OFFICE OF THE STATE INSPECTOR GENERAL
Report to Governor Terence R. McAuliffe

INVESTIGATION OF CRITICAL INCIDENT AT HAMPTON ROADS REGIONAL JAIL

April 2016

June W. Jennings, CPA
State Inspector General
Report No. 2016-BHDS-002

COMMONWEALTH OF VIRGINIA

Office of the State Inspector General

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April 5, 2016

The Honorable Terence R. McAuliffe
Governor of Virginia
Patrick Henry Building, Third Floor
1111 East Broad Street
Richmond, VA 23219

Dear Governor McAuliffe:

The Office of the State Inspector General (OSIG) performed a review of the August 2015 critical incident at the Hampton Roads Regional Jail pursuant to *Code of Virginia (Code)* § 2.2-309.1: Additional powers and duties; behavioral health and developmental services. The objectives of this review were to: examine the sequence of events surrounding the death of an individual in the Hampton Roads Regional Jail (HRRJ); review processes in place related to referral and admission of HRRJ inmates to Eastern State Hospital (ESH); review the Department of Behavioral Health and Developmental Services (DBHDS) Office of Internal Audit Investigation Report released March 16, 2016; identify potential risk points; and make recommendations for systemic improvement in order to prevent similar events in the future.

On behalf of OSIG, I would like to express our appreciation for the assistance of multiple agencies and facilities including, but not limited to, Hampton Roads Regional Jail, Eastern State Hospital, and Portsmouth Department of Behavioral Healthcare Services. If you have any questions, please call me at (804) 625-3255 or email me at osig@osig.virginia.gov. I am also available to meet with you in person to discuss this report.

Respectfully,

June Jennings, CPA
State Inspector General

CC: Paul Reagan, Chief of Staff to Governor McAuliffe
Suzette Denslow, Deputy Chief of Staff to Governor McAuliffe
Dr. William A. Hazel Jr., Secretary of Health and Human Resources
Brian Moran, Secretary of Public Safety and Homeland Security
Members, Virginia Joint Commission on Health Care
Jack Barber, M.D., Interim Commissioner, Department of Behavioral Health and Developmental Services
Kathy Drumwright, Chief Deputy Commissioner, Department of Behavioral Health and Developmental Services
Jennifer Faison, Executive Director, Virginia Association of Community Services Boards
Colonel David Simons, Superintendent, Hampton Roads Regional Jail
Dr. Curtis Edmonds, Chairman, Hampton Roads Regional Jail Board
Colleen Miller, Executive Director, disAbility Law Center of Virginia
Mira Signer, Executive Director, National Alliance on Mental Illness Virginia

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Executive Summary

On August 24, 2015, the Office of the State Inspector General (OSIG) received a complaint regarding the death of an individual at Hampton Roads Regional Jail (HRRJ). The original complainant was a family member of the individual who was found dead in a jail cell on August 19, 2015, while awaiting transfer to Eastern State Hospital (ESH) in Williamsburg. The relative reported the individual had been in custody since April 2015. The individual was also reported to have lost a significant amount of weight in the four months spent in the jail, and the relative suspected the death was related to the individual refusing to eat.

OSIG conducted a review of the sequence of events surrounding the death of the individual in HRRJ, the processes in place related to referral and admission of HRRJ inmates to ESH, and the Department of Behavioral Health and Developmental Services (DBHDS) Office of Internal Audit Investigation Report released March 16, 2016, to identify potential risk points and make recommendations for systemic improvement in order to prevent similar events in the future. The review of this event involved multiple agencies and facilities including DBHDS, ESH, HRRJ, Portsmouth Department of Behavioral Healthcare Services (PDBHS), Portsmouth General District Court, NaphCare Inc., and Bon Secours Maryview Medical Center.

The scope of this review was not to evaluate the medical care provided in HRRJ, nor to repeat every element of prior investigations related to this event. Select information related to the clinical care and treatment of this individual was reviewed to identify additional areas for future review.

The following observations were identified during the course of the review:

- The current process of transferring inmates from HRRJ to ESH has multiple, significant risk points. In the absence of written and agreed upon protocols with responsible parties, timelines, and monitoring systems in place, the root causes of the significant event in HRRJ remain at risk for recurrence. For each step in the process, there must be a way to consistently substantiate completion, and each of the identified risk points must be addressed fully. DBHDS has facilitated regional admission and discharge protocols but none exist for management of this vulnerable population.
- ESH has experienced a significant increase in its operational burden since the implementation of the safety net law of 2014. The impact has been felt by multiple departments, including the admissions office, which prior to this event, had not modified its admissions process accordingly. While the structure of the admissions office and communication were revised following this event, the process for developing and ensuring the accuracy of the Jail Transfer Waiting List, also known as the Forensic Log, or for facilitating regional ownership has not. As the maintenance and accuracy of this document has been found to be <u>one</u> of the root causes of the significant event at HRRJ,

the accuracy and management of the list is critical to preventing similar events in the future.

