HEFTY WILEY & GORE, P.C.

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On behalf of the Riverside Regional Jail Authority and Superintendent Larry Leabough, please find the enclosed response to your November 22, 2021, letter and December 2021 Report entitled "Cracks in the System: An Investigation into a Death at Riverside Regional Jail". The contents of this response were prepared with the assistance of expert medical professionals in the field of correctional health care, with significant coordination and assistance from Riverside Regional Jail's Superintendent, Col. Larry Leabough and his staff. RRJA appreciates the opportunity to provide this response and is open exploring opportunities to further a cooperative relationship with dLCV to improve inmate health care and behavioral health care, particularly for those individuals with disabilities who too often end up in jail instead of being more appropriately served in a non-correctional, community setting.

Sincerely,

Jeffrey S. Gore
RRJA General Counsel

Cc: Col. Larry Leabough

I. Introduction and Background

Riverside Regional Jail Authority was established pursuant to Chapter 726 of the 1990 Acts of the General Assembly of Virginia. It is the only regional jail in the Commonwealth created by the General Assembly, which did so after a comprehensive three year study on local jail overcrowding initiated by Governor Jerry Baliles. In 1991, under the leadership of Governor Doulgas Wilder, the Commonwealth of Virginia donated 152.6 acres of land in Prince George County to the Riverside Regional Jail Authority for its use in constructing and operating a regional jail, and on July 12, 1997, the jail officially opened. RRJ houses approximately 1300 inmates every day and processes over 20,000 inmates per year. It serves seven member jurisdictions: the Cities of Petersburg, Colonial Heights, and Hopewell, and the Counties of Chesterfield, Prince George, Surry and Charles City, only one of which (Chesterfield) has its own jail.

Most inmates that arrive at RRJ, or any major correctional institution for that matter, come with pre-existing conditions, including serious mental illness, substance use disorders, and, often, chronic medical conditions, which may have gone untreated in the community. While RRJ strives to provide the best possible care for these inmates, RRJ is not a medical hospital, nor is it a licensed mental health facility or drug treatment center; and as such cannot reasonably held to the same standards as those specialized facilities. RRJ relies heavily on the trained, licensed, and qualified medical and mental health professionals it retains under contract, working in coordination with jail security staff to respond to inmate health needs, and RRJ meets this challenge successfully. On occasion, negative outcomes occur, just as they do every day in hospitals and medical facilities around the Commonwealth. All large jails, like all state and federal prisons, periodically experience inmate deaths, largely because of the poor general health of inmates and often due to the lack of community based services and deflection or diversion programs that would serve to keep the sickest and most severely mentally ill or disabled inmates out of jail in the first place. But jails do not have the luxury or the legal authority to control which inmates are sentenced to their custody. Frequently, RRJ will request the Court to remove an inmate who the Superintendent and medical staff strongly feel should not be in a correctional setting and who pose no threat to public safety, to place such inmate on home electronical monitoring or other more appropriate setting. However, that decision is up to the Court and Commonwealth Attorney, not the jail, and in RRJ's experience such requests are rarely granted.

RRJ supports the work and mission of dLCV. However, in this case, RRJ feels, respectfully, that dLCV unfairly attributes the death of inmate MD to the jail's failures. While in fact, close examination of this case reveals very few minor policy violations that clearly did not contribute to MD's death, as well as nearly constant attention to MD from RRJ's medical and mental health care providers and correctional staff. RRJ and its medical provider did all they could to prevent the unfortunate outcome in this case. This response provides dLCV with additional information and context, which RRJ hopes will serve as the basis for dLCV to revisit some of its conclusions.

