MEMORANDUM FOR CHIEF EXECUTIVE OFFICERS

/s/
From: [redacted], Assistant Director

Subject: Program Summary Report - FY 2019, 3rd Quarter

The attached Program Summary Report contains cumulative findings from program reviews conducted the 3rd quarter of FY 2019 (April 1, 2019 through June 30, 2019). The information is intended to highlight strengths and indicate areas of possible program weaknesses. The report contains issues and ideas as well as summary information for all disciplines reviewed during this quarter.

Attachment

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ISSUES AND IDEAS

Program Review Branch:

Review Team Participation: Examiners continue to face difficulties staffing program review teams. Participation on program reviews provides valuable experience and training. All CEOs are encouraged to support their staff's involvement as participants on program review teams.

Operational Review & Working Papers: Untimely and incomplete operational reviews remain an issue across all disciplines. The operational review is an important local evaluation process that enables staff to closely evaluate the strengths and weaknesses of a program and take corrective action. By using this process effectively, weaknesses can be identified and corrected quickly through strategic planning. Action plans can be developed to ensure correction over time and the strengthening of the program. In addition, the operational review process enables program managers to establish strong internal controls to ensure corrective action continues to be effective. P1210.23, Management Control and Program Review Manual, Chapter 3, provides guidance on the operational review process. Sites are strongly encouraged to review this information to ensure policy compliance. Additionally, the Program Review Division is available to provide training in person (requester expense), or via VTC training for field, regional, and central office staff. This training outlines many segments of P1210.23, and outlines the review process and quality control.

Working papers provide a systematic record of the work done by a reviewer or team. They contain the information and evidence necessary to support the findings and recommendations presented in the operational review report.

The operational review working papers are to be placed in a file that would facilitate their use and prevent loss or mutilation. The department head, or administrator of the program reviewed, must retain the working papers for subsequent operational reviews, as well as the report, until the next scheduled program review has been conducted and a final report issued. During the next program review, the reviewers are to examine working papers from the operational review(s) to determine that the review was comprehensive and the adequacy of controls were assessed.

PROGRAM SUMMARY REPORT - FY 2019, 3rd QUARTER

AFFIRMATIVE EMPLOYMENT

NUMBER OF REVIEWS: Ten Affirmative Employment Program Reviews were conducted from 4/1/19 – 6/30/19, with overall ratings of two superior and eight acceptable. Two repeat deficiencies and twenty deficiencies were identified.

MOST FREQUENT DEFICIENCIES THIS REPORTING PERIOD:

- Vacant SEPM and ROPC positions were not advertised within 30 calendar days.
- Newly selected SEPMs, alternate SEPMs, and ROPCs have not met training requirements.
- Not all AEP Meeting minutes document the review of the DVAAP, FEORP, and MD-715 reports.

REVIEWERS' COMMENTS:

Vacant SEPM/ROPC positions are not announced within 30 days of becoming vacant. The chairperson should forward a copy of the employee's resignation memorandum/E-mail to the HR office in order for the collateral duty position to be advertised again. Collateral duty positions should continue to be re-advertised until they are filled. HR and the AEP chairperson should work closely together to ensure positions are advertised timely.

Newly selected SEPMs, alternate SEPMs, and ROPCs are not meeting training requirements. Newly selected committee members have 6 months to complete training as outlined on the Affirmative Employment Sallyport page at http://sallyport.bop.gov/co/prd/aa/index.jsp. Staff who have served on AEP Committees previously will be given credit for training received, as long as it is documented in their training record. It is recommended that AEP chairpersons conduct yearly AEP retreats and cover any new items during the retreat. A sign-in sheet should be utilized, and provided to HR to key into the employees training record.

One of the purposes of the AEP Meeting is to review the progress being made towards the initiatives outlined in each of the following reports: FEORP, DVAAP, and MD-715, on at least a quarterly basis. The chairperson can pick one month each quarter (i.e., first month of each new quarter) to review the reports (review the goals, accomplishments made, and what the focus is for the next quarter), and ensure it is documented in the meeting minutes, as required by policy. It is important to refrain from cutting and pasting the same information from one month to another.

When responding to the program review report, include both components (Human Resource Management and Affirmative Employment Program), and ensure all subsequent communication relative to the review is provided in one response, not separate responses. All correspondence regarding the program review/operational reviews needs to be sent to [redacted].

PROGRAM SUMMARY REPORT - FY 2019, 3rd QUARTER

CORRECTIONAL PROGRAMS

NUMBER OF REVIEWS: Eleven Correctional Programs Program Reviews were conducted from 4/1/19 – 6/30/19, with overall ratings of six good, four acceptable, and one deficient. Five repeat deficiencies and seventy-four deficiencies were identified.

MOST FREQUENT DEFICIENCIES THIS REPORTING PERIOD:

- RPP CMA assignments are not always accurate
- State and local law enforcement officials are not always notified of inmates releasing to a term of supervision.
- Sex offender inmates are not always notified of the requirement to register.
- Required unit staff do not always work a late night.
- Unit managers do not always work a weekend/holiday each month.
- Unit staff do not always conduct daily SHU rounds.
- Locator Center staff do not always have the proper SENTRY verb access.
- Authorities holding detainers are not always notified of impending releases as required.

