disABILITY LAW CENTER OF VIRGINIA

Protection & Advocacy for Virginians with Disabilities

Cracks in the System:

An Investigation into a Death at Riverside Regional Jail

A report from the disAbility Law Center of Virginia

December 2021

Cracks in the System:

An Investigation into a Death at Riverside Regional Jail

Table of Contents

Executive Summary

The disAbility Law Center of Virginia (dLCV) conducted an investigation into the death of MD at Riverside Regional Jail. dLCV investigated the circumstances surrounding his death as well as the events leading to his incarceration and found that this death could have been prevented with adequate healthcare, stronger jail oversight, and better community supports.

While we have long known that jails are ill-equipped to provide the necessary care to individuals with disabilities, MD's case highlights the inadequacies in Virginia's current system and the need for better solutions. dLCV's investigation found that:

- Community supports failed to prevent incarceration
- Riverside Regional Jail failed to provide necessary healthcare, follow medical protocols, and their records were unclear, inconsistent, and falsified
- Riverside Regional Jail's investigation into MD's death was not comprehensive and lacked meaningful corrective action

In order to address these failures, dLCV recommends the following:

- Implement adequate healthcare and behavioral health standards in all Virginia jails, including Riverside Regional Jail
- Strengthen jail oversight
- Prevent the criminalization and unnecessary incarceration of people with disabilities

Introduction

On March 24th, 2020, MD[1], an individual with mental illness and developmental disabilities, died while incarcerated at Riverside Regional Jail (RRJ) in Hopewell, Virginia. In June 2020, the Office of the Chief Medical Examiner finalized a Report of Autopsy for MD. The Medical Examiner determined MD's primary cause of death was acute bronchopneumonia. This is a type of lung infection that causes inflammation of a person's airways, with common symptoms including fever, shortness of breath, sweating, chills, fatigue, and confusion.[2] While most people recover from bronchopneumonia within a few weeks, people at higher risk may develop life-threatening complications without treatment.

dLCV is the federally-mandated Protection and Advocacy System for Virginians with disabilities. Federal statutes provide dLCV with unique access to Virginians with disabilities and their medical records, including the Protection and Advocacy for Individuals with Mental Illness (PAIMI) Act and the Protection and Advocacy for Individuals with Developmental Disabilities (PADD) Act. dLCV advocates and attorneys are knowledgeable about disability rights and able to provide individual representation to, and systemic advocacy on behalf of, Virginians with disabilities whether they live in a community or institutional setting.

dLCV was notified of MD's death through the database used by providers licensed by the Department of Behavioral Health and Developmental Services (DBHDS) to report serious injuries and deaths, Computerized Human Rights Information System (CHRIS). Due to the sudden nature of his death and his developmental disability diagnosis, the disAbility Law Center of Virginia (dLCV) launched an investigation into the circumstances surrounding MD's death.

What dLCV uncovered was a broken system: from the lack of crisis response, to MD's arrest, to the deficiencies in care while incarcerated.[3] These failures contributed to the tragedy of MD's death. In order to prevent similar tragedies, it is necessary to address the deficiencies in Virginia's crisis system as well as RRJ's failure to ensure MD's health and safety.

---

[1] In order to protect the privacy of the individual's family and his memory, we will only identify him with initials throughout this report.

[2] Pneumonia. Johns Hopkins Medicine. https://www.hopkinsmedicine.org/health/conditions-and-diseases/pneumonia

[3] dLCV's findings are based on extensive review of MD's treatment records, DBHDS' investigation and supporting documentation, Riverside Regional Jail's investigation report and supporting documentation, and other documents furnished by RRJ, DBHDS, and the Office of the Chief Medical Examiner.

Background

The Commonwealth of Virginia has a long history of prioritizing institutional care over comprehensive community-based services for individuals with complex support needs. In 2012, Virginia entered into a settlement agreement with the Department of Justice (US DOJ) after an extensive investigation revealed that Virginia's service system for individuals with intellectual and developmental disabilities (IDD) was failing to provide them with the most integrated setting for their needs, resulting in their unnecessary institutionalization. As part of this agreement, the parties agreed that an IDD crisis response system was a necessary component to preventing institutionalization.

