ISSUED: September 27, 2004 **IR-02-36-04**

THE UNITED STATES VIRGIN ISLANDS

OFFICE OF THE VIRGIN ISLANDS INSPECTOR GENERAL

INVESTIGATIVE REPORT

REAPPEARANCE OF HIV TEST SPECIMENS
ST. JOHN, VIRGIN ISLANDS

ILLEGAL OR WASTEFUL ACTIVITIES SHOULD BE REPORTED TO THE OFFICE OF THE VIRGIN ISLANDS INSPECTOR GENERAL BY:

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GOVERNMENT OF THE UNITED STATES VIRGIN ISLANDS
OFFICE OF THE V. I. INSPECTOR GENERAL
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September 27, 2004

Honorable Charles W. Turnbull
Governor of the Virgin Islands
Government House
21-22 Kongens Gade
Charlotte Amalie
St. Thomas, Virgin Islands 00802

Honorable David Jones
President
25th Legislature
Capitol Building
Charlotte Amalie
St. Thomas, Virgin Islands 00802

Dear Governor Turnbull and Senator Jones:

This investigative report contains the results of our investigation of the January 28, 2004 recovery of HIV test specimens taken on St. John, Virgin Islands and reported missing on July 15, 2003[1].

On January 29, 2004, the Office of the Virgin Islands Inspector General (V.I. Inspector General's Office) was notified that the missing HIV test specimens had been recovered and were being maintained under lock at the Commissioner's Office for the Department of Health (Health). We met with representatives of Health and were requested to investigate the circumstances surrounding the reappearance of these HIV test specimens. The investigation continued through March 5, 2004. At the conclusion of the investigation, insufficient evidence was found to recommend a criminal prosecution.

A report was prepared and submitted to the Commissioner of Health on March 10, 2004. A response was received on September 8, 2004, and is included as an appendix, beginning on page 12 of this report.

[1]Refer to Investigative Report number IR-01-36-04 entitled "Disappearance of HIV Test Specimens - St. John, Virgin Islands" issued on December 10, 2003.

Before discussing this investigation, it should be noted that the prior report (IR-01-36-04) indicated that it was not possible to make a definitive judgment on whether or not the St. John HIV test specimens were delivered to the St. Thomas Clinic (Clinic).

Evidence developed during this investigation indicated that the Nurse (the person designated to have custody of the HIV test specimens and to deliver them from St. John) had, in fact, delivered the tests to the Clinic as she had said in her statements and interview.

INVESTIGATION

Background and Scope

The purpose and function of the Clinic were discussed in our December 10, 2003 Investigative Report, IR-01-36-04. Of the recommendations made in that report, one significant physical change was noted and this was the relocation of the Outreach Workers from the Clinic to Barbel Plaza, thereby reducing the over crowding conditions in evidence at the time of the first report. In addition, three individuals have been released from employment or resigned since the first report. Tensions between staff at the Clinic appear to have been substantially reduced.

When the test specimens were reported recovered, they were taken into our custody, and remained here until they were returned to Health on April 14, 2004.

A review of the contents of the box discovered at the Clinic on January 28, 2004, determined that the HIV test specimens and attendant paperwork were, in fact, those taken on St. John on June 28, 2003. During this inquiry, we were provided with a memorandum from a Health employee that had not been submitted during the original investigation. The memorandum stated without equivocation that the employee saw the St. John box of test specimens in the Clinic on two occasions between the dates of June 30 and July 2, 2003. On at least one of those two occasions, the box was in the Outreach Workers' Office as described by the Nurse and the Clinic Doctor during the first investigation.

At least three individuals associated with Health purported to have thoroughly searched the offices of the Clinic where the test specimens were reported to have been seen by the Nurse and the Clinic Doctor. Each concluded, independent of the others, that the tests were not in the Clinic at least as late as when refurbishing work was accomplished on the file storage areas some time in December 2003.

The test specimens discovered on January 28, were found in a brown box, on top of a file cabinet, in a storage room behind the Administrative Officer's office in the Clinic. The Administrative Officer found the box while cleaning the file storage area.

This individual initially said the HIV Prevention Coordinator left the box at the Clinic with instructions to "hold on to it." The individual could make no accurate judgment when this occurred. The earliest date would be about November 1, 2003. In fact, the more probable date when the test specimens were actually returned to the Clinic is closer to the January 28, 2004 date. Two observers recollected that the box found on January 28th was not in the file storage room as late as some time in December 2003.