REVIEWERS' COMMENTS:

Management should provide additional oversight with regard to RPP CMA assignments. Additionally, implementation of the Release Orientation Program (ROP) should not negate the "RPP Part" CMA assignment, or the relevance of previously completed traditional RPP courses.

Offenders convicted of certain sexual offenses, drug trafficking crimes, or crimes of violence require notification to designated law enforcement and sex offender registration officials. Notifications should be mailed 2 weeks prior to the inmates' release to a term of supervision to ensure the notifications are received at least 5 days prior to the inmates' release date. Also, inmates convicted of certain sexual offenses should be notified that they may be required to register upon release from custody. Documentation of compliance should be maintained in the inmate central file.

Management should provide additional oversight, and monitor unit staff schedules, to ensure staff are working the required schedules as dictated by policy. Specifically, unit managers, case managers, and correctional counselors must work a late night each week. Also, unit managers are required to work a weekend/holiday each month. Out of eleven reviews conducted this rating period, this area was identified as a deficiency during seven reviews.

The unit team, specifically, unit managers, case managers, and correctional counselors, are required to conduct daily SHU rounds, to include weekends and holidays. The unit team is considered all of the previously stated positions under the direction of one unit manager. For

the purposes of program review, staff may not substitute or sign for another unit team. SHU rounds are not required if there are no inmates assigned to the unit housed in SHU. However, documentation should be maintained demonstrating this is the case.

All staff assigned to the Control Center, on all shifts, and the Correctional Systems Department, should have the WITSEC SENTRY verb access when assigned to these posts. Control Center staff access, to this SENTRY verb, should be provided and removed based on the quarterly rotation. The CIM coordinator should ensure the staff access list maintained by IMS is consistent with the local CSM list of staff.

Authorities holding detainers on inmates in BOP custody should be notified of the inmates' impending release at least 90 in advance. Detainer Action Letters sent, on possible pending charges/sentences for newly arriving inmates, may not be substituted for the release notification.

PROGRAM SUMMARY REPORT - FY 2019, 3rd QUARTER

CORRECTIONAL SERVICES

NUMBER OF REVIEWS: Ten Correctional Services Program Reviews were conducted from 4/1/19 – 6/30/19, with overall ratings of six superior, one good, one acceptable, and two deficient. On repeat repeat deficiency, three repeat deficiencies, and thirty-two deficiencies were identified.

MOST FREQUENT DEFICIENCIES THIS REPORTING PERIOD:

- Inmates in SHU are not observed each 30 minute period, on an irregular schedule, with rounds being no more than 40 minutes apart.
- Special Housing Unit Record, BP-A292.052, forms are not completed to document all required information.

REVIEWERS' COMMENTS:

At three institutions during this review period, inmates assigned to SHU were not being observed in accordance with policy. It is the responsibility of staff to conduct these rounds ensuring the welfare of each inmate, and to document the rounds. Inmates in continuous lockdown must be observed each 30 minute period, on an irregular schedule, and no longer than 40 minutes apart. It is essential that management ensures rounds are being conducted and documented according to policy. A lieutenant must visit SHU during each shift to ensure all procedures are followed.

It was noted, at three institutions during this review period, that Special Housing Unit Records, BP-A292.052, are not properly completed to document that inmates are receiving 5 hours of recreation, medical visits, OIC assignments, showers, and meals. A lieutenant must visit SHU during each shift to ensure all procedures are followed.

PROGRAM SUMMARY REPORT - FY 2019, 3rd QUARTER

EDUCATION/RECREATION SERVICES

NUMBER OF REVIEWS: Thirteen Education Services Program Reviews were conducted from 4/1/19 - 6/30/19, with overall ratings of four superior, six good, and three acceptable. One repeat deficiency and twenty-eight deficiencies were identified.

MOST FREQUENT DEFICIENCIES THIS REPORTING PERIOD:

- Literacy progress assignments, and 240-hour progress reviews, are not monitored and documented appropriately.
- Instructional staff do not spend a minimum of 50 percent of their work hours in direct class instruction.
- Operational reviews are not conducted and documented appropriately.

REVIEWERS' COMMENTS:

In accordance with VCCLEA/PLRA and policy requirements, all inmates enrolled in the literacy program must be reviewed for satisfactory progress every 240 hours of instruction, with the progress results documented on the PERW screen in SENTRY. Also, education progress assignments must be monitored and documented appropriately. In addition to meeting the element of the law, this documentation of inmate progress in literacy is also a behavioral management tool. Review findings this quarter showed evidence that this tool is often not appropriately utilized, and VCCLEA/PLRA literacy requirements are not always documented and followed.

To ensure instructional systems are effective, it is imperative that instructional staff are present and engaged in the learning process. Staff shortages, ineffective scheduling, mismanagement of staff resources, and over usage of inmate tutors have been evidenced during reviews conducted this quarter. Managers are encouraged to reevaluate scheduling and staffing to ensure all staff assigned to literacy classes, to include GED, ESL, and SLN, are actively engaged in their respective classes.