The need for community-based emergency and crisis response for people with serious mental illness or IDD is based multiple factors: the principle that care should be provided in the least-restrictive environment, ideally the community,[4] a failure to adequately fund community-based mental health services,[5] and the potential trauma of institutionalization.[6] People with disabilities are also at significant risk for abuse and neglect in institutional settings, especially in settings not designed to handle their specific needs.[7] Thus, Virginia began devising a system with the goals of diverting people with disabilities from the criminal justice system, reducing the criminalization of behaviors manifested by these disabilities, and ensuring those individuals received appropriate medical care instead of incarceration.

However, according to the Bureau of Justice Statistics, people in prisons are nearly three times as likely to report having a disability as the non-incarcerated population; for jails, it's four times as likely.[8] At least 9% of offenders in prison reported having an intellectual or developmental disability, while 30% of jail inmates reported having a cognitive disability. Severe mental illness afflicts nearly 25% of the US correctional population, including individuals in prisons, in jails, and on probation.[9] More than half of prisoners and jail inmates with a disability reported a co-occurring chronic condition, and inmates with disabilities were far more likely to report having an infectious disease. [10]

In addition to facing higher rates of incarceration, people with disabilities are also disproportionately subject to police violence. Studies have found that people with disabilities

---

[4] Olmstead v. L.C., 527 US 581, 1999

[5] Earley, Pete. *Crazy: A Father's Search Through America's Mental Health Madness*. New York: Berkley Books, 2006

[6] Paksarian D, Mojtabai R, Kotov R, Cullen B, Nugent KL, Bromet EJ. *Perceived trauma during hospitalization and treatment participation among individuals with psychotic disorders*. Psychiatr Serv. 2014;65(2):266-269.

[7] Palusci, V., Datner, E., & Wilkins, C. *Developmental disabilities: Abuse and neglect in children and adults*. Int J Child Health Hum Dev 2015;8(4):407-428

[8] Bronson, J., Maruschak, L., & Berzofsky, M. *Disabilities Among Prison and Jail Inmates*. 2011–12. Bureau of Justice Statistics, U.S. Department of Justice, 2015.

[9] Kim, K., Becker-Cohen, M., & Serakos, M. *The Processing and Treatment of Mentally Ill Persons in the Criminal Justice System*. The Urban Institute, 2015.

[10] Bronson, J., Maruschak, L., & Berzofsky, M. *Disabilities Among Prison and Jail Inmates*. 2011–12. Bureau of Justice Statistics, U.S. Department of Justice, 2015.

comprise 25-50% of all individuals killed by law enforcement.[11] [12] People with disabilities are also more likely to experience brutality at the hands of police, often stemming from misunderstandings related to developmental disabilities, mental illness, and other disabilities.[13] These factors increase their vulnerability to arrest and incarceration, even if they haven't committed a crime.[14]

Inmates with disabilities also face much higher risks while in correctional settings. They are more likely to be subjected to violence and sexual assault, and are four times more likely to report recent psychological distress than inmates without disabilities.[15] Inmates with mental health conditions are often not properly diagnosed, do not have timely access to mental health treatment, and do not receive care based on individualized treatment plans; if they do receive mental health treatment, it is often limited to medications, without individual counseling or psychiatric rehabilitation.[16] A report by the Amplifying Voices of Inmates with Disabilities (AVID) Prison Project documented the widespread failure of correctional facilities to provide necessary access to medical care and other accommodations: inmates being denied access to assistive technology, inmates with cognitive impairments unable to access necessary care because they were unable to fill out request forms, and inmates having their medications discontinued upon admission.[17]

The difficulties people with disabilities face are magnified in correctional settings, where they are at much higher risk of neglect, psychological stress, and lack of adequate medical care. It is for these reasons that it is recognized that correctional facilities are not conducive to rehabilitation for people with disabilities, particularly those with developmental disabilities.[18]

---

[11] Perry, D. M., & Carter-Long, Lawrence. *The Ruderman White Paper on Media Coverage of Law Enforcement Use of Force and Disability: A Media Study (2013–2015) and Overview*. 2016. Ruderman Family Foundation.