II. Mischaracterization of Board of Local and Regional Jails actions

As a preliminary matter, RRJ is compelled to explain how dLCV mischaracterizes the actions of the Virginia Board of Local and Regional Jails ("BLRJ") as it relates to this matter. The dLCV's November 22, 2021, letter states that the BLRJ concluded that "RRJ failed to comply with the minimum correctional standards and was at fault" [for MD's death]. This is not accurate. The BLRJ never made any formal conclusions and never found that RRJ was at fault. The BLRJ's jail standards review committee made *preliminary* findings of fault related to MD's case, however, after being presented with additional information by RRJ, the BLRJ did not endorse those preliminary findings and instead chose to enter into an agreement with RRJ, which dLCV does recognize. The dLCV letter states that the RRJ-BLRJ agreement "includes the addition of a new healthcare provider, new internal audit procedures, and the creation of a standards compliance officer ...". While the agreement does include the creation of these audit procedures and the new position of a standards compliance officer, RRJ had proactively obtained a new inmate healthcare provider, Corizon Health, after MD's death and nearly a year prior to entering into the agreement with the BLRJ. In fact, through the hard work of jail staff and Corizon Health, RRJ obtained full accreditation from the National Commission on Correctional Healthcare in July 2021. NCCHC represents the gold standard in correctional healthcare and few jails in Virginia have obtained this recognition. Also, dLCV characterizes the RRJ-BLRJ agreement as a "probationary agreement". This is not accurate either. The agreement specifically removes the prior probationary status of RRJ and replaces it with a two-year agreement under which RRJ and BLRJ both agree to certain measures aimed at ensuring compliance with applicable state standards and improving communication and cooperation between the jail and the state oversight board.

Finally, dLCV urges RRJ to extend access to the quality improvement measures referenced above to "highlight RRJ's dedication to the BLRJ agreement and to quality assurance through additional oversight." RRJ is certainly willing to meet and discuss its internal quality assurance measures that the jail and its medical provider have implemented, which RRJ feels will become industry best practices to be implemented in other jails across the Commonwealth.

III. Conclusions regarding inadequate community supports

RRJ agrees with dLCV's conclusion that "community supports failed to prevent incarceration." RRJ has no control over who is court-ordered to be housed in the jail, whether those inmates are awaiting trial or have already been sentenced to serve time for a criminal conviction. As stated previously, RRJ often requests the court to remove inmates it feels are not appropriate for the correctional setting, most often those with severe behavioral health diagnosis or disabilities. Unfortunately, and through no fault of RRJ, there is little capacity for appropriate treatment or services in the state behavioral health care system or in the community to care for individuals with such needs. RRJ strongly feels that the state and federal government and private providers should do more to increase capacity in the community and to divert many individuals away from the correctional setting into more appropriate community based services.

IV. Inmate MD: Date of Death March 24, 2020

This section responds to the conclusions in the dLCV Report by providing details specific to MD's incarceration and the care and attention he received. MD came to RRJ with underlying medical conditions of schizoaffective disorder, hypertension, cerebral palsy and intellectual disability. It is likely that MD also came to RRJ with bronchopneumonia, the condition which caused his death. MD's mental health and disabilities made it difficult to obtain an accurate medical history, symptomology, and vitals. Inmate MD was only incarcerated at RRJ for four days, and despite the challenges he posed, during that four day period, he was seen or assessed by medical staff at least 21 times.

In addition, MD's vitals were taken three times during his four day incarceration**.** MD's vitals were taken on 3/20/2020 during his Receiving Screening performed by LPN C. His vitals were within a normal range: Temp- 98.6, Pulse- 100, Respirations-18, BP- 130/79, O2- 100%, and did not suggest an underlying sickness. MD's vitals were taken again on 3/21/2020 at 1437 by Registered Nurse H. While she noted she could not take his blood pressure, she recorded his other vitals as follows: Pulse- 112, O2- 95%, respirations- 20, Temp- 99.1. With the exception of a slightly elevated pulse and temperature, his vitals were still within normal range. She noted that MD was having tremors and sweating. She followed up on her assessment, as indicated by her Chart Note at 1602 that day. RN H. reported she spoke with Nurse P. at MD's group home who advised that when MD was sweating and looking flushed, that meant his anxiety was high and they gave him Lorazepam. RN H. shared MD's condition and the information from the group home with Dr. A. Dr. A. prescribed a one-time dose of Librium.