Operational reviews provide management with an annual opportunity to reexamine program areas that have been identified as crucial to program success through the management assessment process. Review findings suggest that greater emphasis is needed during operational reviews to ensure the accuracy of review findings, timeliness of reporting, and adequate modification of internal controls to prevent reoccurrence.

PROGRAM SUMMARY REPORT - FY 2019, 3rd QUARTER

ENVIRONMENTAL AND SAFETY COMPLIANCE

NUMBER OF REVIEWS: Twelve Environmental and Safety Compliance Program Reviews were conducted from 4/1/19 - 6/30/19, with overall ratings of six superior, five good, and one acceptable. Four repeat deficiencies and sixteen deficiencies were identified.

MOST FREQUENT DEFICIENCIES THIS REPORTING PERIOD:

- Not all Institution Safety Committee requirements are being met.
- CA-7 forms were not always submitted timely to the respective Office of Workers' Compensation District Office.
- OSHA recordkeeping requirements were not always being met. OSHA 300 logs were not always accurately maintained, and did not always include all inmate recordable injuries.

REVIEWERS' COMMENTS:

Institution Safety Committee Meetings must be conducted quarterly. Additionally, they must cover all required topics and meeting minutes must be appropriately disseminated in accordance with policy.

In compliance with the Federal Employees' Compensation Act (FECA), institutions must effectively manage Office of Workers' Compensation Program (OWCP) requirements, including the timely submission of CA forms to the respective OWCP District Office. Regulations require the employer to complete and transmit the agency portion of the CA-7 form within 5 working days of agency receipt.

OSHA 300 logs and OSHA form 301 are not always accurately maintained. These logs are important for spotting injury trends, and are often requested during OSHA compliance site visits. In addition, OSHA issued a final rule, effective January 1, 2017, and phased in over 2 years, which revised OSHA's regulations on "Recording and Reporting Occupational Injuries and Illnesses" (29 CFR 1904). The rule requires employers to begin submitting injury and illness data to OSHA electronically, via a secure website. While the rule has been suspended, OSHA has the prerogative of implementing various rules which makes recordkeeping accuracy critical. Establishments, with 250 or more employees, were required to maintain information from all OSHA recordkeeping forms (300A, 300, and 301). Accurate recording and reporting of work-related injuries is therefore essential.

PROGRAM SUMMARY REPORT - FY 2019, 3rd QUARTER

FACILITIES MANAGEMENT

NUMBER OF REVIEWS: Eleven Facilities Management Program Reviews were conducted from 4/1/19 – 6/30/19, with overall ratings of three superior, three good, four acceptable, and one deficient. One repeat deficiency and thirty-four deficiencies were identified.

MOST FREQUENT DEFICIENCIES THIS REPORTING PERIOD:

- Fire inspections are not being conducted per NFPA.
- Refrigerant quantities reported in CMMS do not match what is entered in the technician's log.
- Operational reviews were not timely or incomplete.

REVIEWER'S COMMENTS:

As per P4200.12, Facilities Operations Manual, fire system inspections and testing shall be conducted and documented in accordance with NFPA 25, NFPA 72 (latest edition), and applicable policies.

As per P4200.12, Facilities Operations Manual, daily refrigerant records must be maintained, within a bound log book or electronic database, by the certified technician (HVAC, Garage, Utility Systems Repairer-Operator, etc.). To enable proper reporting of Ozone Depleting Substances (ODS) to the U.S. Department of Energy, the facility manager or designee must enter refrigerant records into CMMS quarterly.

As per P1210.23, Management Control and Program Review Manual, each program at all organizational levels should conduct an operational review between 10-14 months from the week of the previous program review (including those programs receiving a deficient rating). An additional operational review should be conducted 22-26 months from the week of the previous program review for those programs that receive good or superior ratings. The review authority will direct that a follow-up be conducted to measure the effectiveness of the corrective action. The follow-up review will be conducted 120-150 calendar days after the last day of the operational review. It will be under the associate warden's supervision (institution reviews), and focus on areas of concern and deficiencies.

PROGRAM SUMMARY REPORT – FY2019, 3rd QUARTER

FEMALE OFFENDERS

NUMBER OF REVIEWS: Two Female Offender Program Reviews were conducted from 4/1/19 - 6/30/19, with overall ratings of one superior and one good. One deficiency was identified.

MOST FREQUENT DEFICIENCIES THIS REPORTING PERIOD:

- There were no frequent deficiencies identified during this quarter.

REVIEWERS' COMMENTS:

Reviews conducted this quarter showed evidence of gender-responsive program opportunities being provided, and programming needs being appropriately considered, in accordance with the institution's mission. Staff ensure appropriate documentation, designation, and monitoring is completed for expectant inmates. Gender specific services are provided as necessary to female offenders, to include commissary items, personal hygiene items, and other needs that are unique to the female population.

PROGRAM SUMMARY REPORT - FY 2019, 3rd QUARTER

FINANCIAL MANAGEMENT

NUMBER OF REVIEWS: Ten Financial Management Program Reviews were conducted from 4/1/19 – 6/30/19, with overall ratings of eight superior and two good. Three deficiencies were identified.