[12] The Washington Post. "990 People Shot Dead By Police in 2015." 2016. https://www.washingtonpost.com/graphics/national/police-shootings

[13] Vallas, R. Disabled Behind Bars: The Mass Incarceration of People with Disabilities in America's Jails and Prisons. 2016. The Center for American Progress.

[14] Smith, T., Polloway, E. A., Patton, J. R., Beyer, J. F. *Individuals with Intellectual and Developmental Disabilities in the Criminal Justice System and Implications for Transition Planning*. 2008. Education and Training in Developmental Disabilities, 43(4), 421– 430

[15] Vallas, R. *Disabled Behind Bars: The Mass Incarceration of People with Disabilities in America's Jails and Prisons*. 2016. The Center for American Progress.

[16] Sasha Abramsky & Jamie Fellner. *Ill-Equipped: U.S. Prisons and Offenders with Mental Illness*. 2003. Human Rights Watch.

[17] *Making Hard Time Harder: Programmatic Accommodations for Inmates with Disabilities Under the Americans with Disabilities Act*. 2016. Amplifying Voices of Inmates with Disabilities Prison Project.

[18] Watson, A. C., Compton, M. T., & Pope, L. G. *Crisis Response Services for People with Mental Illnesses or Intellectual and Developmental Disabilities: A Review of the Literature on Police-based and Other First Response Models.* (2019). Vera Institute of Justice.

MD's Story

In the Community

Prior to his incarceration, MD resided at A & J Residential LLC, a state licensed group home for people with IDD in Petersburg, Virginia. MD moved to A & J in January 2020 after a period of homelessness and hospitalizations, where he was connected to psychiatric services and saw his psychiatrist and his primary care physician regularly.

As an individual with IDD and mental illness, MD was also connected to the REACH program. REACH (Regional Education Assessment Crisis Services Habilitation) is a statewide crisis system of care for IDD individuals that arose directly from the DOJ settlement. It is designed to provide a variety of services, including 24/7 crisis assessment and intervention, post-crisis direct services, and brief residential therapeutic services.[19] REACH supports individuals experiencing crisis events that put them at risk for homelessness, hospitalization, and incarceration. In order to fulfill this imperative, REACH is to be notified early in a crisis to prevent the need to seek law enforcement involvement.

On March 16, 2020, MD was involved in an altercation with staff. The group home called REACH, but MD refused to speak with them directly and REACH did not come out to the home to provide on-site support. The group home then called the police, who executed an Emergency Custody Order (ECO) and transported MD to the hospital. However, once the ECO ended, MD was taken back to A & J, which gave him a 30-day notice for eviction.

On March 20, 2020, MD had an appointment with his primary care physician due to his recent behavioral crisis. MD's doctor advised him to quit smoking, but there were no other medical or health issues present at the time of the appointment. The doctor advised MD to continue on his current medications and did not recommend any follow up appointments. Back at the group home, MD began escalating with disruptive and threatening behaviors. MD, as well as A & J staff, contacted REACH over 20 times. Unfortunately, REACH repeatedly declined to provide on-site support. The group home once again contacted the police. This time, despite having previously being able to maintain MD's behaviors, the staff chose to press charges against him for making threats. Rather than execute an ECO and transport MD to a hospital to seek treatment, the police placed him under arrest and took him to Riverside Regional Jail.