- DBHDS has convened or participated in numerous workgroups, committees, and sub-committees in the past several years centering on improving services for individuals with mental illness who encounter the justice system. All of these, including the DBHDS Transformation Team for the Justice Involved, have resulted in recommendations for additional funding, ongoing committee work, oversight, training, and system re-design.
- The DBHDS Office of Internal Audit Investigation Report's two conclusions and two recommendations did not include a review of all potential root causes.
    - Although the first conclusion — that the ESH Jail Transfer Waiting List never contained the information related to the Competency Restoration Order (CRO) for the individual in question — is accurate and was substantiated by OSIG, the resulting recommendation does not address the root cause of the event. Educating the sole mailroom clerk and anyone who receives mail related to admissions does not correct or suggest a revision to the process that would ensure root cause(s) are addressed. Stating that admissions staff are to log court orders as received was the existing process when court orders were placed in an ESH desk drawer and remained there for weeks.
    - The second conclusion — that PDBHS staff never completed the required evaluation of the individual requested by HRRJ — is also accurate. However, recommending that DBHDS develop guidelines relating to court orders has no connection to that lapse in responsibility. The report recommends no process change to the Portsmouth agency to ensure they meet their *Code* requirements for emergency evaluations when requested. The last portion of that recommendation— that DBHDS explore the feasibility of a single point of entry for court orders — may address a process change but the connection to the events is not entirely clear to the reader. The report also contains no recommendations regarding the issues surrounding Crisis Intervention Teams (CIT) and jail diversion.
- HRRJ has a direct responsibility to provide quality medical and mental health care for those in their custody. Although NaphCare is no longer the contract agency providing medical and mental health services at HRRJ, a change in provider offers limited promise of improvement in care or documentation in the absence of a change in oversight practices. Review of NaphCare records raised significant concerns regarding the quality of assessment, care, follow-up, and documentation. It is those professionals trained and licensed to provide clinical care who have a duty to provide that care, and the agency that contracts with the provider is responsible for ensuring that care is provided.

Upon completion of the review, OSIG makes the following recommendations:

- **Observation #1 Recommendation**

DBHDS should take the lead on development of a regional protocol relevant to the management of individuals in HRRJ with mental illness, working together with HRRJ, local police departments, ESH, PDBHS, and the Health Planning Region (HPR) V Reinvestment Project Office. The focus of the agreement should include but not be limited to:

- Cross Systems Mapping Sequential Intercepts (including re-mapping)
- Crisis Intervention Teams (CIT)
- Jail Diversion
- Court Orders
- ESH admissions and discharges
- Mental health contact in HRRJ by PDBHS and other HPR V CSBs, and ESH staff

The regional protocol should include clearly identified responsible parties, timelines, and process flows. All five intercepts identified in regional Cross Systems Mapping efforts should be included, and the protocol should address gaps and opportunities for improvement. DBHDS should consider the applicability to regions across the state.

- **Observation #2 Recommendation**
  ESH should revise the process for the development, management, and oversight of the Jail Transfer Waiting List. A system for consistently reviewing the individuals on the list should be created and include the courts, CSBs, HPR V Reinvestment Project Office through the Facilities Management Committee (FMC), and HRRJ.

- **Observation #3 Recommendation**
  The recommendations of DBHDS's Transformation Team for the Justice Involved were substantive and — had they been implemented at an earlier time — would have had a significant impact on the justice-involved individuals with mental illnesses. This situation should be considered urgent and implementation plans developed immediately.

- **Observation #4 Recommendation**
  DBHDS's investigations of critical events should be conducted independently by professionals trained and experienced in conducting healthcare root cause analyses and who have experience working in the behavioral health system(s) in question. Reports should include all relevant risk points and analysis of root causes with specific recommendations targeting those root causes.

- **Observation #5 Recommendation**
  HRRJ should revise the process for overseeing the quality and outcomes of any contract agency that provides medical and mental health care in their jail. This process should ensure regular monitoring, direct oversight, and direct feedback and correction for areas of concern.

Purpose and Scope of the Review

OSIG performed a review of a complaint regarding a significant event at Hampton Roads Regional Jail (HRRJ) pursuant to *Code of Virginia (Code)* § 2.2-309.1: Additional powers and duties; behavioral health and developmental services. The original complainant was a family member of the individual who was found dead in a jail cell on August 19, 2015, while awaiting transfer to Eastern State Hospital (ESH) in Williamsburg. The relative reported the individual had been in custody since April 2015. The individual was also reported to have lost a significant amount of weight in the four months spent in the jail, and the relative suspected the death was related to the individual refusing to eat.

The objectives of this review were to examine the sequence of events surrounding the death of this individual, the processes in place related to referral and admission of HRRJ inmates to ESH, as well as the DBHDS Office of Internal Audit Investigation Report to identify potential risk points, and make recommendations for systemic improvement in order to prevent similar events in the future. The scope of this review was not to evaluate the medical care provided in HRRJ, nor to repeat every element of prior investigations related to this event. Select information related to the clinical care and treatment of this individual was reviewed to identify additional areas for future review.