MOST FREQUENT DEFICIENCIES THIS REPORTING PERIOD:

- There were no frequent deficiencies identified during this quarter.

REVIEWERS' COMMENTS:

The accountability of property is a growing concern. Although there are procurement and property positions vacant throughout the Bureau of Prisons, the requirement for conducting inventories remains policy driven. All efforts should be made to complete all required inventories timely.

Operational reviews continue to be a concern. Operational reviews must be completed using the correct guidelines, the working papers must be signed and dated, and all identified areas of concern documented in the report. In addition, responses, follow-up reports, and closures are required for operational reviews. P1210.23, Management Control and Program Review Manual, provides procedures and time frames for completing operational reviews.

PROGRAM SUMMARY REPORT - FY 2019, 3rd QUARTER

FOOD SERVICE

NUMBER OF REVIEWS: Eighteen Food Service Program Reviews were conducted from 4/1/19 - 6/30/19, with overall ratings of two superior, eight good, seven acceptable, and one deficient. Seven repeat deficiencies and sixty-seven deficiencies were identified.

MOST FREQUENT DEFICIENCIES THIS REPORTING PERIOD:

- Machine guarding is not always in place during operation to prevent injury to staff and inmates.
- Potentially hazardous food is not always protected from possible overhead cross-contamination.
- Temperature logs are not always maintained according to policy.
- Potentially hazardous foods are not always maintained according to policy.
- Hand washing sinks are not always utilized or maintained in accordance with policy.
- Access panels, leading to energized circuits and gas components, are not always secured with locks or security screws to prevent unauthorized access.
- Walk-in refrigerators and freezers do not have a device that allows the door to be opened from the inside, even if locked from the outside.
- Wiping cloths are not always stored in a chemical sanitizer according to policy.
- Budget projections are not always accurate, and do not include all foods needed to support the National Menu.
- Operational reviews are not always complete and/or timely.

REVIEWERS' COMMENTS:

Inspection of equipment revealed machine guards are not always in place and/or functional on machinery. Daily monitoring of equipment is needed to ensure guards, for all machines that require them, are properly in place and functional prior to the use of the equipment. This will greatly reduce the possibility of injuries to staff and inmates.

Food items stored, prepared, or served below an unsanitized area greatly increases the probability rate of cross-contamination. Food items must be protected from all possibilities of contamination from an overhead source. Detailed sanitation practices are imperative to assist in preventing the possibility of contamination. Evidence of condensation, ice, dripping water, food debris, dust, dirt, mildew, and chipping paint are to be reported immediately to the FSA/AFSA, the Facilities Department must be notified to make repairs, if necessary, and/or a detail cleaning performed to remove possible contaminants from all sources.

A review of temperature logs revealed that temperatures are not always recorded and/or annotated according to policy. Temperature logs are often missing the required temperature readings, and in some cases, the logs are not present. Additionally, corrective action and/or justification for temperatures recorded outside the acceptable ranges are not listed on the temperature logs. Additional training should be provided to increase staff awareness of the importance of proper temperature monitoring and annotation of the temperature logs.

Observations this quarter identified the need for closer oversight in the handling of potentially hazardous food items. Potentially hazardous foods (hot and cold) were found being stored, prepared, and served outside the acceptable temperature ranges. Additional training should be provided to increase staff awareness of the proper techniques of monitoring food temperatures to prevent the potential for food borne illness. Consistent temperature checks, in food storage, production, holding, and serving, will reduce the potential for problems in this vital function area.

Hand washing sinks, and/or hand washing stations, were not always utilized or maintained in accordance with policy. Utility and food preparation sinks were observed being utilized for hand washing. Hand washing stations were lacking warm water, soap, and/or the means to dry hands. Not all hand washing stations were equipped with a sign instructing food handlers to wash their hands upon reporting for duty, or after the use of restroom facilities. Regular monitoring of all hand washing sinks/stations is recommended to ensure policy is being adhered to.

Inspection of equipment and physical plant revealed access panels leading to energized circuits and mechanical components continues to be an issue. Observations during this review period revealed that access panels are not properly secured with locks or security screws. Daily monitoring of equipment is needed to ensure all equipment is properly secured, and there is no evidence of tampering with security features. Building a cooperative relationship, and maintaining open lines of communication between Food Service and the Facilities Department, is paramount to a functional and safely operated Food Service Department.

Wet wiping cloths were observed not being stored according to policy. Wet cloths, used for clean contact or non-contact food surfaces, are to be stored in a chemical sanitizer at a concentration specified by the manufacturer. Wet cloths used for raw animal foods must be kept in a separate sanitizing solution. Wet wiping cloths not in use were observed being stored improperly. Additional training should be provided to increase staff and inmate awareness of the importance of properly storing wet wiping cloths to minimize the risk of cross-contamination.

Issues are still occurring in the budget process. Oversight and additional training is needed to ensure budgets are accurate and include all items needed to support the approved menus. Closer attention should be paid to ensure the information in FNS is accurate and updated to

correctly reflect the needs of the department. This includes recipes being accurate, and the acceptability of menu items being in close proximity to the actual usage and updated as needed.

