on June 27, 2008
Deputy Lettsome worked 16-hour shifts on June 29, July 13, 2008
Deputy Brooks worked 16-hour shifts on June 20, July 11-12, August 8,11, 2008
Deputy Blyden worked a 16-hour shift on July 29, 2008
Deputy Shaw worked a 16-hour shift on July 9, 2008
Deputy James worked 16-hour shifts on July 21 & 23, 2008
Deputy Harrigan worked 16-hour shifts on August 8-9, 2008

The following deputies worked 16-hour shifts in Clusters 3&4, June 8-12, 2008
Deputy Blyden worked 16-hour shifts on June 8, 11&12, 2008
Deputy Rodriguez worked a 16-hour shift on June 9, 2008
Deputy Francis worked a 16-hour shift on June 10, 2008

Aside from such routine double-shifting evidencing chronic staff shortages, security is obviously compromised through officer fatigue, boredom, and inattentiveness. Moreover, officers who very

often work double-shifts are more prone to utilize sick leave, thus furthering cycles of staff shortages.

It is alarming that while officials are acutely aware of staffing shortages, they are not managing or compiling information to establish the extent and nature of the shortages and the concomitant impact they have on the risks of harm accruing to the prisoner population (see below, Prisoner File Reviews). While I was on-site, facility officials were unable to produce any cumulative or performance data on staffing. They could not produce a master roster or routinely reported data on vacancies, new hires, etc. (compare Exhibit 4 as an example of a monthly staffing report for the Golden Grove Adult Correctional Facility (ACF)). I was provided a daily staffing roster that was undated and failed to reflect to which shift it pertained.

As stated, BOC leadership has failed to devise a staffing plan for either facility. Development of a staffing plan involves a highly detailed, time-consuming analysis of staff duties and prisoner activity throughout the jail. The Director told me he has asked the acting Warden to devise a staffing plan for both the CJC and the CJC Annex. The Warden acknowledged he had never developed a staffing plan before, and he asked me what should be his first steps to devising a plan. The Warden also has a heavy burden of day-to-day responsibilities in managing the jail's operations. Given these facts, I would strongly encourage BOC leadership to follow the path of many other corrections systems administrators and hire an outside consultant with substantial experience in this field to devise a detailed staffing plan for the CJC and CJC Annex. Without a comprehensive and detailed plan, the understaffing at the CJC and Annex will continue to endanger prisoners' health and safety.

The Agreement requires that all new officers receive 4 hours of orientation training and 120 hours of training during their first year, and that all employees receive 40 years of annual in-service

training, covering the full range of their duties.[7]

As aforementioned, the CJC and Annex officers are provided no in-service training. One officer with whom I spoke had not received any in-service training for over five years. In-service training is an essential component of a confinement operation. Annual training provides not only refresher coursework, but equally important, ensures that revised/new practices, policies and procedures are incorporated into the operation. In questioning officers during the site work it was painfully obvious that areas usually addressed with an in-service training program are dangerously lacking. For instance, very few of the officers I interviewed knew how to operate emergency equipment like the "Scott Air-Pack" (emergency breathing apparatus). Without in-service training records, it is near impossible to determine which officers have such mandatory refresher training (first aid, CPR, fire and emergency procedures, use of force tactics, etc.). Given the lack of training, it is not surprising that I found a number of incidents where officers used improper control techniques, and misused restraints, on prisoners. Some of these incidents are describe under the Record Review section, below.

D. Facilities Security.

1. Security Systems. There have been longstanding problems with inoperable security systems at the CJC and CJC Annex, as documented in the Court's 2001 and 2003 contempt decisions. In order for essential security systems (locking mechanisms, door control panels, surveillance equipment, etc.) to remain fully functional, facilities must have both maintenance repair and preventive maintenance programs. There was no evidence that the CJC and Annex have either. The acting warden stated that the facilities at the time of the site work had been without maintenance personnel for over a month.

[7] Agreement ¶VI.D.

Evidence of a totally non-functioning maintenance program was seen throughout both facilities. The following list identifies only a sampling of faulty or inoperable security systems observed during the site work. A comprehensive security audit would no doubt reveal substantially more problems.