When the box was found, the Clinic Doctor was notified. The employee also later notified her immediate supervisor. The Clinic Doctor identified the contents of the box as the missing test specimens and made a phone call to the St. Croix HIV Office leaving a message for her immediate superior that the specimens had been found. The supervisor of the employee that found the box notified an Acting Deputy Commissioner and was subsequently directed to deliver the box to the Commissioner's Office. We were notified the following day and an investigation commenced.

Missing HIV Test Specimens

A total of five people were interviewed beginning with three individuals present when the box was first delivered to the Commissioner's Office. An analysis was also made of the information available from the documentation returned with the test specimens. The box containing the test specimens was fingerprinted with no conclusive results.

Prior to being interviewed, written statements were obtained by Health, from the three people directly involved with the discovery of the HIV test specimens at the Clinic. These individuals and two others, identified during the inquiry, were interviewed at the Inspector General's Office.

Three of the persons involved with the discovery of the test specimens had access to the Clinic both during and after working hours. All three were subpoenaed by us; each was asked to complete a questionnaire concerning their knowledge of the discovery. Two of the three complied. One individual, the Program Administrator, refused to complete the questionnaire.

This same individual, during questioning, was openly defiant and refused to cooperate with the interview process. After some time, the belligerence became less open but was nonetheless near the surface throughout the interview. Often, the individual would respond to questions with incomplete answers, half-truths and untruthful answers. The belligerence initially in evidence would erupt from time to time when faced with conflicting statements or improbable scenarios suggested by the answers to questions.

However, this same individual willingly discussed alleged long-term inept management within Health. It was explained how Health had used the individual's education, talent and experience, but had not acknowledged these attributes, or provided compensation for them. The individual was most disgruntled over having been disciplined over having "questioned a decision." The individual was recently moved from the largest office to the smallest office in the Clinic and was denied access to or input in the Clinic's budget.

One of the untruthful statements made by this individual was regarding the box containing the discovered St. John HIV test specimens. It was this person who called the Commissioner's Office and subsequently delivered the box to the Commissioner's Office. However, the individual maintained that the box recovered from the Commissioner's Office was not the box that had been taken there. Investigation by us determined that this was an untruthful statement. The individual was asked to explain how the box would have been changed. The individual did not know, but stated that someone at the Commissioner's Office would have had to be responsible.

In the alternative, the individual opined that someone with the Inspector General's Office might have switched boxes. When informed that three people present when the box was delivered had identified the box at the Inspector General's Office as the same one that had been delivered, the individual had no response other than to maintain that the box at the Inspector General's Office was not the box delivered to the Commissioner's Office.

These facts and the responses to questioning are not, in and of themselves, conclusive proof that this individual had a hand in getting the missing test specimens back into the Clinic. However, taken as a whole, it is our opinion that this person was active in the replacement of the missing tests and was deceptive in providing complete information on their reappearance. This individual may also have been involved with or had knowledge of the person or persons who took the test specimens. If involved with the return then logic dictates that either the individual took the test specimens initially or conspired with one or more other persons in their disappearance. Of all the people interviewed concerning the reappearance of the HIV test specimens, this is the only person with a motive, ability and opportunity.

The Clinic Doctor is the second individual, with daily access and in a position of authority, who could have been responsible for, or cooperated in, getting the box of tests into the file storage area to be discovered. However, there was nothing in this person's answers or demeanor to suggest that she was less than truthful when speaking about the test specimens going missing or their return. In fact, it appeared to the investigators that she was much less interested in the tests or who took them or how they got back than she was about her clinical work with patients.

This person showed no particular concern over the disappearance or the reappearance of the test specimens. After having determined that the test specimens in the box were, in fact, from St. John, this person made one telephone call to her superior and went back to her work. She gave no instructions on what to do with the box of test specimens, and there was no known motive for this person to either take them originally or to eventually return them.

The third individual, the Administrative Officer, was obviously under great stress when interviewed. The written statement, the pre-interview questionnaire and the statements made in the interview were consistent, as far as they went. However, when questioned closely, the details of this person's knowledge, where that knowledge came from and the actions the person took were not consistent nor did the actions of this person meet "the reasonable man standard."