[19] *REACH Program Standards*. Virginia Department of Behavioral Health & Developmental Services. 2018. https://dbhds.virginia.gov/assets/doc/DS/cs/reach-program-standards-7-1-18.pdf

In The Jail

March 20

MD arrived at RRJ at 9:00pm and began the intake process at 10:30pm. During the intake screening process, MD confirmed his history of mental illness but denied any history of substance abuse. His diagnoses were entered as Hypertension and Schizoaffective Disorder; his diagnosis of Cerebral Palsy was not included. RRJ staff contacted A & J Residential for his medication list, but at no time did the group home inform RRJ that MD had a legal guardian. One of the forms completed during intake was a release of records authorization for District 19 Community Services Board. MD signed this form and the section for Parent/Guardian/Authorized Representative was signed by the intake nurse. After his intake was completed, MD was transferred to the Medical Housing Unit.

March 21

At midnight, a nurse checked on MD. The nurse seemingly took MD's vitals, though the numbers entered are an exact match to the ones taken at his intake assessment an hour and a half before. MD expressed suicidal thoughts to the nurse and was placed on suicide watch. He was checked again by a nurse at 3:30am, where they found MD on the floor nude with his hands around his neck. Nursing notes reported "no signs of distress."

At 12:00pm, the jail administered a Mental Health Assessment and Suicide Watch Assessment to MD, both of which documented a history of substance abuse and included no mention of his developmental disability. The Mental Health Assessment described MD as acutely distressed and exhibiting extrapyramidal symptoms, characterized by restlessness and irregular, jerky movements. The Suicide Watch Assessment described similar distress: MD was disheveled, irritable, had difficulty putting on his safety smock, and demonstrated spastic movements. Despite this, the assessment reported that MD was exhibiting appropriate behavior. MD was scheduled for a mental health follow up on March 22, was referred to a psychiatrist, and was placed on 15-minute Suicide Watch precautions.

The nurse checked on MD again that afternoon and noted that MD was having tremors and sweating profusely. His vitals showed an increased heart rate, a high respiratory rate, and a temperature of 99.1 degrees. For his agitation, a nurse gave him an injection of Haldol. The nursing staff followed up with A & J Residential regarding MD's condition. The group home advised that MD often sweated and became flushed when anxious. After a consultation with the doctor, MD was given a one-time dose of Librium for anxiety. This is also when RRJ's psychiatrist discontinued two of MD's medications: Hydroxyzine for anxiety and Ziprasidone, an antipsychotic.

March 22

At midnight, the psychiatrist saw MD for the Initial Psychiatric Evaluation. He reported that MD was "naked, very restless, his body contorting and twisting," and that MD was pacing, had difficulty engaging in the meeting, and had not slept in 24 hours. He also noted that MD "looked like he had cerebral palsy," and updated the records to include a diagnosis of Cerebral Palsy and Intellectual Disability, Moderate. The psychiatrist adjusted MD's medications, prescribing Hydroxyzine for anxiety and Librium, which is used for anxiety, alcohol withdrawal symptoms, and tremors. He also discontinued Haldol, clearly stating in his notes "No Haldol."

At the same time of psychiatric evaluation, a nursing staff checked on MD. They took no vital signs, and their notes state that MD had "no signs of distress."

A nurse checked in on MD again at 8:25am. She did not take his vitals, but noted that he was "confused at times... unsteady gait… face red in color," but reported "no evidence of other health problems." She confirmed that the suicide watch protocols were in place, and she also stated that MD was placed on "detox protocol" and that "detox medications" were given that morning. Two more nursing checks were completed, one at 11:00am and another at 12:30pm. Vitals were not taken at either check, and they both described MD as anxious and pacing, with an unstable gait, tremors, and restlessness. At the 11:00am check, the nurse informed the doctor about MD's continuing symptoms; the doctor increased his Librium dose.

A Suicide Watch Follow-Up/Discharge Assessment was completed by mental health staff at 12:30pm. The behavioral health technician noted that MD denied suicidal ideation and seemed calmer on medication. Suicide watch was discontinued, and nursing staff did not check on him for the rest of the day.