Operational reviews were frequently found not being timely and/or complete. The timeliness of operational reviews was not always in accordance with P1210.23, Management Control and Program Review Manual. Operational reviews were found to be missing working papers and/or memorandums. Staff conducting operational reviews should become familiar with all aspects of P1210.23.

Throughout this rating period, there continues to be numerous repeat deficiencies and deficiencies attached to ACA mandatory standards, and deficiencies that are considered vital functions. To ensure there are no concerns during upcoming ACA reaccreditations, and continued deficiencies with vital functions, food service management must place more emphasis on, and monitoring of, all ACA mandatory standards to ensure compliance.

As a reminder, all items listed in Attachment B of the Program Review Notification are to be present in the work area of the review team when they arrive at the facility to conduct the review. This is imperative to ensure that adequate time is available to complete working papers and stay on schedule to complete the review in the 3 day time frame.

PROGRAM SUMMARY REPORT - FY 2019, 3rd QUARTER

HEALTH SERVICES

NUMBER OF REVIEWS: Eighteen Health Services Program Reviews were conducted from 4/1/19 – 6/30/19, with overall ratings of four superior, seven good, four acceptable, and three deficient. One significant finding, six repeat deficiencies, and seventy-three deficiencies were identified.

MOST FREQUENT DEFICIENCIES THIS REPORTING PERIOD:

- Physical, dental, and female examinations for new commitments were not always completed as required by policy.
- Inmates enrolled in chronic care clinics were not always evaluated timely, and/or had clinically indicated treatment completed as ordered.
- Inmates with HIV infection were not always managed according to guidelines.
- Inmates with latent TB infection (LTBI) did not receive chest radiographs timely, and/or offered treatment appropriately.
- Emergency disaster drills were not conducted as required, and did not always have appropriate critique and/or corrective actions.
- Medication Administration Records (MARs) were not always completed after administering narcotic medications.
- Licensed Independent Practitioner (LIP) privileges were not always granted and approved in accordance with policy, and/or licenses were not verified timely.
- Ancillary staff licenses were not always verified timely.
- Practice agreements were not always completed properly.
- Peer reviews for LIPs were not completed in accordance with policy.
- T&A files were not always accurate.
- Operational reviews were not always completed according to policy.

REVIEWERS' COMMENTS:

Reviews conducted this quarter revealed three deficient reviews due to a lack of administrative and clinical oversight, as well as a breakdown in compliance with ACA mandatory standards. There was one significant finding noted as well. During the significant finding review, it was found that the Health Services Department is not maintaining strict and accurate monitoring and tracking of inmates with significant medical conditions. Failure to evaluate, examine, and provide ongoing medical needs and treatment presents the potential for rapid deterioration of the health of inmates. This review could negatively impact the institution’s ability to regain ACA reaccreditation. Non-compliance with ACA mandatory standards continues to have a huge impact on program review ratings and ACA accreditation.

Physical and dental examinations for new commitments must be conducted within the required time frame. It is essential to complete the examination timely to determine an inmate's medical needs. Failure to identify inmate health issues can cause deterioration of patient health and possible legal consequences.

Inmates enrolled in chronic care clinics must be evaluated every 12 months, or more often if clinically indicated. Clinically ordered testing must be completed as ordered to ensure chronic illnesses are monitored closely to prevent further disease progression.

Clinical management of inmates with HIV infection is essential in controlling the disease process. Proper immunizations and timely evaluations help prevent further disease progression and appropriate management of laboratory testing results.

Timely chest radiographs, on inmates with latent TB infection (LTBI), helps prevent spreadable infections throughout the inmate population. Clinical review of each case, with appropriate treatment offered, prevents future outbreaks from latent infections.

Emergency disaster drills need to be completed twice per year. Appropriate drills help test the resources available of each health services department, and ensures proper supplies and responses to emergencies are accurate and effective. Critique and corrective actions will help identify weaknesses which can be corrected prior to actual emergencies.

MARs were not always completed after administering narcotic medications. Accountability is very important for DEA controlled medications, therefore, administering of medications must be documented in the MARs after it is dispensed.

Credential files must be maintained appropriately. LIPs must have accurate privileges and all licenses verified timely. Practice agreements must be complete and institution specific. Mid-level practitioners and dental hygienists must have a practice agreement with a licensed physician/ dentist prior to providing any health care in the institution. Peer reviews should address all required elements and have corrective actions addressed appropriately. Continual training to field staff, and frequent review of credentialing policy requirements, as well as monitoring of internal local tracking mechanisms, is paramount in reducing the number of recurrent deficiencies. Failure to maintain accurate credential files imposes risks for both ACA and Accreditation Association for Ambulatory Health Care (AAAHC) reaccreditation.

Proper management of T&A files continues to be an issue throughout the institutions. Eight deficiencies were identified due to inaccurate maintenance of T&A files. Proper documentation of leave, overtime, and corrected T&A's need to be maintained to prevent waste, fraud, and abuse.