- Main Control Panel @CJC not fully functional
- CCTV Panels in Main Control @CJC not fully functional
- Control Panel for Clusters 1&2 @CJC not fully functional
- Main Control Panel @Annex not fully functional
- Unit A @Annex had two cells with inoperable locks
- Perimeter fencing @Annex not maintained

Each of these systems is essential to providing adequate safety and security to the jail's prisoner population. Without functioning control panels, deputies must manually lock and unlock all cell doors individually. This poses a grave risk to prisoners and staff in the event of a fire or other emergency at the jail that would require moving the prisoners quickly out of the unit. Also, CJC prisoners have been able to "pop" open their locked cell doors, and the absence of cell indicator lights in both panels means that they may be able to do so without being detected by deputies assigned to the units. This is a particularly serious problem in Clusters 3 and 6. In Cluster 3, which is designated to house the most seriously mentally ill inmates, the officer cannot see the back two cells of the cluster from his post. In Cluster 6, which is designated to house segregation prisoners, the officer cannot see activity in the back six cells of the cluster from his control office. Below are examples on prisoners in these units opening their cell doors without being detected by corrections staff:

- Prisoner DC was housed in Cluster 6 on special security measures during his entire stay at the CJC. On August 27, 2007, prisoner DC picked his cell lock and entered the day room. Several officers filed incidents reports, stating that DC was "physically restrained" and placed back in his cell. Sgt. Warner wrote that he hurt his elbow and knee as DC fought being placed back in his cell.

- On May 25, 2008, DC again picked his cell lock and was seen by the cluster officer in the day room. Sgt. Warner wrote an incident report that day stating

> that it appeared DC was sharpening a piece of Formica in the cell gate of Cluster 6, Cell 3.
>
> • Prisoner CP is mentally ill, and has a long history of assaulting fellow prisoners and staff during his numerous stays at the CJC. On July 11, 2007, Dep. James wrote the following in an incident report: "at 5:40am I left the Cluster Control to use the bathroom at the front lobby area. When I returned I saw inmate [CP] walking about the Cluster. He picked the cell gate door lock and came outside the cell."

The monitors for the jail's closed circuit monitoring system are located in Main Control. The officers who work the Main Control post told me they have not received orders on their duties to monitor activity on this system. They also say that the videotapes in the system are never replaced, they do not record, and they are not kept. Several officers on this post were unaware if the taping system even worked. Plaintiffs' counsel previously have asked for videotapes of particular incidents at the jail, and were told that no such tapes exist. Their last request for tapes was prompted by an alleged beating of prisoner CC by several officers in August 2007. Defendants' response was that the tapes were not available either because (1) the recorder was not working, (2) no tapes were available, or (3) the tape had been reused and the incident "taped over."

2. Security Breaches. Serious security breaches were observed throughout both facilities. It is plainly evident that the absence of proper operating procedures and security inspections/audits has resulted in fundamentally un-secure facilities. Security and control of a confinement facility can be divided into the following general categories: a) current security manual; b) control center security; c) current post orders; d) controlled access to secure areas; e) contraband control; f) key control; g) control of tools and equipment; h) firearms and equipment control; i) perimeter security; j) control of entrance and exits; k) controlled access to support service supplies/equipment (food service and sanitation articles/materials). During the course of the site work, I observed breaches that would fall

within each and every category. The following list is a sampling of the more serious breaches observed. Such breaches can and often do result in risks of harm to both staff and prisoners.

- No security manual or schedule of security inspections at either facility
- No post orders at either facility
- Prisoner allowed in Main Control @ CJC
- Entry door of Main Control @ CJC propped open with water bottle
- No reliable system for key control @ CJC
- No reliable system for weapons control @ CJC
- Emergency telephone numbers not available from Main Control @ CJC
- Open access to supply closet @ CJC
- Primary security doors @ CJC left unsecured without officer supervision
- No backup access to armory @ CJC
- No reliable system for key control @ Annex
- Entry key to Unit C @ Annex lost
- Lockbox for weapons in Main Control @ Annex not fully secure
- Inoperable radios and phones @ Annex
- Inoperable cell door locking mechanisms @ Annex
- Perimeter fencing @ Annex not secure

I was able to identify these problems through nothing more than a cursory security review. It was clear that CJC management did not have in place a process to regularly inspect their security systems and physical plant. I spoke with Warden Hansen about the need for such inspections, and he agreed that they should be implemented.