Background

Mental Illness in Virginia Jails

The Virginia State Compensation Board's annual report on Mental Illness in Jails was released November 1, 2015. Although there are limitations to the data, including the fact that it is a snapshot survey and contains self-reported and unverified data, it is the only current source for data on mental illness in the jails. The 2015 report states that there are 3,303 inmates (13.2 percent of the average daily jail population) with a serious mental illness (SMI) defined as schizophrenia, schizoaffective disorder, delusional disorder, bipolar disorder, major depression, and post-traumatic stress disorder. According to the Compensation Board Report, in 2015 jails reported the highest percentage of both male and female inmates with mental illness in the four years shown.

Percentage of Female/Male General Population with Mental Illness (Using Inmate Counts)

Year	*Female*	*Male*
2015	25.29%	13.63%
2014	20.87%	12.43%
2013	16.13%	12.64%
2012	14.40%	10.35%

Source: 2015 Compensation Board Report

In 2015, 10 out of the 60 local and regional jails and jail farms in Virginia accounted for 52 percent of the SMI population in jails, and HRRJ was second only to Riverside Regional Jail in the number of inmates with an identified SMI. Forty-nine percent of inmates with SMI in all jails were incarcerated for non-violent crimes. This was the case of the individual who died in HRRJ. Although one-third of jails, including HRRJ, operate mental health units, inmates are frequently held in segregation for either their own or others' protection. More than two-thirds of Virginia's jail mental health beds are located in eight jails, three of which are located in the Tidewater region (HRRJ, Chesapeake Jail, and Virginia Beach Jail). Those inmates not held in a mental health bed or segregation are housed with the general jail population.

CSBs currently have no statutory requirement to provide treatment in jails, so, many do not unless resources are provided by localities. According to the Compensation Board Report, the greatest percentages (44 percent) of mental health services in jails are provided by private contractors. According to the Compensation Board Report, CSBs provide 35 percent of jail-based treatment. CSB staff performing emergency evaluations in jails are the same emergency services professionals that respond to community emergencies and have been significantly impacted following the implementation of the 2014 changes to the civil commitment laws.

Crisis Intervention Teams and Assessment Centers

The CIT model was originally developed by the Memphis, Tennessee, Police Department, and has subsequently spread throughout the country as a recognized best practice. The CIT model includes programs designed to improve responses to individuals experiencing behavioral health crises who come into contact with law enforcement first responders. Virginia's civil commitment laws have made it such that law enforcement officers have consistent and prolonged exposure to individuals in mental health crisis and are often the individual's first contact during a crisis. The 40-hour CIT training enables law enforcement and others who participate in the training to better understand individuals suffering with mental health issues, to communicate more effectively with those individuals, to develop more effective ways to de-escalate crisis situations, and, possibly, connect individuals with needed treatment, in lieu of incarceration.

Virginia's first CIT was developed in the New River Valley area. In 2009, the Virginia General Assembly acted to support the establishment of CIT programs in areas throughout Virginia. As of August 2015, Virginia had 26 CIT programs at various levels of operation, with an additional 11 programs in planning or development stages. Essential to the CIT concept is the partnership between law enforcement, mental health providers, and the community.

Jail Diversion

Beginning in 2007, the Virginia General Assembly approved funding to support efforts to divert those with mental illnesses away from unnecessary incarceration by way of jail diversion programs. Jail diversion programs are designed to identify individuals with serious mental illnesses and co-occurring disorders early in the process, divert them from the criminal justice system either pre- or post-arrest, and connect them with treatment in lieu of incarceration. Select CSBs received funding to provide this program, while others have elected to do this without additional funding.

DBHDS

DBHDS operates seven adult behavioral health facilities including Eastern State Hospital in Williamsburg. The DBHDS Office of Forensic Services serves individuals involved in the court system and supports programs that provide screening and evaluations, treatment of individuals with mental illness in jail, case management, and restoration to competency to stand trial. In addition, the division focuses on providing services and supports to individuals at risk for involvement in the criminal justice system.

In the past several years, DBHDS has been involved in numerous initiatives focused on individuals with behavioral health issues who become involved with the judicial system. In 2014, then-Commissioner Debra Ferguson, Ph.D., convened several Transformation Teams, whose mission was to make recommendations to DBHDS for system-wide improvement. One of these teams was specifically focused on justice-involved individuals. To date, these recommendations

have not resulted in legislative action or system changes. A summary of recommendations made by this team in spring and fall 2015 is listed below:

- Develop mechanisms for notification and ongoing communication between jails, detention centers, correctional facilities, and CSBs to allow for a more seamless transition between incarceration and the community, and, when unavoidable, from community to incarceration.
- Implement a standardized system for prompt screening, assessment, and identification of behavioral health (BH) and intellectual and developmental disability (ID/DD) issues, in every jail, detention center, and correctional facility.
- Set standards requiring jails, detention centers, and correctional facilities to have a certain percentage of their staff who have received advanced training in BH and ID/DD issues (to include identifying individuals with BH/ID/DD issues, responding therapeutically to individuals with BH/ID/DD issues, and responding to individuals in crisis).
- Increase capacity of jails, detention centers, and correctional facilities to provide a minimum standard of BH services (comparable to outpatient level).
- In order to promote quality, access, and continuity of care it would be best if CSBs were the designated provider of services for this population.
- Regardless of who is providing BH services in the jail, each CSB should have at least one staff member whose primary responsibility is to coordinate planning for individuals being released from jail and needing follow-up services from the CSB. The Virginia General Assembly should fund the creation of these positions.
- Ongoing case management services throughout the period of incarceration or detention:
    - Each CSB should maintain an open case for this population.
    - For those not previously opened to the CSB, a case should be opened.
    - Frequency/duration of case management will be dependent on an individual's needs.
    - Caseloads will be determined by acuity of clients served; however, every CSB should have at least one designated staff member whose primary responsibility is case management for those involved in the criminal justice system.
- Prompt access to inpatient psychiatric care (either at a DBHDS facility or a designated facility) when the need arises.

Virginia Cross Systems Mapping

In 2008, then-Governor Timothy Kaine issued Executive Order 62 establishing the Commonwealth Consortium for Mental Health and Criminal Justice Transformation. One of the key programs that resulted from that Executive Order was the Cross Systems Mapping initiative. The primary objectives of Cross Systems Mapping are as follows:

1. To develop a comprehensive map of how individuals with mental illness and co-occurring disorders flow through the criminal justice system along five distinct intercept points:
    a) Law enforcement and emergency services;

b) Booking and initial detention/initial court hearings;
c) Jails and courts;
d) Re-entry from jails and prisons; and
e) Community corrections/community support.

2. To identify gaps, resources, and opportunities at each intercept for individuals in the target population.
3. To develop a list of priorities and action steps designed to improve system and service-level responses for individuals in the target population.

The Cross Systems Mapping for Portsmouth was completed in April 2011. The progress on any action plans was not evaluated as a part of this review. Since that time, DBHDS has assisted several localities in updating their maps. The re-mapping program is voluntary and, although PDBHS has expressed an interest, they have not completed a re-mapping as of March 2016.

Eastern State Hospital

ESH is a DBHDS-operated facility with an operational bed capacity of 304. That number does not account for the closure of the five-bed acute hospital unit nor the beds taken offline several years ago to support a programming revision.

Jail Transfer Process

Individuals in jails may be transferred to ESH for evaluation and treatment in one of two ways. Individuals may be court ordered by a judge to ESH, as was the case with the individual who died at HRRJ, or they may be admitted to ESH under a Temporary Detention Order (TDO) after being evaluated by a CSB emergency services worker. At the time an individual receives a TDO they are subject to the same laws as any individual in the community with the exception of instances when a facility is not available as stated in *Code* § 37.2-81.

HRRJ

Regional jails, such as HRRJ, provide jail space to multiple localities, which may or may not operate local jails in their own localities. They are administered by a superintendent, who serves the regional jail board or jail authority. The Board of Corrections sets standards for administration and operation of jails among other responsibilities, and the Department of Corrections monitors jails' compliance with those standards. HRRJ has a high population of inmates with mental health and medical issues compared to other jails. The participating jurisdictions send many of their inmates with severe mental health or medical issues to HRRJ, which maintains a mental health pod and medical pod with 24-hour on-site nursing staff.

In August 2015, NaphCare was the contractor responsible for providing medical and mental health care at HRRJ. Naphcare, based in Birmingham, Alabama, employs more than 1,000 medical professionals nationwide. The company provides on-site comprehensive care, dialysis,

electronic health records implementation and support, and off-site management services to clients in 28 states, including the Federal Bureau of Prisons; the Departments of Corrections for New York, Oklahoma, and Oregon; and the Virginia cities of Richmond and Virginia Beach. NaphCare no longer holds the contract to provide medical care at HRRJ.

PDBHS

According to the PDBHS website, "DBHS gives precedence to the following Priority Populations (sic) with intellectual disabilities, mental health and/or substance use disorder; pregnant females, intravenous (IV) drug users; HIV+, and individuals who are experiencing a mental health crisis, have been discharged from a psychiatric hospital or state training facility, and/or diverted from a psychiatric hospital or jail. Individuals are assessed and triaged within 24 hours of contact with the agency." As HRRJ employs a contractor to provide medical care, including mental health services, PDBHS does not provide mental health services in the jail except on occasions when PDBHS is called to complete an emergency evaluation.

PDBHS began receiving funding for its jail diversion program in 2008. PDBHS also supports a CIT assessment center that was established in partnership with Chesapeake Integrated Behavioral Healthcare Services, local law enforcement, and a local medical center. Funding also supports one full-time position to provide pre- and post-booking services for individuals currently in jail identified as having symptoms of mental illness, and are charged with minor, non-violent crimes.