March 23

At 8:30am, RRJ mental health staff recommended Mental Health Observation for MD, citing their reason as "discontinue detox protocol." Thirty minutes later, a nursing check noted that MD was pacing, flushed, and sweating heavily; he was given Librium. When his symptoms did not resolve, mental health staff completed another Suicide Watch Assessment. MD was disheveled, "sweating and red," and expressed suicidal ideation, and he was placed back on Suicide Watch.

A nurse checked in on MD at 2:30pm and noted that MD was unsteady on his feet. They spoke to a unit officer, who told them that MD was on Detox Protocol. But, when the same staff spoke with another nurse, they said that MD had Cerebral Palsy and was not detoxing. When staff informed the doctor that MD was in medical housing, he responded that "he was aware."

Late that evening, around 11:00pm, observation records described MD's attempts to stand on his feet but being unable to do so. He was restless, rolling from his back to his stomach and back again, and breathing fast, evident by the rapid rise and fall of his chest and stomach. Eventually, his movement ceased.

March 24

At midnight, MD was lying face down on the floor, naked and unmoving. Fifteen minutes later, two officers and a nurse entered his cell to give him his medications. They had to hold up his head for him to take his medications; once released, his head fell forward. MD was laid back on the floor, and the nurse left the cell to check "his data (history and diagnosis)," while one of the officers stayed behind. At 12:20am, another nurse arrived at the Medical Housing Unit and entered MD's cell. She found him lying on the floor, his breathing shallow and rapid, and his pupils fixed and unresponsive.

At 12:31am, MD was transferred to a stretcher and transported to the medical clinic, where he stopped breathing. The staff began CPR and used an AED. They administered Narcan, a drug used to treat narcotic overdose, not once, but twice. Emergency Services were contacted, and they arrived at RRJ at 12:49am, where they continued life-saving efforts until 1:29am, and they pronounced MD deceased.

The System Breaks Down

The tragedy of MD's death is multifold. What is clear is that the breakdown in the system, from the community, to crisis services, to incarceration, all contributed to the circumstances that led to MD's death.

Community Supports Failed to Prevent Incarceration

MD had IDD and mental illness, which required a strong system of supports in order to ensure his success in the community. When he came to A & J Residential, they were aware of his diagnoses and the various challenges that he experiences as a result. As a group home licensed by DBHDS, they were required to provide services designed to meet an individual's physical and emotional needs, as well as to provide protection, guidance, and supervision.[20] It is also generally recommended that providers use appropriate clinical measures and address the underlying problems that the challenging behaviors suggest prior to seeking legal remedies, as such actions can alienate patients from the treatment system and increase negative outcomes.[21] Despite agreeing to admit MD into their program, fully knowing about his diagnoses and behavioral history, and despite their ethical and contractual obligations to provide MD with support, A & J Residential decided to press charges against MD instead of seeking a higher level of treatment.

REACH was contacted multiple times during MD's ongoing behavior crisis. On the day of his arrest, MD and his group home contacted REACH over 20 times. According to REACH's program standards, any referral that comes into the 24/7 crisis call that is considered a crisis requires on-call staff to be dispatched for a face-to-face assessment.[22] Despite this, REACH never responded on-site to provide crisis support. Even if law enforcement are contacted due to imminent danger, REACH staff are still required to be present to support the individual as well as assist law enforcement and other responders with information or consultation. If REACH had been present, it is possible that they would have been able to mitigate the immediate crisis and potentially prevent unnecessary incarceration.

RRJ Failed to Provide Necessary Medical Care

During the three days that MD resided at RRJ, MD consistently showed signs of physical distress, including heavy sweating, constant flushing, restlessness, jerky and spasmodic movement, and an unsteady gait. There is no evidence that MD slept at all during the entirety of

---

[20] Chapter 105 Rules and Regulations for Licensing Facilities and Providers. Department of Behavioral Health and Developmental Services. 2018.