E. Prisoner File Reviews. While on-site I reviewed more than forty prisoner files. These particular files were selected based on information collected and assembled by plaintiffs' counsel. The observations and opinions set out below are based on my detailed review of each of these files in combination with the observations and opinions set out in Section VII. A thru D, above. Rather than provide individual digests of some forty file reviews, I have elected to utilize four operational components of essential facility management, all of which directly relate to prisoner protection from harm issues, i.e., systemic failure by BOC personnel to properly manage these components will result

in needlessly heightened risks of harm to prisoners. The four components are as follows: Prisoner Classification, Staff Use of Force, Management of Special Needs Offenders, and Prisoner Disciplinary and Segregation Practices. Each file review (by prisoner initials) will be placed within one or more of these component headings with a brief narrative of observations or opinions in an attempt to establish its relevancy. The patterns and practices that emerge from these reviews in combination with the deficiencies set out in the previous sections illustrate significant and pervasive risks of harm to prisoners confined at both facilities. Many of these deficiencies likewise subject staff to an unsafe work environment.

1. Prisoner Classification and Population Management. Classification is the primary management tool employed by correctional personnel to identify custody, security, and programming needs of detainees based on reliable factors in order to safely house and supervise them, e.g. gender, age, enemies, offense seriousness, escape risks, institutional risks, special needs, programming needs, etc. The Agreement requires the Defendants to establish an objective classification system, consistent with National Institute of Corrections (NIC) Guidelines.[8]

There was little if any evidence through the file reviews that personnel are routinely classifying/reclassifying the prisoner population. Very often there is simply no evidence that any classification had been conducted. There is no system in place to separate enemies either upon reception or based on incidents occurring after reception. Inmate-on-inmate assaults occur frequently and with impunity. These incidents are poorly documented, and often are only recorded in the unit logs, rather than in incident reports filed in prisoners' records. The following incidents are illustrative of harm and risks of harm that can be attributed in varying degrees to the near-arbitrary housing of

inmates at both facilities.

- Prisoner RB: assaulted by three prisoners and was thereafter housed with one of the three; no separation orders located in RB's file. RB subsequently in another fight and again no separation orders or notation in his file. No record of RB having been classified.

- Prisoner EB: undated and incomplete classification form in file. Unit log documents assault incident involving EB but no record or incident report in file. Involved in another assault in which he sustained laceration to left eyebrow; no record or incident report in file.

- Prisoner CC: no initial classification form in record; on August 28, 2007, filed a grievance asking to be moved to another cluster because he was having problems with inmates in his cluster; no written response in the file; on November 15, 2007, filed a similar grievance asking to be moved from Cluster 4 to Cluster 2, but no written response in file; two days later, filed another grievance complaining that he had been moved to Cluster 6, where he had an enemy, and asking to be moved to Cluster 2; again no written response; CC has been involved in at least three altercations with other inmates, but no corresponding incident reports are in his record.

- Prisoner MC: requested move from cellblock due to his cooperation with police; three days later was stabbed at his cell front when prisoners released to shower.

- Prisoner DD: had three recent incidents of assault none of which was reflected in his classification documents.

- Prisoner JG: was involved in a "big fight" on March 3, 2008 according to a unit log, but no corresponding incident report is in his file; ten days later he and another prisoner assaulted a detainee. While an incident report was in the victim's file there no corresponding report in JG's file.

- Prisoner WH: no initial classification form for WH; on October 5, 2007 he was accused of assaulting another prisoner; although an investigation report was completed it, neither it nor any incident or disciplinary reports were placed in his file; on October 27, 2007, WH and three other prisoners committed another assault.

- Prisoner RL: on February 7, 2008 a prisoner reported that he was having problems with RL; officers took no action and two days later RL assaulted the prisoner with a weapon.

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[8] Agreement VI.A.2.

- Prisoner LL: LL has repeatedly been involved in altercations with other detainees and has never been designated for special management.

- Prisoner PM: there is no classification record in his file; he has been involved in two altercations, neither of which is reflected in his file.

- Prisoner MO: there is no initial classification record in his file; on June 11 and June 20, 2008, MO was involved in altercations; he was placed on lock down for one week after the first altercation; his file contains no incident report, investigation form, or documentation of a disciplinary hearing connected to these two incidents.

- Prisoner TP: this prisoner has engaged in behaviors indicating possible mental health issues (eating cellmate's court papers and flooding cell); however, these incidents not reflected in his file or incorporated into a classification process.