This person initially said the HIV Prevention Coordinator left the box at the Clinic with instructions to "hold on to it." Also, this individual, like the fist individual discussed above, initially maintained that the box taken from the Commissioner's Office was not the box found in the file room. It appeared to us that the person was in some way "coached" in answering questions. When faced with the facts of the box's history, this person ultimately stated that the box in which the missing HIV test specimens were, was not the box left by the HIV Prevention Coordinator as previously claimed.

To believe the HIV Prevention Coordinator for St. Croix left the box with test specimens in it defies logic. The HIV Prevention Coordinator was a pivotal person of interest in the original investigation. She was on St. John when the tests were collect and boxed for return. It was she who directed the Nurse to take custody of the box and to deliver it to the Clinic.

It is quite probable that the HIV Prevention Coordinator did deliver "a box" to the Administrative Officer at the Clinic some time after the test specimens were reported missing, as claimed. It is equally improbable that she delivered "the box" containing the missing test specimens to the Clinic and left them there to be found sooner or later. If that were the truth, there is no way she could anticipate that the box of missing test specimens would be discovered "later." The risk of identification would be too great if they were discovered "sooner." At the same time, logic dictates that one who was intimately involved in the original investigation would not; in her own person, return the missing test specimens, in-hand, to be discovered and her involvement reported.

On the same day that the administrative personnel who received the box were interviewed, the fourth individual, the HIV Prevention Coordinator, was also interviewed. She denied that she ever gave any box containing the HIV test specimens to anyone. She agreed that she might have, from time to time, delivered boxes and other items to the Clinic but that in each such case, the contents were in the ordinary course of her position.

A fifth person, the HIV Surveillance Officer, was interviewed and provided information about the box delivered to the Office of the Commissioner of Health. This person recalled giving the box, before the test specimens were placed in it, to either a now retired employee or to the Program Administrator.

Security at the St. Thomas Clinic

It could not be determined if the test specimens were delivered to the Clinic during normal working hours or after the building was closed. If they were delivered to the file storage room during normal working hours, then there leaves little question that someone within the Clinic is the responsible party. There are times when the Administrative Officer's office door is open, the door to the file room behind that office is open and the Administrative Officer is not there; for example, when she leaves the building on an errand or when she is out sick.

It should also be noted that the security measures in place at the Clinic are for the most part reasonable and adequate. However, they are less that optimum. There is room for additional implementation and better use of the security measures in place.

If the tests were brought back into the Clinic after hours, there were 7 potential security barriers that had to be negotiated:

- A locked gate at the vehicle entrance to the Clinic grounds;
- A security guard on the outside premises;
- A security alarm within the building;
- A padlocked iron gate at each entrance door;
- A deadbolt lock on each entrance door;
- A keyed lock to Administrative Officer's office door;
- A keyed lock to the file room behind the Administrative Officer's office.

However, the gate to the outside perimeter fence is missing from one side of the vehicle entrance, leaving the entrance to the grounds open for unrestricted ingress and egress. The outside security guard is frequently absent from duty. The security alarm keypad uses a common number for everyone in the office so that it is impossible to determine who enters the building after normal working hours.

The keys to the iron gate at the entrance doors, the deadbolt at the entrance doors and the locks to the Administrative Officer's office and that of the file room behind the Administrative Officer's office had been changed after the disappearance of the St. John test specimens, and possession restricted to 4 people: the Clinic Doctor, the Program Administrator, the Administrative Officer and the Programs Director. However, as previously indicated, the Administrative Officer's office and the file room were often left open and unattended during the course of a business day. In addition, the Programs Director did not have access to all of the keys need to get into the locked file cabinet room prior to the discovery of the HIV test specimens.

The security weaknesses from the missing entrance gate and the absent security guard are obvious. The security alarm system weakness may not be so obvious. The inside motion detector is armed and disarmed by pressing a 4-digit code in the key pad located at the back door to the Clinic. Everyone uses the same 4-digit number. If each individual authorized in the Clinic were provided their own secure 4-digit code, there would be a record at the alarm company of who went in after hours, how long they stayed and exactly when they left the building.

Finally, there is one security measure that seems to be lacking. Currently, the file cabinets, used for case file and for filing test information that indicates no HIV/STD/TB infection, are inexpensive, non-locking and non-fire resistant cabinets. Given the nature of the files, and their importance, the file cabinets used to store all Clinic records should be locking, fire resistant cabinets.