[21] Hoge SK, Gutheil TG. *The prosecution of psychiatric patients for assaults on staff: a preliminary empirical study*. Hosp Community Psychiatry. 1987 Jan;38 (1):44-9.

[22] REACH Program Standards. Virginia Department of Behavioral Health & Developmental Services. 2018. https://dbhds.virginia.gov/assets/doc/DS/cs/reach-program-standards-7-1-18.pdf

his stay: his Initial Psychiatric Evaluation stated that he had not slept in 24 hours since his admission, and Riverside's review of the security footage showed that MD did not sleep at all the day before his death. He repeatedly removed his clothing and then put it back on; he paced around the cell constantly; he repeatedly laid down before getting back up again to pace; he appeared to have tremors and jerking movements and was sweating and flushed, potentially feverish.

Despite clear signs of medical distress, RRJ did not refer MD for a medical evaluation at any time. When he met with mental health staff on March 21, they reported that MD was acutely distressed, exhibiting restlessness, irregular, jerky movements, and difficulty putting on his safety smock. The psychiatrist noted the same restlessness, jerky movements, and that he had not slept in over 24 hours. One of the correctional officers recalled that, on March 23, MD was having difficulty breathing and he informed the unit nurse. There is no record that any medical check was conducted.

When nursing staff noted these symptoms, rather than conduct an assessment, take his vitals, or refer him to the medical clinic, they contacted MD's group home for advice on how to proceed. The group home's advice that this was anxiety was then repeatedly cited in MD's medical records as the reason behind his physical distress. RRJ staff used the judgment of an off-site provider rather than refer MD for an on-site evaluation or assessment. While nursing rounds repeatedly described MD's physical symptoms, they apparently dismissed them and documented that there was "no discomfort or signs of distress."

RRJ Failed to Follow Medical Protocols

As part of MD's intake screening, nursing staff entered an order into his medical chart for MD's vitals to be taken daily for two days. While nursing staff reportedly took MD's vitals on March 21, they did not do so again until he was in acute medical distress on March 24, violating the medical order.

On March 21, Riverside's psychiatrist discontinued two of MD's medications: Hydroxyzine, which is used for anxiety, and Ziprasidone, an antipsychotic. Discontinuing medications, particularly psychotropic medications, is a potentially risky endeavor. Typically, the medical establishment agrees that the safest way to discontinue use of an antipsychotic is to taper it slowly, as discontinuing too quickly can result in physical symptoms, such as nausea, tremors, and insomnia, as well as increase the possibility of a relapse of psychotic symptoms.[23] Even more startling is that MD's medications were discontinued before the psychiatrist had even seen him.

[23] Brandt L, Bschor T, Henssler J, et al. *Antipsychotic Withdrawal Symptoms: A Systematic Review and Meta-Analysis*. Front Psychiatry. 2020;11:569912. Published 2020 Sep 29. doi:10.3389/fpsyt.2020.569912

On March 22, a nursing note stated that MD was placed on "detox protocol" and that "detox medications" were administered. When dLCV reached out to Riverside regarding who initiated the detox protocol, Riverside replied that "there is no record of [MD] ever being placed on Withdrawal or Detox Protocol." While this may technically be true, there are numerous instances in MD's medical records that indicate medical and correctional staff *believed* MD to be on detox protocols--a seemingly false belief that would have likely impacted his medical care. Furthermore, RRJ's policy regarding medically supervised withdrawal requires that inmates exhibiting medical or mental instability be sent to an emergency room, and the policy lays out clear monitoring guidelines involving taking vital signs, medication administration, and visual observation. However, MD was never referred to a medical center or emergency services, and staff failed to follow any of the monitoring guidelines.

While MD was never actually on Withdrawal or Detox Protocol, several of the staff clearly believed that he was. Since these staff believed that the Detox Protocol was in effect, it was their responsibility to follow the policy as written, which they failed to do.