CSBs, including PDBHS, often consider themselves "out of the process" if an individual, even those known to the CSBs, is in a local or regional jail, as the individual is deemed to be "in a safe environment." A November 2015 report to the House Appropriations Committee titled Overview of Mentally Ill in Local and Regional Jails states:

> "Individuals held in jails are deemed to be in a safer environment than referrals from community, so are lower admission priority for DBHDS … In June of 2015, Jails reported that 77 inmates were waiting for transfer to state mental health facility [sic] more than 72 hours after TDO issued."

This mindset is in conflict with the fact the jails are not currently considered to be an appropriate or "safe" setting for treating the mentally ill. If jails are to be providing quality behavioral health services to inmates, funding and operations must support that intent and not leave the jails to simply absorb and house an increasing mental health population.

OSIG

In January 2014, OSIG released a report entitled A Review of Mental Health Services in Local and Regional Jails. Several recommendations remain relevant to the focus of this review including:

- "CSBs and local jails should develop written and joint agreements among affected CSBs when individuals with mental illness are in regional jails. At a minimum, these agreements should address:
  - The timely exchange of information at point of entry and release.
  - The capacity for CSBs to provide onsite engagement with individuals identified as current consumers or likely to need CSB community follow-up on release.
  - Transition procedures for individuals who are actively receiving mental health treatment at release.
  - Pre-admission screening roles and responsibilities, including time limits for responding to jail requests."

Review Methodology

This review was conducted in compliance with the Association of Inspectors General Principles and Standards for Offices of Inspector General: Quality Standards for Inspections, Evaluations, and Reviews (May 2014). In preparation for this review, OSIG utilized the following documents as part of conducting extensive background research into the events preceding and following the death of the inmate at HRRJ:

- HRRJ documents
- NaphCare documents;
- Maryview Medical Center documents;
- ESH documents and policies;
- State Compensation Board Report (2015);
- Numerous reports from DBHDS and members of the General Assembly; and
- DBHDS Office of Internal Audit Investigation Report.

Interviews were conducted with:

- Hampton Roads Regional Jail staff;
- Portsmouth Department of Behavioral Health Services staff ;
- Eastern State Hospital staff;
- NaphCare staff;
- Virginia Community Services Boards Association (VACSB) leadership;
- DBHDS staff;
- Virginia Deputy Secretary of Public Safety and Homeland Security;
- HPR V Reinvestment Project Director; and
- Hampton Newport News CSB (current) Executive Director.

Review Results

Observation No. 1

In reviewing the process for jail transfers to ESH, OSIG identified multiple decision points, risk points, and opportunities for variation in the process, all of which have the potential to create risks through which unanticipated and egregious outcomes may occur. In summary, the entities involved include the following in order of occurrence:

1. Portsmouth Police Department
2. Portsmouth CIT
3. HRRJ, which includes NaphCare
4. PDBHS-Jail Diversion
5. Portsmouth General District Court
6. ESH
7. Bon Secours Maryview Medical Center
8. PDBHS-Emergency Services

The following is a list of decision points that create the potential for variation in decision-making and outcomes, thus creating risk for individuals. OSIG also found no evidence of the existence of any standards, protocols, decision trees, or required time frames, or that monitoring had been established for these decision points at the time of the HRRJ death.

1. **Decision Point 1** — At the time of the alleged crime, the determination is made whether or not to engage the local CIT and assessment center. This may be impacted by availability of CIT trained personnel and assessment center availability.
2. **Decision Point 2** — Once in jail, a decision is made whether or not to bond out an individual who does not appear to have a mental illness and has committed a minor or non-violent offense.
3. **Decision Point 3** — If not bonded out, an individual with a suspected mental illness may receive an evaluation by the local CSB with one of the following possible outcomes:
    - The individual may be placed under a TDO, if it is determined an inpatient bed is needed urgently;
    - Recommend to the court that the individual should be transferred to ESH at some time in the future; or
    - The individual remains in the jail and receives treatment there. Note: It is not clear why this individual was permitted to decline jail diversion and that this decision did not call into question the individual's competency to be able to make that decision.
4. **Decision Point 4** — Following the evaluation by the local CSB — and dependent upon the evaluator's recommendations — the court makes the decision whether or not to issue a Restoration to Competency Order (RCO).

5. **Decision Point 5** — If a RCO is written, the court determines the manner by which to communicate the order to ESH including U.S. Postal Service, email, or fax. No confirmation of receipt was required in the case of the individual who died at HRRJ. There have also been occasions when the order has been sent to DBHDS Central Office before or in lieu of being sent directly to ESH.
6. **Decision Point 6** — Once ESH receives the RCO, the decision is made by individual ESH staff regarding how much and when to obtain collateral information from the jail and to schedule admission. ESH also established a process in 2011 allowing staff to bypass the policy to obtain collateral information and decide to admit individuals with significant symptoms if the individuals were arrested for minor or non-violent crimes. (That exception was not exercised in this instance.)
7. **Decision Point 7** — In the case of the individual who died at HRRJ, and with other inmates, the jail staff may decide during the course of the inmate's stay that the individual meets the criteria for an emergency evaluation and probable TDO. Currently there is no process in place regarding timelines for completion, communication, responsible parties, or follow-up.