- Prisoner TW: there is no initial classification record on file; there are no classification/incident report in his file even though he was involved in two assaults within a matter of days in June 2008.

- Prisoner RW: prisoner involved in multiple altercations with no information in his file or those he assaulted. After one of the fights, he was placed in the same cellblock with a prisoner with whom he had earlier assaulted.

The Agreement also requires the Defendants actively to manage its prisoner population, to "seek pre-trial detention alternatives, reduce bails, and to offer sentences of time served for prisoners charged with misdemeanors and non-violent offenses." There is little evidence that officials have actively managed the prisoner population. Some prisoners apparently have been held longer than their maximum possible sentences awaiting trial on minor charges, while other prisoners have been held in excess of one year awaiting trial.[9]

[9] For example, the following are illustrative cases from the October 2008 population report: Prisoner AW has been incarcerated for 103 days on a disturbance of the peace charge, a crime that carries a maximum sentence of 90 days. *See* 14 VI Code Ann. § 622. MB has been incarcerated since January 3, 2005 (1376 days) on second degree assault and destruction of property charges. JJ has been incarcerated for 133 days on a simple assault charge, a crime that carries a maximum 6 month sentence. *See* 14 VI Code Ann.299.

Under the Settlement Agreement, Defendants must make jobs available to sentenced and long-term detainees.[10] Given the understaffing and serious security breaches that plague the jail, providing jobs and programs to prisoners is an important population management tool that can reduce idleness and the serious threat of prisoner-on-prisoner violence. The CJC Annex used to offer work programs which allowed Annex inmates to work off-site for a number of public employers. On March 16, 2007, prisoner HC, a CJC Annex inmate with a history of gun violence and a pending immigration hold, walked away from his job at the Public Works Department.[11] BOC officials waited five days to announce the escape to the public, and corrections staff were not notified for three days.

It is not clear why, given his status as an immigration detainee and his violent criminal history, HC was considered eligible to work outside the security fence in the jobs program. Plaintiffs asked the BOC to produce the program description and eligibility criteria for participation in the work program, and were told that no such documents exist.

The Annex used to offer a limited number of educational and rehabilitative programs, including a GED class and an anger management class. Rosalind Titley, the Chief of Programs, told me that these programs have been discontinued. I asked for program descriptions and attendance sheets for all programs over the past ninety days before my site visit. None were provided.

2. Staff Use of Force.

The Agreement requires the following regarding the use of force:

This is not a new problem. As of May 25, 2007, JJ had been incarcerated for 102 days on a disturbance of the peace charge, 12 days past his possible maximum sentence.

[10] Agreement ¶VI.B.5.

[11] Virgin Islands Daily News, "Officials derided for delayed announcement of jail escape," Mar. 22, 2007.

> Defendants must develop a use of force policy that clearly defines when force may be used, shift supervisors must observe use of force incidents where feasible, all use of force incidents must be documented by all staff involved, medical personnel must be notified when force or restraints are used against prisoners, and must examine those prisoners, all documentation of use of force incidents must be forwarded to the assistant warden, and any allegations of physical abuse must be referred to the Department of Justice and plaintiffs'' counsel.

Allegations and evidence of excessive or unnecessary force by staff require scrupulous, consistent and systematic administrative review and/or investigation by management personnel in a confinement setting. CJC and Annex officials fail to properly review and/or investigate allegations of misuse of force. Given the frequency of such allegations and evidence, as illustrated below, and the failure to properly review/investigate these incidents, there are most certainly incidents of use of force violations occurring with no action taken by management personnel. As aforementioned, CJC and Annex officials operate with virtually no guidance on when to use force, when to report it, when to review it, or when to investigate it. Use of force incidents are often not documented by incident reports; in many cases, the only documentation that an officer has used force against a prisoner can be found by piecing together unit logs with medical records.

Prisoners have been restrained purely as a form of punishment, in ways that are potentially dangerous, without appropriate security and health care checks. There are no specially designated cells for restraining prisoners,[12] and prisoners have been restrained in cells that are not directly observable by corrections staff.

Listed below are some examples that illustrate the problems described in this report:

> • Prisoner SB: this prisoner claimed an officer assaulted him with a walkie-talkie in February 2008. Medical records confirm he sustained an injury. There is no record of this matter having been reported or investigated

[12] *See*, *e.g.*, Metzner Report at 25.

notwithstanding there was a witness to the incident.

