# 52 Inmates Inappropriately Double-Celled, Unacceptably Low Staffing, Surge in Contraband Flow Including 18-Inch Machete: Scathing Report on B.O.C. Leads to Consent Decree Score Downgrade

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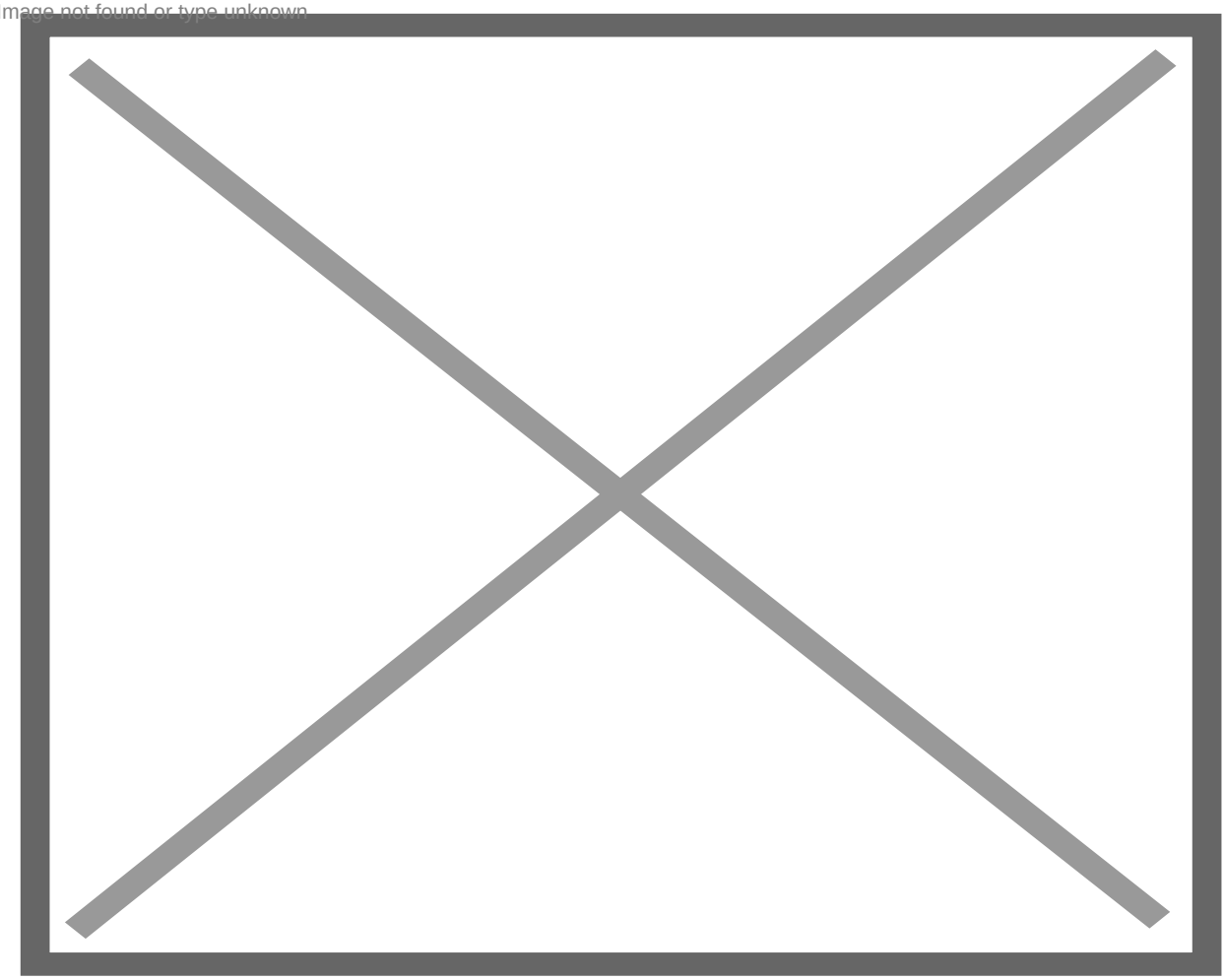

**The John A. Bell Adult Correctional Facility, formerly known as the Golden Grove Correctional Facility on St. Croix. By. ERNICE GILBERT/ V.I. CONSORTIUM**

Inadequate staffing levels and obsolete facilities are the predominant barriers preventing the Bureau of Corrections from making timely progress in complying with the terms of a 36-year-old consent decree surrounding the operations of the John. A. Bell Adult Correctional Facility, formerly named the Golden Grove Prison.

That’s the assessment of court-appointed independent monitor Kenneth Ray, who last week Tuesday submitted the 24th Independent Monitor’s report to the Court. The 195-page document chronicles Ray’s findings from the assessment process which was conducted virtually from October 18 through 21st, 2021. The purpose of the settlement is to "remedy constitutional violations involving the care and custody of prisoners incarcerated at the facility." Further, the agreement between the Virgin Islands and the federal government seeks to “ensure that conditions at the prison respect the rights of prisoners confined therein by ensuring that conditions of confinement are constitutional”.