In the absence of written and agreed upon protocols with responsible parties, timelines, and monitoring systems in place, the root causes of the death of the inmate in HRRJ remain at risk for recurrence. For each step in the process, there must be a way to consistently substantiate completion, and each of the identified risk points must be addressed fully. DBHDS has facilitated regional admission and discharge protocols but none exist for management of this vulnerable population.

Observation No. 1 Recommendation

DBHDS should take the lead on development of a regional protocol relevant to the management of individuals in HRRJ with mental illness, working together with HRRJ, Local Police Departments, ESH, PDBHS, and the HPR V Reinvestment Project Office. The focus of the agreement should include but not be limited to:

- Cross Systems Mapping Sequential Intercepts (including re-mapping)
- Crisis Intervention Teams (CIT)
- Jail Diversion
- Court Orders
- ESH admissions and discharges
- Mental health contact in HRRJ by PDBHS and other HPR V CSBs, and ESH staff

The regional protocol should include clearly identified responsible parties, timelines, and process flows. All five intercepts identified in regional Cross Systems Mapping efforts should be included, and the protocol should address gaps and opportunities for improvement. DBHDS should consider the applicability to regions across the state.

OBSERVATION NO. 2

ESH is the state facility that has most significantly been impacted by the 2014 civil commitment law changes. However, during the time period this individual was under a CRO these changes did not limit the bed availability on the ESH unit that accepts jail transfers. At the time of the individual's death in HRRJ last August, ESH operated two units that accept jail transfers, 3B, a female unit, and 4A, a male unit. The maximum bed capacity for unit 4A is 22. OSIG learned during the course of this review that between the dates of the individual's court order for transfer to ESH (May 21, 2015) and the individual's death (August 19, 2015), Unit 4A only had one day, May 21, 2015, where its average daily census was at full capacity (22). Although the average daily census for that one day may have indicated that ESH's male jail transfer unit was full, had the individual been placed on a TDO, the 2014 commitment law changes should have meant a bed would be available prior to a jail transfer of someone who was not on a TDO. On July 31, 2015, the date of the second court order and the day HRRJ also requested PDBHS perform a preadmission screening for a possible TDO, Unit 4A had an average census of 18 indicating that several beds were available to accept admissions.

On August 28, 2015, following the death of the individual at HRRJ and more than a year after the implementation of the safety net law, ESH re-organized admissions in an effort to streamline the process and improve efficiency. The revised process included:

1. Re-organizing the skill mix of admissions staff;
2. Adjusting admission staff hours to enhance response to inquiries and admissions from CSBs, area jails, and Central State Hospital; and
3. Improving readiness of individuals already admitted under a TDO to attend court hearings.

Prior to this revision, the ESH admissions office had up to four staff present during the hours of 7 a.m. and 3 p.m. and none present for the remaining hours of the day or on weekends, despite reports that the majority of admissions occur between 3 p.m. and 2 a.m. During these hours, nursing supervisors coordinated all admissions in addition to their responsibilities for patient care and staff supervision. The revised plan does not address the completion or updates to the Jail Transfer Waiting List or the development of a monitoring system to ensure it is kept up to date. This list is utilized by ESH forensic leadership, the DBHDS's Competency Restoration Counselor, and the Region V Facilities Management Committee (FMC). The FMC is comprised of representatives from HPR V's nine CSBs, ESH, and the HPR V Reinvestment Project Office. During the weekly meeting, staff review updates on non-forensic individuals in private community beds who are receiving regional funds for payment and briefly discuss the number of individuals on the ESH Jail Transfer Waiting List. In years past, the committee reviewed the Jail Transfer Waiting List in detail and discussed individuals' clinical status and updates on progress

in obtaining a bed at ESH. Among the staff interviewed, no one was able to recall why or when that in-depth review stopped.

ESH has experienced a significant increase in its operational burden since the implementation of the safety net law of 2014. The impact has been felt by multiple departments including the admissions office, which prior to this event, had not modified its admissions process accordingly. While the structure of the admissions office and communication were revised following this event, the process for developing and ensuring the accuracy of the Jail Transfer Waiting List or for facilitating regional ownership has not. As the maintenance and accuracy of this document has been found to be one of the root causes of the death of the inmate at HRRJ, the accuracy and management of the list is critical to preventing similar events in the future.

Observation No. 2 Recommendation

ESH should revise the process for the development, management, and oversight of the Jail Transfer Waiting List. A system for consistently reviewing the individuals on the list should be created and include the courts, CSBs, HPR V Reinvestment Project Office through the Facilities Management Committee (FMC), and HRRJ.