RRJ Records were Unclear, Inconsistent, or Unsupported

MD had Cerebral Palsy, a developmental disability. Despite the intake forms noting "Intellectual Disability," this diagnosis was never entered into the medical record system. Riverside staff spoke with MD's group home (who provided his medication list and was aware of his diagnoses) several times during his initial 24 hours of incarceration, yet his records were not updated accordingly. The initial Mental Health Assessment and Suicide Watch Initial Assessment did not screen for developmental disabilities, despite noting "below average intelligence." MD was not properly identified as having Cerebral Palsy until midnight on March 22 after his initial psychiatric evaluation. Even so, the psychiatrist's determination that MD had a developmental disability was not based on his history or a medication list provided by the group home; instead, it was based solely on his observation that MD "looked like he had CP."

There were several inconsistences in the records. According the Vitals section in his record, staff only took MD's vital signs twice, during his intake and just before he died, though other nursing notes contradict this. In RRJ's Report of Inmate Death submitted to the Department of Corrections, the date of submission was recorded as February 21, 2020, and the date/time of MD's death was also recorded as February 21. This is clearly incorrect, as this was before MD was even at Riverside, much less his passing.

There were also the conflicting records regarding MD's substance abuse history. While the intake screening and subsequent calls to the group home confirmed that MD did not have a substance abuse history, the initial Mental Health Assessment and Suicide Watch Initial Assessment both indicate that MD had a history of substance abuse. Aside from cigarette use, dLCV was unable to find any factual information used to report this history.

As part of our records request, dLCV asked for MD's Medication Administration Record. Medication Administration Record is a standard part of an individual's record of care, which should include signed authorizations from medical staff indicating that medications were given at certain times. RRJ responded that there were no signed authorizations, as all documents are computer generated. While the medical records provided to dLCV include a medication list, which indicates dosage, effective date, frequency, and status, none of these records actually document whether his medications were given, much less what time they were administered and by whom. This means that there is no way to know exactly when MD received medications or which staff administered them.

As reported by RRJ, MD was never placed on Withdrawal or Detox protocols. However, several staff document that he was on Detox Protocol. In a statement during RRJ's internal investigation, one of the nurses stated that MD wasn't "technically" on "protocol" but that he was being given protocol medications. In another nurse's statement, she stated that MD was on Detox Protocol and "it is written on the endorsement paperwork." RRJ attempted to explain this series of errors by explaining that MD was given a medication that is also given to individuals undergoing Detox Protocols. They also explain that one of the documents reporting MD's discontinuation of Detox Protocol was created in error and provided "incorrect information." However, this incorrect information was perceived as correct by a number of medical and correctional staff, and there is little evidence in the record that RRJ attempted to rectify this confusion.

RRJ Records Were Falsified

Most egregiously, there were multiple instances of RRJ staff falsifying records. As part of the intake assessment, a record release form was completed and signed by MD. In the section for Guardian or Authorized Representative, one of Riverside's staff wrote in their own signature. MD had a legal guardian, whose information was provided by the group home and whose existence was confirmed throughout his incarceration. RRJ staff writing their signature on a legal document as MD's authorized representative is inappropriate and potentially illegal.

As part of their investigation, RRJ interviewed the staff involved in MD's care during his incarceration and the medical event that resulted in his death. The mental health professional who conducted MD's initial Mental Health Assessment and Initial Suicide Watch Assessment claimed that MD had a substance abuse history, but admitted that that MD had not provided that information during the assessment. Rather, the staff reported that a correctional officer had told him that MD had a substance abuse history. This correctional officer allegedly also stated that MD has a history of coming to RRJ and, when he came, it was due to drinking and assaulting someone. When RRJ inquired as to which officer provided this information, the mental health professional could not or would not name the officer.

There were also several instances involving the falsification of observation records. One officer reported that she was unaware that MD was on Suicide Watch, which required 15-minute checks. When reviewing the records, RRJ found that she had not completed her rounds despite documenting that she did so. Another staff was found to have done the same. The officer admitted that he only observed MD "in passing."