A large number of reviews were conducted this quarter, and there were many deficiencies and repeat deficiencies identified. Operational reviews were a finding on three occasions. Solid operational reviews can be used as a tool to monitor the deficiencies which were identified.

PROGRAM SUMMARY REPORT - FY 2019, 3rd QUARTER

HUMAN RESOURCE MANAGEMENT

NUMBER OF REVIEWS: Ten Human Resource Management Program Reviews were conducted from 4/1/19 – 6/30/19, with overall ratings of one superior, five good, and four acceptable. Two repeat deficiencies and thirty-four deficiencies were identified.

MOST FREQUENT DEFICIENCIES THIS REPORTING PERIOD:

- T&As were not accurate.
- Not all mandatory payroll reports were run each pay period.
- Mandatory training standards were not in compliance.
- Not all staff received female offender training.
- Not all staff completed firearms training timely, and approved waivers and supporting documentation was not on file for the entire lapse period, nor did they contain projected completion dates.

REVIEWERS' COMMENTS:

T&A records were not accurate. Timekeepers/keyers are responsible for accurately recording and keying time and attendance data for the employees assigned to them to ensure accuracy of entitlements/pay. Timekeeper/keyers are responsible for ensuring each T&A is certified as accurate by the supervisor prior to transmitting to the National Finance Center. Annual refresher training must be provided by HR to ensure policy compliance.

Documentation must be maintained to verify which mandatory payroll reports were run each pay period. HR must ensure that mandatory payroll reports are run each pay period, and have a clear audit trail reflecting corrective action when warranted.

Mandatory training is not being completed within the required time frame. There are reports in BLU that will assist HR offices in ensuring mandatory training is completed prior its expiration. HR needs to notify managers, and/or supervisors, before staff certifications are due to expire. Executive staff should also be kept abreast in order to support HR in their effort to ensure mandatory training compliance is met.

HR managers are responsible for ensuring all new staff, and staff transferring to institutions housing female offenders, complete the training developed by the Women and Special Populations Branch and the trauma-informed correctional care module. P5200.02, Female Offender Manual, states in relevant part: "All staff at institutions or complexes housing female offenders are required to complete training developed by the Female Offender Branch and the trauma-informed correctional care module." In addition, the Bureau Mandatory Training Standards require the training be completed within 60 days of entry on duty to a facility housing female inmates.

Approved waivers, and supporting documentation, was not on file for the entire lapse period for staff unable to maintain firearms certification. Annual firearms certification is an ACA mandatory requirement, therefore, it is imperative, when staff are unable to certify annually, there is a signed waiver (by the CEO), and supporting documentation, on file to justify the lapse period (i.e., military leave, extended sick leave, OWCP). If the employee is unable to complete the certification by the projected due date, HR must ensure another waiver, which is supported by updated documentation, is routed to the CEO for signature. A waiver must be on file for the entire firearms certification lapse period.

When responding to the program review report, include both components (Human Resource Management and Affirmative Employment Program), and ensure all subsequent communication relative to the review is provided in one response, not separate responses. All correspondence regarding the program review/operational reviews needs to be sent to [redacted].

PROGRAM SUMMARY REPORT - FY 2019, 3rd QUARTER

INFORMATION SYSTEMS AND SECURITY

NUMBER OF REVIEWS: Eleven Information Systems and Security Program Reviews were conducted from 4/1/19 – 6/30/19, with overall ratings of two superior, seven good, one acceptable, and one deficient. Twenty-one deficiencies were identified.

MOST FREQUENT DEFICIENCIES THIS REPORTING PERIOD:

- Critical and sensitive systems have not been identified in the current contingency plan.
- Staff are not aware of the proper procedures for protecting sensitive information.

REVIEWERS' COMMENTS:

Critical and sensitive systems have not been identified in the current contingency plan. Staff must ensure critical and sensitive systems are properly documented in the current contingency plans. The guidance provided at national IT training, quarterly video conferences, and most recently by your regional computer services administrators, should be followed. There were four deficiencies identified for this step this quarter, and one deficiency identified last quarter. P1237.16, Information Security, provides guidance on critical and sensitive systems.

Sensitive information is not labeled. Staff are not aware of, or adhering to, local and national information security procedures. End users must be trained in the protection of sensitive information. There were five deficiencies identified for this step this quarter, and one deficiency identified last quarter. P1237.16, Information Security, provides guidance on sensitive materials.

Although not a frequent deficiency, additional oversight is needed to ensure required annual recertifications are completed by the due date provided by the Office of Information Systems. There were two deficiencies identified for this step this quarter. P1237.14, Personal Computers and Network Standards, provides guidance on annual recertifications, and OIS Technical Bulletins outline the due date and method of submission.

Additionally, operational reviews not being timely and complete is another recurring finding. In order to ensure operational reviews are complete, the correct guidelines must be used, all working papers must be completed (this includes the standard program review steps), working papers must be signed and dated, and all identified issues must be documented on the report. The entire process includes completion of the follow-up review/report and obtaining closure. There were two deficiencies identified for this step this quarter. P1210.23, Management Control and Program Review Manual, provides guidance on the operational review process. The program review team also provided guidance on this subject at annual training in Denver in August 2018.