Analysis of Returned HIV Test Specimens

A specific number of HIV test specimens and their paperwork were recovered. In analyzing the information available from all the paperwork recovered it was determined that at least two test specimens and their paperwork were not in the box of recovered tests. After consultation with the Center for Disease Control in Atlanta, it was determined that there would be no need to locate those two individuals.

In addition there may have been 3 to 6 additional people tested for whom there was no information. This was based on the statement of one of the Outreach Workers who worked on the St. John Project. Our analysis of the test specimens information indicated that this particular Outreach Worker tested 6 people on June 28, 2003. However, she was certain that she tested at least 9 people and as many as 12. Therefore, there may be an additional 3 to 6 people tested whose identities are completely unknown.

Detailed questioning of this Outreach Worker developed that the most likely number tested by her on June 28th was 10. This would mean that there are likely 4 HIV test specimens with the attendant paperwork yet to be recovered.

Misplaced Paperwork Documentation

During the investigation, a significant number of file papers were found deposited in a locked filing cabinet. The documents we retrieved were from one of the individuals interviewed during the first inquiry. Most of these papers were locked in the employee's desk drawer. Some of the paperwork were active files she was working with.

The files were retrieved in August 2003 in the presence of the Programs Director, who took immediate custody of them. We never had custody of the paperwork, which consisted of primarily completed "Purple Forms", completed "Confidentiality Forms" and other casework material. What subsequently happened to that paperwork was not known.

During the interview of one of the employees in this current investigation, it was mentioned that the Programs Director, had, at some time in the past, given her a large bag with instructions to "hold on to it", saying its contents were related to the missing HIV test specimens. The bag was locked in a file cabinet in the storage room behind the Administrative Officer's office. This person said she did not know what was in the bag. The Programs Director did not tell her what was in the bag and she did not look.

When asked, she provided us with a black and red canvas bag inside a black trash bag. When this bag was opened, the paperwork work found were the documents that we had obtained in August 2003 and had given to the Programs Director. Approximately 900 "Purple Forms" and 268 "Confidentiality Agreements" were in the black and red bag.

A sample of 24 "Purple Forms" was selected and provided to Health Officials to assess whether or not there was a filing problem. In addition to the 24 randomly selected cases, 3 HIV-positive cases, 1 STD-positive case and one Pregnancy-positive case were included. From this sample it was determined that approximately 25% of the cases were not identifiable and another 25% of the files were incomplete. 33% of the HIV-positive files could not be located and the one STD-positive case could not be identified.

CONCLUSIONS

Missing HIV Test Specimens

After reviewing all the evidence and conducting interviews of the various individuals, it is our opinion that there is insufficient evidence to refer the matter for prosecution; and, the evidence is insufficient to say with certainty why and how the test specimens came to be returned.

It is our opinion that the St. John test specimens and the attendant paperwork were taken away from the Clinic in July 2003 by a person or persons unknown; and, the return of the test specimens to the Clinic was accomplished by or in cooperation with the person(s) who took the tests in July 2003.

It is our opinion that the St. John test specimens were returned to the Clinic between late December 2003 and late January 2004; with the most likely time being shortly before they were discovered on January 28, 2004.

The test specimens were returned to the Clinic either during normal office hours or after normal office hours. If the responsible person(s) returned the test specimens after normal working hours several security measures would have been compromised; and, this would indicate a person employed at the Clinic in January 2004.

It is also possible the HIV test specimens were returned during normal office hours. If this were done, then again, the most likely person to accomplish this would be someone employed at the Clinic on January 28, 2004.

Of all the individuals interviewed in this investigation the only person who refused to cooperate was the Program Administrator. This is also the only person that we were able to identify with motive, ability and opportunity.

Virtually anyone who worked at the Clinic would have the ability to carry out the box containing the missing test specimens. The same is true for the opportunity to return the missing test specimens during the day; anyone working at the Clinic could find the opportunity to place the box in the file cabinet storage room.

However, if the return was made after hours, only three people were identified as having all of the keys and knowledge to get into the building after it had been locked. Of those three, only the Program Administrator, was found to possess any motive; that being the treatment received from Health over the years. The Program Administrator clearly stated that Health's management was totally inept and had been so for a long time; that the individual was not appreciated for the education, commitment and longevity with Health; and, that quite to the contrary, the individual was improperly disciplined for efforts in questioning what was believed to be incorrect decisions.