• Prisoner CC: this prisoner claimed he was assaulted by four correctional officers while he was restrained. Multiple injuries were observed on the prisoner by his attorney four days after the incident. These injuries were also confirmed by a facility nurse. There is no evidence this matter was ever investigated. According to defense counsel, copies of surveillance tapes were not available because the recorder was not working, no tapes were available, or the tape had been reused.

• Prisoner BF: he claimed he was assaulted by officers at the Annex. A number of his fellow prisoners allegedly witnessed the incident. There is no record of this matter having been reported or investigated.

• Prisoner DF: a prisoner who opened his cell door was forcibly restrained to his bed for over two hours. Forcibly restraining a prisoner to a fixed object in his cell would at the minimum require a written administrative review–these is no evidence of any review and/or investigation–the only documentation was in the cellblock log book.

• Prisoner JI: according to cell block logs, an inmate who was shaking his cell door and shouting was forcibly restrained in leg irons and handcuffs. There was no incident report written nor any records of how long he was left in restraints or whether medical staff was notified.

• Prisoner RJ: this prisoner alleged that he was subjected to a beating by multiple correctional officers after he refused to take a shower. He was later taken to the emergency room at which time it was noted that he was covered with multiple contusions, hematomas, and abrasions. The prisoner's attorney later requested an update on the status of the investigation into this matter–no response was provided and the matter remains unresolved.

• Prisoner KM: this prisoner alleged that he was assaulted after a basketball shot by another prisoner bounced and hit a CO in the leg; the officer went to the recreation office, returned with four other correctional officers and indicated that KM threw the ball; KM reported that he was taken to a stairwell and hit in the head by one CO and struck in the back with a baton by another CO. A medical exam confirmed that he sustained injuries to his face, back, and head. An incident report noted that he was "restrained and taken downstairs to Cluster 4 and placed on lock down." There is no evidence this matter was reviewed and/or investigated.

• Prisoner KR: this prisoner alleged that he was struck in the eye with an

officer's key protruding from his fist. A nursing note confirmed an abrasion above the prisoner's left eye and a laceration on the left side of his neck. There is no evidence this matter was reviewed and/or investigated.

- Prisoner KS: this prisoner alleged that he was forcibly restrained to his bed and struck on his ankle with a baton in November 2008. I interviewed him and observed a swollen ankle. I also interviewed his cellmate who confirmed he was restrained to his bed. I was unable to locate an incident report that documented this use of force.

- Prisoner GW: this prisoner alleged he was assaulted by an officer and thereafter filed a grievance. He also provided the names of two prisoners who allegedly witnessed the incident. There is no written response to the grievance and nothing in his file indicating the matter was ever investigated.

3. Management of Special Needs Offenders.

The Agreement requires Defendants to establish protective custody and segregation cells, and to transfer prisoners in need of long-term segregation to ACF.

Special needs detainees require special handling and treatment by staff due to mental and/or physical conditions. They include, but are not limited to, drug/alcohol addiction, emotionally disturbed/mentally impaired, physically impaired, and chronically ill. In an interview with the CJC/Annex nursing coordinator, Lisa LaPlace, it became clear that sufficient treatment personnel are simply not employed to properly identify and manage special needs offenders. The nursing coordinator acts as the on-site nurse for both facilities in addition to her management/administrative duties. The nursing coordinator is the single full time on-site medical professional for both facilities. Among the issues discussed with Ms. LaPlace was intake screening, a critical process essential to identifying special needs offenders. She acknowledged that intake screening is very limited due to lack of properly trained personnel. For those offenders who are identified with mental health issues, they are housed on Cluster 3, which as aforementioned is assigned an officer who also must supervise

Cluster 4. It was evident during the site inspection that Cluster 3 is not managed any differently from the other clusters and operates without any specialized post orders. The following narratives are illustrative of serious problems that arise when these offenders are not properly managed.