PROGRAM SUMMARY REPORT - FY 2019, 3rd QUARTER

PSYCHOLOGY SERVICES

NUMBER OF REVIEWS: Eighteen Psychology Services Program Reviews were conducted from 4/1/19 - 6/30/19, with overall ratings of six superior, five good, and seven acceptable. Three repeat deficiencies and eighty-four deficiencies were identified.

MOST FREQUENT DEFICIENCIES THIS REPORTING PERIOD:

- Suicide watch log books are not always utilized, in accordance with the post orders, to document constant observation of suicidal inmates.
- Suicide Risk Assessments are not always conducted and documented in PDS-BEMR within 24 hours of the referral.
- Identified high risk inmates are not always screened by a psychologist within 24 hours of SHU placement.
- Sexual Abuse Interventions are not always documented in PDS-BEMR within 24 hours.
- Inmates coded as CARE2-MH do not always have a rationale for their diagnosis and care level documented in PDS-BEMR.
- Inmates prescribed antipsychotic medication do not always have the rationale for frequency and type of care documented in PDS-BEMR.
- Inmates participating in follow-up drug treatment do not always have timely progress reviews documented in PDS-BEMR.

REVIEWERS' COMMENTS:

Suicide watch log books are not always utilized, in accordance with the post orders, to document constant observation of suicidal inmates. Post orders need to be adhered to when staff are watching suicidal inmates. Staff are typically required to sign suicide log books every 15 minutes to document the constant observation of suicidal inmates. Coordination between Psychology Services and Correctional Services staff is required when conducting suicide watches.

Suicide Risk Assessments are not always conducted and documented in PDS-BEMR within 24 hours of the referral. Suicide Risk Assessments need to be documented in the PDS record or review queue within 24 hours of the referral. Please be mindful, policy discusses it being 24 hours from the referral and not 24 hours from the time the Suicide Risk Assessment was completed.

Identified high risk inmates are not always screened by a psychologist within 24 hours of SHU placement. Any inmates coded as CARE3-MH, CARE4-MH, PSY ALERT, and/or who are on the Psychology Advisory List, need to have a restrictive housing mental health screening within 24

hours of placement in SHU. Please be mindful, the policy time frame is 24 hours and not one working day.

Sexual Abuse Interventions are not always documented timely. Sexual Abuse Interventions, for victims of sexually abusive behavior, need to be documented in PDS-BEMR within 24 hours of the contact.

Inmates coded as CARE2-MH do not always have a rationale for their diagnosis and care level documented in PDS-BEMR. Inmates coded as CARE2-MH need to have a rationale for the diagnosis and assigned mental health care level documented in a Diagnostic and Care Level Formulation. Additionally, inmates who are prescribed antipsychotic medication need to have the rationale for frequency and type of care documented in PDS-BEMR. Current and thorough documentation assists in guiding the treatment process, and with continuity of care if inmates transfer to different institutions or are released.

Inmates participating in follow-up drug treatment do not always have timely progress reviews documented in PDS-BEMR. Inmates who have completed the residential component of the RDAP, and are participating in follow-up services, need to have timely progress notes completed and documented in PDS-BEMR.

PROGRAM SUMMARY REPORT - FY 2019, 3rd QUARTER

RELIGIOUS SERVICES

NUMBER OF REVIEWS: Ten Religious Services Program Reviews were conducted from 4/1/19 - 6/30/19, with overall ratings of five superior, three good, and two acceptable. One repeat deficiency and ten deficiencies were identified.

MOST FREQUENT DEFICIENCIES THIS REPORTING PERIOD:

- There were no frequent deficiencies identified during this quarter.

REVIEWERS' COMMENTS:

Chaplains should be mindful of the special needs populations [i.e., female inmates, and inmates in Special Management Units (SMUs), Communication Management Units (CMUs), and Mental Health Units (MHUs)]. Also, care should be given in providing spiritual resources to inmates housed in SHU.

All incoming chapel media, whether purchased or donated, should be previewed and logged into the "Standardized Chapel Library Catalog" (SCLC) prior to distribution to the inmate population, per the Second Chance Act of 2007. Several chapels have developed a log sheet, of all incoming media items that are currently under review, comprised of the title and date of purchase (or donation), which has proven to extremely beneficial.

PROGRAM SUMMARY REPORT - FY 2019, 3rd QUARTER

RESIDENTIAL REENTRY

NUMBER OF REVIEWS: Four Residential Reentry Program Reviews were conducted from 4/1/19 – 6/30/19, with overall ratings of two acceptable and two deficient. One repeat significant finding, one repeat repeat deficiency, two repeat deficiencies, and thirteen deficiencies were identified.

MOST FREQUENT DEFICIENCIES THIS REPORTING PERIOD:

- Operational reviews were not conducted within the required time frames, and were not complete.
- Escape reports were not always completed on all escapes (actual or technical).

REVIEWERS' COMMENTS:

There was one repeat significant finding identified this quarter in contracting. Proper oversight of contracts is not being accomplished. Basic contract administration tasks, to include staff clearances, tracking of contract actions, and proper contract monitoring procedures, are not being followed. This causes a lack of credible accountability of the contract and assurance to the public, while increasing liability to the agency.