Security at the St. Thomas Clinic

Security at the Clinic, while recently improved, lacks the attention to detail such matter should be given. Of the 7 security measures available to Health's management during the period of time that the missing HIV test specimens were returned, several were ignored or overlooked.

Although the entrance perimeter gate is closed and locked at the end of each day's business, the exit gate is missing and that allows unobstructed ingress and egress to the property. The security guard is reported to be frequently absent. This along with the missing gate makes access to the property easy. The motion detection alarm is armed and disarmed with the same number-code used by all employees. By using only one common number, there is no way of determining who may have entered the Clinic building after hours.

It was also noted that the file cabinets used to store all files, patient charts and correspondence are basic sheet metal cabinets with no locking device. This storage, especially in light of other security lapses, is inappropriate.

Analysis of Returned HIV Test Specimens

Not all of the HIV test specimens with their attendant paperwork were recovered when the box of missing HIV test specimens was found in the Clinic storage area. It is all but conclusive that at least two tests are missing; and, there may be as many as 4 more missing.

Missing Paperwork Documentation

It is our opinion that the paperwork collected from the Senior Case Manager in 2003 was given to the Administrative Officer for safe keeping and was then forgotten. It appears from the analysis of the sample of these documents that one or more HIV-positive and STD-positive patients went without treatment and/or follow up.

Health's administration is in part at fault because there is no departmental policy covering the use and storage of paperwork developed in the course of the Clinic's work with people. A standard operating procedure on how this paperwork is to be processed would have provided the Programs Director with guidance on what should have been done with the papers.

RECOMMENDATIONS

We recommend that the Commissioner of Health:

1. Establish a mission statement for each unit/division of Health consistent with Health's overall mission statement.

2. Establish a written protocol for outreach work that clearly defines each employee's responsibilities and the authority the employee may assert in accomplishing the work.

3. Establish written job descriptions for each position and make them easily accessible to anyone with an interest in the position.

4. Provide for, and insist upon, proper and effective management at the Clinic. Some thought might be given to separating the functions of the Medical Director from those of the Clinic Administrator.

5. Discourage individuals from contacting management and administrative personnel outside the formal chain of command.

6. Insist upon clear, frequent and accurate information from the line-level supervisors and management personnel so that the administration can know of needs and conflicts in the work place, sufficiently in advance, to properly address them before the problems become major.

7. Provide for an effective means of addressing employees' grievances beyond the line supervision level.

8. Take appropriate administrative action regarding any individual(s) involved in the reappearance of the missing HIV test specimens.

9. Take appropriate administrative action regarding the sequestration of the Health papers.

10. Review the physical security policies at the Clinic and take appropriate action to insure proper control of ingress and egress to the grounds, particularly after normal working hours.

11. Review the job title and work habits of the security guard on the outside grounds.

12. Provide each individual with a separate and individually identifiable alarm code for use with the security motion detector.

13. Install locked filing cabinets for all HIV/STD/TB records.

14. Establish written policies and procedures for the operation, management and maintenance of the Clinic.

15. Ensure that the written policies and procedures establish a protocol for paperwork creation, intake, processing, initial filing and use after filing.

16. Ensure that the written policies and procedures establish for control of keys for all locked doors and entrances of the Clinic.

17. Establish a definitive chain of command with clearly defined lines of authority and job responsibilities.

18. Manage the managers and line supervisors to insure accountability.

Department of Health's Response

The Commissioner of Health in her September 8, 2004 response agreed with all of the recommendations made in the report. The response detailed various management improvement steps to include the establishment of detailed policies and procedures, the creation of a management team, and the reassignment of personnel to better meet the needs of the program. The attached appendix beginning on page 12 of this report is the Commissioner's response.

V. I. Inspector General's Comments

Based on the response submitted and our limited review of the operations of the Clinic, we consider the recommendations resolved.

Should you our your staff require additional information, please feel free to contact me at 774-3388.