Over two years ago, in February 2020, BOC Director Wynnie Testamark testified before the Senate Committee on Homeland Security, Justice & Public Safety, one year after initially being hired. She attested to the severe operational and financial deficits she found in the prison system upon her assumption of her post.

"When I walked into my office on day one, I realized that I was facing a crisis. I found bills piled high on my desk that had not been paid. Vendors were threatening to cut off essential services or demanding to be paid up front before doing business with the Bureau. Bills for goods and services that are critical to running a jail or prison went unpaid or were paid dangerously late. I found contracts not executed or not in existence, even though the Bureau had been conducting business with those vendors for years. Work was stalled on critical projects, even though the Court ordered them completed; some contractors walked off the job to pursue more lucrative work elsewhere. And projects that were represented as having been completed – such as the kitchen at Golden Grove – were, in fact, abandoned," said Ms. Wynnie Testamark.

She spoke of a department in crisis, recounting a court hearing she attended shortly after assuming the post where she saw footage of a corrections officer who was caught on video assaulting a roommate but against whom no disciplinary action was taken or could be taken because the timeframe for action had expired. At the time, Testamark told the Senate committee that the Bureau’s former legal counsel was of the opinion that it would take an additional two decades or more for conditions to be brought up to standard.

"The judge asked how much longer  would it take to achieve full compliance with the consent decree, now that 25 years had passed. Our then-legal counsel said that it could take another 25 years to reach full compliance. In other words, we represented to the Court that it would take a total of 50 years – half a century – for the federal consent decree case to finally end. I was dumbfounded. That meant that after 25 years of going to court and paying taxpayer dollars to experts, there was still no plan in place to get out from under the consent decree. That was unacceptable."

Two years onward from that testimony, the conditions Testamark called unacceptable largely remain. In his report, Ray explains that the territory’s compliance with the agreement is assessed via a scoring system, where each of the agreement’s 123 provisions is measured against the facility’s current circumstances. Full and sustained compliance, the level at which the agreement would be terminated, is scored at 369 points. The independent court monitor’s latest assessment scores the territory at 167 points, down one from the 168 achieved at the 23rd assessment.

Mr. Ray says the decline in progress towards full compliance was caused by a number of factors, chief among them being an increase in the prisoner population alongside severe staffing shortages that have only worsened. He notes an “unprecedented” increase in key posts and shifts not being staffed, along with a commensurate “unprecedented” increase in violence within the facility. In addition to the wholly inadequate staffing levels, Mr. Rays says those employees who are in place

at the John Bell Correctional Facility — management and staff alike — do not follow established policies and procedures, a failing which in some instances has resulted in harm to inmates.

Among the major issues that continue to plague the St. Croix prison are pre-trial detainees still being housed with sentenced inmates, a circumstance reportedly caused by a lack of bed space to appropriately house prisoners. Additionally, prisoners of varying classifications were found to have been placed in the same cell, leaving some at elevated risk of harm. Mr. Ray reports that 52 inmates are currently inappropriately double-celled, based on their classifications. Information about the lack of adequate bed space, Mr. Ray says was not formally reported to the monitoring team.

Unacceptably low staffing levels were also found to be creating an environment of elevated risk at the correctional facility. The independent court monitor cited two incidents in which the lack of adequate supervision likely led to harm. In one of these, two inmates who were supposed to have been kept separate from each were escorted to recreation together with a third. One of the three was assaulted, an occurrence which Mr. Ray believes would have been avoided should the necessary procedures have been followed for the “keep separate” assessment that was in place.

A subsequent incident, this time involving sexual misconduct, occurred when a male and female inmate were kept within sight and sound of each other absent the necessary staff supervision, a violation of BOC policy. The male detainee, it was discovered, was housed in the prison’s medical building despite not being classified for medical housing and not having any known healthcare needs. He was placed in medical, with management approval, Mr. Ray reported, for security reason — another policy violation.

A third incident reported that two inmates classified as lockdown detainees were instead placed with the general population of pre-trial detainees because no staff were available to man the Special Management Unit.

The chronic lack of adequate staffing  has been exacerbated in recent months. Two weeks ago, a measure calling for Director Testamark’s ouster came before the Senate Committee on Rules & Judiciary. In prosecuting the draft legislation, bill sponsor Senator Franklin Johnson disclosed that 37 corrections officers had resigned their posts since the BOC director began her tenure in May 2019. He used the officer’s departures to shore up his argument that Ms. Testamark’s stewardship of the organization was doing more harm than good, but his attempt to convince his Senate colleagues that they should support his effort to remove her ultimately failed.

Mr. Ray’s report reignites scrutiny on Ms. Testamark’s human resource management abilities, however, as it claims that while raw numbers of staff in the prison are unacceptably  low, how the prison’s existing employees are deployed is exacerbating coverage problems. The court monitor writes “staffing management practices is likely the larger driver of increases in shifts and posts not being staffed, not staffing shortages per se”.

The management decision to implement 12-hour shifts was lauded for its intended and demonstrated effect of reducing overtime, but Ray called the failure to at the same time consider the documented and knowable risks to the safety of prisoners and staff “troubling”. With the lack of a critical staffing plan which anticipated increasing staffing shortages, the safety and security of prisoners and staff has been compromised by the gaps in coverage.