OBSERVATION NO. 3

DBHDS has convened or participated in numerous workgroups, committees, and sub-committees in the past several years centering on improving services for individuals with mental illness who encounter the justice system. All of these, including the DBHDS Transformation Team for the Justice Involved, have resulted in recommendations for additional funding, ongoing committee work, oversight, training, and system re-design.

Observation No. 3 Recommendation

The recommendations of DBHDS's Transformation Team for the Justice Involved were substantive and — had they been implemented at an earlier time — would have had a significant impact on the justice-involved individuals with mental illnesses. This situation should be considered urgent and implementation plans developed immediately.

OBSERVATION NO. 4

A panel of national experts in healthcare and safety authored the 2000 book entitled To Err Is Human. The publication challenged prior assumptions surrounding medical errors and their consequences — not by placing blame on the backs of individual healthcare professionals who make honest mistakes. Instead, the book called for a more sensible and effective plan for reducing errors and improving patient safety through the design of a safer health system. In order to accomplish that, the book recommended that a careful examination should be made of how the surrounding forces of legislation, regulation, and system activity influence the quality of care provided by healthcare organizations and before reviewing the handling of healthcare mistakes.

To Err Is Human asserts that the problem is not bad people in healthcare; rather, it is that good people are working in bad systems that need to be made safer.

In Chapter 3 of the book entitled Why Do Errors Happen, the authors describe the difference between active and latent errors. Active errors are defined as being those caused by individual front line staff and whose effects are noted almost immediately. Such was the case of the admissions director at ESH placing forms in a desk drawer. Latent errors are those that are removed from the control of front line staff and include such things as poor process design, poor policy, and poor management. Latent errors are also those that pose the greatest threat to safety. Often, superficial corrective actions focus on disciplining or re-educating an individual, usually a staff member lower down the organizational chart. At times, this may be appropriate as a part of the action if it is determined that there was a deliberate negative action by the individual staff member. According to the book's authors, it is not an effective way to correct a system or process problem or to prevent recurrence of similar events.

In an April 2015 article from the Joint Commission (TJC) periodical, The Source, the authors discuss the importance of considering Human Factors Engineering and developing root cause analyses and corrective actions following a significant event. The article also reinforces the importance of reviewing active and latent failures when analyzing an event. The article goes on to report that the most common strategies for addressing active errors, training and policy changes, are less sustainable and weaker actions and neglect to address the more systemic issues related to latent errors. Although more time consuming and requiring a tolerance for examining management, systemic, and process issues, any action plan that does not include them should be considered weaker and incomplete.

On March 16, 2016, OSIG received a copy of the DBHDS Office of Internal Audit Investigation Report on the death at HRRJ. The investigation was performed by the DBHDS Internal Audit Director and one internal audit staff member. According to emails from the Office of Internal Audit, the report was completed last December and forwarded to the Assistant Commissioner for Forensic Services for review and then the Office of the Attorney General for several weeks prior to its release.

Included in the DBHDS investigation was a brief background, timeline, summary of interviews, review of documents determined to be pertinent to the investigation including phone records, DBHDS forensic admission waitlists, PDBHS records, and Portsmouth General District Court records. Omitted from the investigation were the following documents determined by OSIG to also be relevant to a thorough investigation of this event:

- Census reports from ESH for the male jail transfer unit (4A) between April and August 2015;
- ESH records related to the individual in question;

- ESH policies related to admissions of jail transfers;
- ESH Admission Process re-organization dated August 28, 2015 (and updated September 24, 2015);
- PDBHS policies; and
- Medical records from Bon Secours Maryview Medical Center.

As part of the investigation, the DBHDS internal auditor emailed Dr. Kristen Hudacek, ESH Psychology Director, regarding ESH's work at HRRJ. Dr. Hudacek reported that the DBHDS Competency Restoration Counselor, employed by DBHDS Central Office, visits HRRJ to work with individuals on the Jail Transfer Waiting List generated by the ESH Admissions Department and that she and another psychologist use the same list to "work off," although the meaning of that is not clear in the report. As the Jail Transfer Waiting List is generated by the Admissions Department, verifying the accuracy of that list is critical as it is now known that the list was inaccurate at the time of the HRRJ inmate's death. Additionally, the DBHDS investigation, reported on House Bill 645 that details revisions to orders for sanity evaluations, competency to stand trial, and competency restorations. The bill requires the clerk of the court to provide a copy of the relevant order to the appointed evaluator or hospital as soon as practicable or no later than the close of business on the next business day after the order is signed. The evaluator or hospital must acknowledge receipt of the order to the court clerk on a standardized form. The bill requires the same confirmation process for an order to a psychiatric hospital of an inmate from a local correctional facility. The bill does not address the process for adding individuals to the Jail Transfer Waiting List or confirming the accuracy of that list.

The DBHDS report made two conclusions. The first conclusion, that the ESH Jail Transfer Waiting List never contained the information related to the CRO for the individual in question, is accurate and was substantiated by OSIG. The second conclusion, that PDBHS staff never completed the required evaluation of the individual requested by HRRJ is also accurate.