Sincerely,

Steven van Beverhoudt

Steven van Beverhoudt
V. I. Inspector General

Appendix:

GOVERNMENT OF
THE VIRGIN ISLANDS OF THE UNITED STATES

DEPARTMENT OF HEALTH

48 SUGAR ESTATE, ST. THOMAS, U.S.V.I. 00802

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September 8, 2004

Mr. Steven Van Beverhoudt
VI Inspector General
Office of the VI Inspector General
No. 75 Kronsprindsens Gade
Charlotte Amalie, St. Thomas
Virgin Islands 00802

Re: Investigative Report/ Reappearance of the Missing HIV Test Specimens

Dear Inspector General:

This letter serves as a response to the report from the Office of Inspector General's report issued March 5, 2004 concerning the recovery of the missing HIV test specimens from the STD/HIV/TB clinic offices located at the Old Municipal Hospital Complex on St. Thomas. Herein lists the Department of Health's response and update on the status of recommendations outlined in your report. We appreciate the continued diligence and support lent by your Agency during this year long investigation.

OIG RECOMMENDATIONS:

1. **Establish a mission statement for each unity/division of Health consistent with Health's overall mission statement.** Each STD/HIV/TB Program Administrator/Coordinator was instructed on July 23, 2004 to provide a mission statement for their unit/program . It was suggested that they visit either the CDC or HRSA website and download the statement specific for their program. If they could not locate one then, they were charged with the task of developing a statement. Each program currently lists specific goals and can be found in the July 2004 STD/HIV/TB Monthly Progress Report FORM A, attached hereto.

2. **Establish a written protocol for outreach workers that clearly defines each employee's responsibilities and the authority the employee may assert in accomplishing the work.** The current job specification for the Outreach Worker positions list clearly roles and responsibilities. Under review by the Centers for Disease Control and Prevention (CDC) are the Counseling and Testing Procedural Guidelines developed with the assistance of the National Minority AIDS Council (NMAC).

3. **Establish written job descriptions for each position and make them easily accessible to anyone with an interest in the position.** Currently the Interim Territorial Director has procured copies of all STD/HIV/TB Program Government NOPA job descriptions and is in the process of adding these descriptions to the file which contains contract position job descriptions. Two separate Job Description folders will be available in the Administrative Offices in the Knud Hansen Clinic in St. Thomas and the Orange Grove site in St. Croix for accessibility by staff. These folders will be added to the file drawer

which currently houses copies of ALL SIX STD/HIV/TB Program Federal Grants that are available for review by the general public.

4. **Provide for, and insist upon, proper and effective management at the St. Thomas Clinic. Some thought might be given to separating the functions of the Medical Director from those of the Clinic Administrator.** The STD/HIV/TB Program has created an Upper Management Team consisting of five (5) individuals who report directly to the Territorial Director. There are two (2) co-management teams consisting of a Senior Administrator and a Medical Director one team per district clinic site. A member of the Upper Management Team is the Fiscal Officer who is located in the STT Barbel Plaza site and therefore provides day-to-day on-site supervision of employees at that site. Program Administrators/Coordinators on staff are subordinate to the Upper Management Team and all remaining staff are subordinate to the Program Administrators/Coordinators. This promotes a clear and effective hierarchy and proper chain of command.

5. **Discourage individuals from contacting management and administrative personnel outside the formal chain of command.** Staff have had input into the development of new program organizational charts on July 23, 2004 and were apprised to utilize the proper chain of command when filing a grievance. Grievances should be filed with the direct Supervisor and if the supervisor does not respond within three (3) working days then staff may defer to the Territorial Director. In no instance should staff contact the Commissioner's office directly, specifically the Deputy Commissioner of Health Promotion and Disease Prevention unless the grievance is with the Territorial Director. This policy needs to be included in the written policy and procedure manual governing program operations. In the interim, the staff has been apprised of the grievance procedure via interoffice memorandum.

6. **Insist upon clear, frequent and accurate information from the line-level supervisors and management personnel so that the administration can know of needs and conflicts in the work place, sufficiently in advance, to properly address them before problems become major.** As of July 20, 2004 there have been several Executive Staff meetings and one joint staff meeting to address issues in the Division. Executive Staff has concluded that the best course of action is to have bi-monthly joint audiovisual staff meetings with an agenda inclusive of an update from each program. Additionally, utilizing the Government House issued format for Monthly Program Progress Reports allows a section of Form B, attached hereto, for Program Administrators/Coordinators to list major challenges/obstacles for that month. These reports are forwarded to the Territorial Director and then compiled and forwarded to the Deputy Commissioner of Health Promotion & Disease Prevention.