The result of these gaps can be seen in the data — violent incidents increase as the number of unstaffed housing shifts also rises.

The volume of contraband flowing through the facility is also cause for concern. The levels of contraband items found from January through April of this year, Mr. Ray reports, are higher than those found each year since 2016 with the exception of 2020. Items such as money, drugs, and assorted weapons flow into the prison each month, and these weapons, Mr. Ray says, are then used to commit acts of violence against fellow inmates and prison staff. Ray documents one instance in February 2021 where prisoners were found fighting with dangerous weapons, one of which was an 18-inch machete.

The court monitor noted that some of the processes established to prevent the introduction of contraband into the facilities were not being followed by staff. Again, Mr. Ray points to severe staffing shortages which render corrections officers ineffective and incapable of conducting the necessary level of random and scheduled searches to deal with the problem. Detection of contraband already inside the facility is also an issue, as is ensuring that officers correctly log all the contraband found and intercepted.

In fact, there is persistent failure of staff to complete administrative work as it relates to logging and reporting of incidents. Ray notes missing reports and forms, incomplete or inaccurate documents, missing signatures on forms, and erroneous approval of reports by supervisors, and a lack of documentation from senior management to assess how reported incidents are handled.

Some of these failures and inaccuracies were deliberate, the court monitor found. In Mr. Ray's report, he details how lapses in proper procedure coupled with delinquent corrections officers who cover their tracks may have led to a preventable death at the John Bell Correctional Facility.

On Monday, September 20th, 2021, Consortium journalists reported that 55-year old Bryan Glasgow was found dead in his cell the week prior. After initially refusing to confirm that the death had even occurred, the Bureau eventually disclosed that a DOJ Medical Examiner found that he had died of congestive heart failure, a chronic condition in which the heart is unable to pump blood as efficiently as it should.

The investigation into Glasgow's death laid out a timeline in which the desperately ill inmate was left unmonitored for approximately 20 hours.

On September 16th, one officer failed to conduct 12:00 p.m., 3:00 p.m., and 6:00 p.m. formal counts, and then falsified logbook entries to claim that he conducted the head counts and security checks that were not done. A supervisor made a similar false log entry on the same day.

A different officer counted Glasgow on the 16th but the investigation found that she never opened his cell door to verify the person she was counting was actually alive. That officer failed to make hourly observations of the prisoners and conducted zero security checks during her 12-hour overnight shift from 8:00 p.m. on the 16th to 8:00 a.m. on the 17th. She also failed to conduct the requisite 7:00 a.m. prisoner count. By the time anyone suspected something might have been wrong, Glasgow was dead.

Could Bryan Glasgow have been saved if any of the required security checks or counts was executed correctly during his last 20 hours of life? Consortium journalists spoke to three medical doctors in the fields of cardiovascular medicine and pathology who believe it to be a possibility.

The latest monitoring report also highlights that inmate complaints/grievances are not being investigated in a timely manner, and those relating to safety, medical and/or mental healthcare are not being prioritized.

Apart from the other major issues identified, Mr. Ray notes in his report that inmate mental health provisions were not being adhered to. Almost a fifth of all prisoners in segregation between August 2021 through February 2022 were classified as having serious mental illness — a type of prisoner that is explicitly prohibited from being housed in segregation by prison policy. In addition to the prison violating its own policy regarding the segregation of inmates with serious mental illness, data shows the SMI prisoners spend an average of roughly six months longer than non-SMI inmates in segregation, functionally isolated by the lack of out-of-cell time. The absence of a special housing or mental health unit was pinpointed as the critical issue behind the problem. Even if such a specialized housing unit did exist, Mr. Ray noted that the lack of adequately trained security and mental health staff would mean that it would be difficult to safely operate.

Despite the serious flaws in the design and operations of the territory's prison facility that were identified in this 24th monitoring report, Mr. Ray says there are some bright signs. This year, the territory and the Bureau of Corrections made sufficient progress to be upgraded from last year's status in 12 of the 123 categories. Twenty-one provisions have now, as of this report, been assessed to be in sustained compliance with a further 18 in substantial compliance and 71 in partial compliance.

In 2020, after a year on the job, Ms. Testamark was optimistic about the Bureau's trajectory, telling senators that she and her team had been able to turn around an agency she said she found in crisis.

"I had no choice but to take immediate, corrective action to avoid disaster. Because of the tireless work of the dedicated men and women at the Bureau, I can report to you today that we stopped the free fall; we leveled off; and now we're beginning to climb," she said.

Two years later, the independent court monitor in this most recent report (seen here), found reason to downgrade the BOC to partial compliance or complete non-compliance for 9 provisions across 5 sections — testament that Ms. Testamark's initial optimism, in the absence of any fundamental, systemic changes, may have been somewhat misplaced. Mr. Ray cautions that only focused, sustained attention (and resources) spent by the territory on its prison system will result in the kind of progress necessary to fulfill the conditions of the consent decree pertaining to Golden Grove Prison.