The DBHDS report recommendations were for ESH to educate mailroom staff (and others) who receive mail on the importance of ensuring admissions staff receive court orders despite the fact there was no clear evidence in this case that the court order was ever mailed or that the failure was that of the mail room staff, and that admissions staff should log in receipt of the court orders. Educating mail room staff and others who receive mail does not correct or suggest a revision to the process that would ensure root causes are addressed. The recommendation also makes the incorrect assumption that logging in the mail will ensure the orders are not lost, misplaced, or placed in a drawer, or translates to adding the individual to the Jail Transfer Waiting List. The second recommendation is that DBHDS develop more uniform guidelines regarding how courts should convey court orders to DBHDS. The recommendation does include a statement that these guidelines should include more standardized processes (than current ones, of which there are none) for forensic admissions. While OSIG supports DBHDS's recommendation that DBHDS

should "consider" developing a single point of entry for court orders for the entire system, recommending that DBHDS develop guidelines for the management of court orders has no connection to the lapse by PDBHS in meeting their *Code* requirements for emergency evaluations when requested. The report makes no comment on issues surrounding CIT or jail diversion.

Observation No. 4 Recommendation

DBHDS's investigations of critical events should be conducted independently by professionals trained and experienced in conducting healthcare root cause analyses and who have experience working in the behavioral health system(s) in question. Reports should include all relevant risk points and analysis of root causes with specific recommendations targeting those root causes.

OBSERVATION NO. 5

OSIG reviewed NaphCare records relevant to the individual who died in HRRJ and the clinical care received. Documentation provided was incomplete and inconsistent, but several key points were noted. The individual's weight on April 22, 2015, at the Portsmouth City Jail where the individual was originally placed, was documented as 178 pounds. On May 8, 2015, the individual's weight at the Portsmouth City Jail was 182 pounds. HRRJ documented a weight of 190 pounds on a Daily Confinement Record that spanned the dates of June 15-21, 2015. This weight was closer to the individual's 2013 weight of 193 found in records from a prior ESH admission.

On July 15, 2015, it was noted that the individual had "4+ pitting edema in the lower extremities." Pitting edema may be defined as an observable swelling of body tissues due to fluid accumulation that may be demonstrated by applying pressure to the swollen area (for example: depressing the area with a finger). If pressing results in an indentation that persists for greater than 20 seconds (and may last for more than four minutes) after the release of the pressure, the edema is referred to as pitting edema. 4+ pitting, described as severe, also means that a finger pressing on the area is able to depress the flesh by 8mm. HRRJ records indicate that no action was taken at that time.

On July 30, 2015, a medical clinic note documented 4+ pitting edema extending to the backs of the individual's knees and that the individual was, "disheveled, psychotic, and uncooperative." The individual's weight was recorded as 158 pounds, 13 pounds more than the weight of 145 pounds obtained at the emergency room the same day. The manner and frequency by which each setting calibrates their scales — or other possible reasons for the discrepancy — were beyond the scope of this review.

NaphCare records provided to OSIG included care plan goals and interventions addressing

suicide risk. There was no documentation provided to indicate that the individual was actively evidencing suicide risk at any time. Suicide risk assessments provided were incomplete and interventions required the individual to independently report changes in lethality, use, "effective coping skills as needed," and independently put in sick call requests as needed. As the individual was thought to lack capacity to assist an attorney in his own defense, expectations that the individual would have the ability to seek out medical treatment independently while acutely symptomatic seems unreasonable and likely to fail. There was no mention in the treatment planning notes that were provided of psychosis, inability to care for self, meal refusal, or weight loss. Documentation provided for sick calls on July 7 and 16, 2015, only addressed medication management. No mention was made of the individual's weight loss or edema.

Currently, unless a court ordered individual inmate is seen as being in crisis and in need of a TDO in order to expedite inpatient treatment, individuals subject to a CRO remain in HRRJ until such time that a bed is available at ESH and an admission can be facilitated. In the event that the jail determines the individual warrants emergency inpatient treatment, the responsibility lies with the jail to contact the local CSB requesting an evaluation as was the case in this instance on July 31, 2015. There was no evidence that HRRJ sought to follow-up on either the first or second CRO or their request for an emergency evaluation by PDBHS.

HRRJ has a direct responsibility to provide quality medical and mental health care for those in their custody. Although NaphCare is no longer the contract agency providing medical and mental health services at HRRJ, a change in provider offers limited promise of improvement in care or documentation in the absence of a change in oversight practices. Review of NaphCare records raised significant concerns regarding the quality of assessment, care, follow-up, and documentation. It is those professionals who are trained and licensed to provide clinical care who have a duty to provide that care and the agency that contracts with the provider is responsible for ensuring that care is provided.

Observation No. 5 Recommendation

HRRJ should revise the process for overseeing the quality and outcomes of any contract agency that provides medical and mental health care in their jail. This process should ensure regular monitoring, direct oversight, and direct feedback and correction for areas of concern.