> Prisoner MB: This detainee has a lengthy history of mental health problems. He has repeatedly been involved in altercations with other prisoners and has sustained injuries as a result on at least two occasions. While in Cluster 3 in March 2007 he was housed with an inmate with whom he had previously fought and the two again had an altercation. There is currently no separation order in the files of either prisoner.
>
> Prisoner CP: This detainee has a history of mental illness and has repeatedly been involved in altercations with other prisoners and staff. In September 2007 a classification assessment was conducted that failed to note both his mental health issues and his institutional history. As a result, he was classified as a minimum custody prisoner.
>
> Prisoner AW: This detainee entered the facility in July 2008 on a disturbing the peace charge and was immediately disruptive exhibiting self-abusive behaviors (hitting face against the cell gate). There is no evidence of any intake screening or classification and incidents noted in the cluster logs are not evident in his file.

4. Prisoner Disciplinary and Segregation Practices.

Detainees are frequently subjected to lockdowns and placement in Cluster 6 (segregation block) with incomplete or no documentation as to the basis for such placements. Officers impose cellblock lockdowns in a summary fashion based only on their spur-of-the-moment say so. The file reviews seldom reflected fully-completed disciplinary hearing records. The orientation handbook given to prisoners describes a disciplinary process that does not exist at the jail. Prisoners have been placed on lockdown without receiving notice of the institutional rule(s) they violated, they generally do not receive a hearing regarding their infraction, they generally are not told how much lockdown time they will serve, they usually are not moved to a segregation unit, and they are not given the means to appeal.

Once placed in lockdown or segregation, some detainees are not allowed recreation for substantial periods.

The jail also generally imposes the same sanctions for all locked down prisoners. Most notably, they are all denied personal and family visitation privileges. This is not a sound correctional practice. Visitation is often the most valuable privilege available to prisoners, and denying visitation for all violations, regardless of their severity, may cause locked down prisoners to become more of a long-term management problem. Also, by denying visitation for a first offense, jail officials lose the leverage to use the potential loss of visitation as a means of curbing further disciplinary violations by prisoners already on lockdown. I discussed this matter with Warden Hansen, who agreed to look at this practice.

On December 21, 2007, the BOC announced a "no tolerance policy" regarding smoking in the CJC and CJC Annex's housing units. Under the policy, "any form of smoking including the scent of cigarettes . . . will be punishable by a three day lockdown for the entire cluster."[13] Prisoners report that they have been locked down pursuant to this policy even if a prisoner confessed to being the culprit, and they were not smokers. This form of collective punishment, bypassing any investigation, is inappropriate, and poses the risk of prisoners assaulting or retaliating against prisoners whom they feel were responsible for their being locked down.

> Prisoner DB: This prisoner filed a grievance on December 27, 2007 alleging that the entire cellblock had been on lock down for smoking, and had since been denied recreation, visitation, or phone calls since December 20. There is no response to this grievance.
>
> Prisoner CB: This prisoner had been on lock down for over two weeks

[13] *See* Dec. 21, 2007 memo from the Bureau of Correction to All Inmates. Several CJC prisoners report they have filed grievances regarding this policy.

without receiving an incident report or a hearing. After numerous complaints he was on the authority of an assistant warden released.

Prisoner DB: This prisoner was placed on lock down for admittedly throwing water on another prisoner. After having been in lock down for a week he filed a grievance because he had been given no written charge, incident report or hearing. There is no written response to this grievance.

Prisoner WC: When transferred to the Annex from the CJC, WC reported to a CO that he had testified against three other Annex prisoners; the three prisoners were placed on lockdown and WC transferred back to the CJC, but there is no record in WC's file regarding his testimony against fellow prisoners, no corresponding incident report, and no record at all of his incarceration at the Annex.

Prisoner HD: This prisoner was placed on lock down after another prisoner claimed he had assaulted him. There is no corresponding incident report or disciplinary record in his file.

Prisoner MP: This prisoner has been in lock down for months without an explanation. A review of his file contains no classification or incident report documentation that provides any basis for the lock down status.

Prisoner YT: This prisoner had an altercation with another prisoner in May 2008. Cluster log notes indicate he remained on lock down for the next four months. There is no information in his file related to this extended lock down status.

It should be noted many issues raised by prisoners in the above narratives were reflected in grievances contained in their respective prisoner files. While staff members occasionally file a written response, most of these grievances remain unanswered. On any number of occasions, prisoners filed multiple grievances on the same issue without any official response. An unresponsive grievance system, especially in the absence of a formal disciplinary process, leaves prisoners without any formal mechanisms to question or contest restrictions and limitations imposed on them by facility personnel.

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