Operational reviews are often not completed according to policy. Staff should monitor operational review and follow-up date requirements to ensure they are in compliance with policy. Staff should ensure each guideline step is completed for an effective, policy compliant operational review. RRO staff are reminded that operational reviews must be closed prior to their next program review. P1210.23, Management Control and Program Review Manual, provides guidance on the operational review process.

Oversight needs to be strengthened to ensure all contracting documentation (e.g., monitoring reports, IGAs, CEFs, and contractor training) is reviewed for accuracy, completeness, and policy requirements, as well as ensuring it is in accordance with BOP guidelines and in the best interest of the agency. Failure to do so causes a lack of credible accountability of the contract and assurance to the public, while increasing liability to the agency.

Victim/Witness notifications were not always submitted immediately upon an inmate being placed on escapes status. RRO staff failing to notify victims/witnesses of escapes could have life threatening consequences.

PROGRAM SUMMARY REPORT - FY 2019, 3rd QUARTER

TRUST FUND

NUMBER OF REVIEWS: Ten Trust Fund Program Reviews were conducted from 4/1/19 – 6/30/19, with overall ratings of nine superior and one good. One deficiency was identified.

MOST FREQUENT DEFICIENCIES THIS REPORTING PERIOD:

- There were no frequent deficiencies identified during this quarter.

REVIEWERS' COMMENTS:

Although not a frequent deficiency, inmate performance pay continues to be a concern. Procedures should be put in place to ensure inmate pay is posted, reconciled, and transmitted, via IPAC to the Deposit Fund, Trust Fund Branch, no later than the 15th of the month. Refer to P4500.12, Trust Fund/Deposit Fund Manual, Chapter 9, Para 9.10, and Chapter 11, for further guidance.

Operational reviews continue to be a concern. Operational reviews must be completed using the correct guidelines, the working papers must be signed and dated, and all identified areas of concern documented in the report. In addition, responses, follow-up reports, and closures are required for operational reviews. P1210.23, Management Control and Program Review Manual, provides procedures and time frames for completing operational reviews.

PROGRAM SUMMARY REPORT - FY 2019, 3rd QUARTER

UNICOR

NUMBER OF REVIEWS: Four UNICOR Program Reviews were conducted from 4/1/19 – 6/30/19, with overall ratings of four superior. One deficiency was identified.

MOST FREQUENT DEFICIENCIES THIS REPORTING PERIOD:

- There were no frequent deficiencies identified this quarter.

REVIEWERS' COMMENTS:

Work measurement files need to be maintained for all products manufactured within the factory, and for all processes within factory operations. The set-up and run times in the work measurement file should reflect accurate data and match the times on the current Item Standard Routings.

The current policy on production scheduling requires production schedule stability (PSS) of 85 percent or better. This rate is determined by the number of jobs with no changes x 100, then divided by the number of released jobs for the period being reviewed. Although there are a variety of reasons or justifications why a job would start late or finish late, factory managers are reminded to document the reason or justification in the job header text within SAP.

Staff should ensure that operational reviews are conducted based on the week of the last program review (10-14 months and 22-26 months afterwards). Current PRGs and operational review working papers are available on Sallyport. Staff are reminded, when conducting an operational review, all components, with the exception of the climate, must be completed. If a step does not apply to the site, then N/A can be used on the working paper and that step should be retained with the working papers.

The program review process continues to be policy driven, and regardless of the overall performance, the operation must still adhere to all policies, procedures, and laws. Staff are encouraged to stay abreast of program statements and other directives for program compliance. Use of the program review guidelines as the only means of program compliance is inadequate, as the guidelines were developed for periodic program examination, and only cover small parts of various processes and procedures.

PROGRAM SUMMARY REPORT - FY 2019, 3rd QUARTER

VOLUNTEER SERVICES

NUMBER OF REVIEWS: Ten Volunteer Services Program Reviews were conducted from 4/1/19 – 6/30/19, with overall ratings of four superior, two good, and four acceptable. Fourteen deficiencies were identified.

MOST FREQUENT DEFICIENCIES THIS REPORTING PERIOD:

- There were no frequent deficiencies identified during this quarter.

REVIEWERS' COMMENTS:

Reentry Affairs Coordinators (RACs) should retain the old Volunteer Checklist (BP-A0578), along with the new checklist, in section one of the Official Volunteer File (OVF). This will ensure the approving official's signature is on file certifying the 4-hour training and packet completion.

RACs are to enter "end dates" for all Level 2 inactive volunteers in the National Automated Volunteer System (NAVS). Inactive OVFs should be maintained for 3 years from the end date of service, inclusive of the expired volunteer badges.

The Volunteer Services Institution Supplement does not need to be approved annually by the regional reentry affairs coordinator. This is only necessary when the supplement is updated.

As a reminder, RACs are to use and maintain the official forms, as noted in Attachment A, P5300.22, Volunteer Services. Maintaining the appropriate volunteer documentation is the responsibility of the RAC.