The Investigation was Incomplete and Lacked Corrective Action

A review of the circumstances that led to MD's death reveals significant shortcomings during MD's incarceration. RRJ's own investigation showed that staff were not responsive to MD's needs, medical documentation was inconsistent, and staff falsified records. However, RRJ failed to conclude that his death was the result of medical neglect.

Though RRJ identified the mental health professional who undermined MD's mental health assessment by including information that was not self-reported or reliable, there is no evidence that RRJ concluded that such an action was unethical or a violation of policy. While RRJ's investigation demonstrated the inconsistencies in staff's understanding of MD's care, there was no attempt to address these errors or remedy them.

Most egregious is RRJ's response to falsified documentation. Their own investigation report shows that two staff had falsified records. However, neither the investigator nor RRJ recommended any formal corrective action. Instead, the investigator personally advised the staff "of the consequences of falsifying documentation and advised [them] to discontinue the practice." The fact that falsifying documents is unlawful and unethical should be both obvious and covered in basic and ongoing staff training. The investigator further advised an officer "to be especially attentive to Inmates who presented with Mental Health issues to ensure that all efforts are being put forth to provide them with adequate care." This statement clearly insinuates that Riverside staff did not provide MD with adequate care. Despite this, RRJ did not recommend any corrective action plan.

dLCV requested security footage of MD's cell covering the last 24 hours prior to his death. dLCV received two video files: one from March 23 beginning at 07:00am and ending at 06:00pm, and the second from March 24 beginning at 12:00am and ending at 02:00am. When dLCV specifically requested the footage from 06:00pm to 12:00am on March 23, Riverside reported that this footage was no longer available, as it was not deemed necessary to their investigation and had since been deleted. dLCV believes that video from this critical time period would have provided vital information about MD's condition and any decompensation leading to his death. This critical time period would have the clearest evidence of MD's condition and probable decompensation prior to being found unresponsive in his cell. The fact that these six hours would be considered unnecessary to RRJ's investigation is astonishing and horrifying.

Conclusion & Recommendations

dLCV's investigation revealed that MD's death was the result of a broken system: from the lack of community supports to prevent his incarceration to the deficiencies in care while incarcerated. In order to prevent similar tragedies, dLCV makes the following recommendations.

Implement Adequate Health and Behavioral Health Standards in RRJ and all Virginia Jails

- Officially implement the Minimum Standards for Behavioral Health Services in Local Correctional Facilities as drafted by HB 1942
- Strengthen jail healthcare standards including: adequate healthcare staffing, access to medications, timely hospital transfer and continuity of care, and improved screening
- Implement state-wide cultural competency training that addresses developmental disabilities for all jail staff that interact directly with inmates

Strengthen Jail Oversight

- The Board of Local and Regional Jails (BLRJ) should make all inspection, investigation, and quality assurance procedures transparent and available to the public
- Any probationary agreements with jails regarding found violations are to be made available to the public to ensure transparency and build public trust
- Each jail's certification status and compliance history, including inspections, investigations, and corrective action, should be made available on the BLRJ's website
- Develop an annual public report summarizing jail inspection and investigation results to identify potential improvement in jail operations across the state
- Create an ombudsman to handle complaints by inmates, staff, and the public

Prevent the Criminalization and Unnecessary Incarceration of People with Disabilities

- Expand community support systems for individuals with disabilities who need healthcare, social support, and help with basic needs such as housing and treatment
- Revise Virginia law to ensure that individuals with acute medical and mental health needs are taken to a healthcare facility, not booked in jail, including the right of jail commanders to refuse to book individuals whose acuity of health symptoms make them at risk of harm in a jail setting
- DBHDS should continue to train group home and other residential staff on how to manage residents who are in crisis and/or exhibiting escalated behaviors
- REACH should be held accountable for responding to crisis calls in person, to alleviate police being called and prevent unnecessary incarcerations