7. **Provide for an effective means of addressing employees' grievances beyond the line supervision level.** SEE RECOMMENDATION #5

8. **Take appropriate administrative action regarding any individual involved in the re-appearance of the missing HIV tests.** Internally, the Department has and continues to conduct fact finding discussions. To date, the Department has uncovered no evidence that directly implicates any individual in the reappearance of the test samples. Given the recent hiring of the Deputy Commissioner for Health Promotion and Disease Prevention, more administrative oversight shall be given directly to the program. At this point, we need to move forward and implement policies and procedures to prevent situations such as these from occurring.

9. **Take appropriate administrative action regarding the sequestration of Health Department papers.** The contents of the "red & black zippered" bag mentioned in the report are currently housed in a locked file cabinet in one of the offices in the Barbel Plaza site on St. Thomas. The Fiscal Officer and the Interim Territorial Director are the only individuals who are aware of this fact and the Fiscal Officer retains the

keys to the file cabinet and the office. Once the Interim Territorial Director obtains a locking file cabinet then the files will be transferred from the Barbel Plaza site to the Knud Hansen clinic. All documents requiring notification to be made to each patient will be made by the STT Medical Director.

10. **Review the physical security policies at the St. Thomas Clinic and take appropriate action to insure proper control of ingress and egress to the grounds, particularly after normal working hours.** Review of the policies has been performed. Consequently, the outside gate locks to the main clinic have been changed twice in the past year. Only four (4) STD/HIV/TB Program staff retain keys to this facility. The VIDOH maintenance and housekeeping department were issued one (1) key for the back service gate. All new employees are required to sign and date a Receipt of Keys form which is kept by the Territorial Director. The Security Department was directed via memorandum to document and report any suspicious activity to the Territorial Director and the Commissioner's Office in the Fall of 2003. An attendant form for such reporting has been developed.

11. **Review the job title and work habits of the security guard on the outside grounds.** The Department currently and continually reviews the work habit of the security guards. The Executive Staff has and continues to review the operations of the Department's security. The Deputy Commissioner of Administrative Services has met with the Coordinators and their supervisors to establish policies and procedures. Also, a cost analysis is being conducted to either augment or supplement the existing services with a private company.

12. **Provide each individual with a separate and individually identifiable alarm code for use with the Centurion Alarm System.** As of August 6, 2004 all current STT Knud Hansen Staff were issued individual PIN #'s to be used with the alarm system. The Centurion Main Office as well as the Interim Territorial Director retains a copy of this list. All entry to the building by PIN # is tracked in an electronic log generated by Centurion Security Systems.

13. **Install locked filing cabinets for all HIV/STD/TB records.** New fireproof locking file cabinets were purchased and all files were removed from the Administrative Officer's ancillary room to a new file room located adjacent to the Program Administrator's office. This ensures triple security of patient files by having the files in locked file cabinets that are located within a locked file room (key access restricted to 3 individuals) within the Program Administrators Office which has 2 locks on the door.

14. **Establish written policies and procedures for the operation, management and maintenance of the St. Thomas Clinic.** W ritten policies governing Virgin Islands STD/HIV/TB program operations for each program site is currently being developed. It is estimated that they will be completed by December 31, 2004. Currently staff are utilizing general CDC protocols found in the Program Operations Guidance for STD Prevention and HIV Prevention.

15. **In particular, the written policies should establish a protocol for paperwork creation, intake, processing, initial filing and use after filing.** SEE RECOMMENDATION #14.

16. **In particular there should be written procedures for key control of all locked doors and gate of the clinic.** SEE RECOMMENDATION #10

17. **Establish a definitive chain of command with clearly defined lines of authority and job responsibilities.** SEE RECOMMENDATIONS #4 &5

18. **Manage the managers and line supervisors to insure accountability.** SEE RECOMMENDATIONS #4 &5

Respectfully,

Darlene A. Carty
Commissioner

cc: Juel T.R. Molloy, Chief of Staff/DOH Liaison
Hubert L. Frederick, Deputy Commissioner Health Promotion and Disease Prevention
Taetia Phillips-Dorsett, Interim Territorial Director/STD/HIV/TB Program

Attachments