Thereafter, RN A. noted that MD still appeared anxious and paced in her Chart Note dated 3/22/2020 at 1050. Dr. A. was notified, and MD was prescribed a higher dose of Librium for anxiety. Later that day, during an observation round at 1230, RN A. noted MD's tremors and restlessness were moderately improved, and that his appetite was good. MD also complained of generalized pain for which she gave him Tylenol.

Inmate MD was consistently observed and checked thereafter[1]. It was not until 3/23/2020 that MD made a complaint that arguably hinted to his underlying pneumonia. He advised Officer G. that he was having difficulty breathing. Officer G. advised Nurse M. who came to see MD during medication pass at 1159 on 3/23/2020. According to her Infirmary Note and interview, Nurse M. gave MD the remainder of his morning medications. She observed MD ambulating without acute distress. She further observed he "remained somewhat anxious and continued to ambulate/pace in cell." She did not observe breathing difficulties, and he made no other complaints. After he was checked by Nurse M., MD was consistently observed by security staff and checked by Nurse B., an unidentified medication pass nurse, and, when MD's health began to decline rapidly, Nurses L. and D. checked on him. It was during this rapid deterioration that MD's vitals were checked a third time and emergency measures were taken.

[1] Log entries by Officers G. and M. are be addressed later. While not all required 15 minute checks were noted, MD was still checked regularly and consistently.

Not only were three vitals checks done in a four day period, but MD was provided extensive care by both medical and security staff. Unfortunately, MD proved an extremely difficult patient to diagnose due to his failure and inability to communicate his needs and symptoms to medical and security staff. Not only were vital checks done, but the checks could not serve as a contributing factor in Inmate MD's death.

Many of dLCV's concerns surround a mental health care provider's notation of substance abuse based on unverified information provided by an unidentified officer, and log entries for checks that either did not match up with checks actually made, or were falsified. Most importantly, these facts did not contribute to Inmate MD's death. dLCV attributes confusion about whether MD was on detox protocol to when the one of the attending providers, Mr. S. noted substance abuse in Inmate MD's Behavioral Health Evaluation based on information provided by an unidentified officer. However, whether or not MD had substance abuse issues, or should have been on detox protocol did not contribute to MD's death from acute bronchopneumonia. Rather, MD's agitation, anxiety, and failure and/or inability to communicate made it extremely difficult to obtain a history and vitals, determine any symptoms or complaints, or make a diagnosis, particularly when MD had only been at RRJ for four days.

RRJ medical provider staff, Mr. S., did state, when interviewed for the RRJ internal investigation, that he normally would have conducted a urinalysis or breathalyzer to confirm substance abuse. However, in this case, he could not do so with MD due to his agitation, as documented by medical staff in the Behavioral Health Initial Evaluation on 3/21/2020 at 1153. He described MD as incoherent, yelling, and refusing to answer whether he had thoughts of self-harm. Mr. S. noted previous treatment at Popular Springs, Tuckers, SRMC, and JRH. Mr. S. described Inmate as acutely distressed with extrapyramidal symptoms. He described MD as a poor historian, and angry, belligerent, and agitated. Mr. S. noted substance abuse based on historical knowledge of alcohol use provided by an unidentified officer. The officer advised that MD had been in the Jail before when he stopped taking his medications and used his social security money for drinking alcohol. Mr. S. noted behavioral health would reevaluate once stable on medications, Behavioral Health staff would follow-up on 3/22/2020, and referred MD to a psychiatric provider.

In addition, MD's ambulation difficulties arising from his cerebral palsy, and the fact that MD was taking Librium[2] for his anxiety may have contributed to confusion about whether he was on detox protocol, but again this confusion did not contribute to Inmate MD's death. Inmate MD was observed almost constantly and treated for his obvious anxiety. When he needed emergency care, it was provided by medical staff, and EMS was summoned.

Furthermore, MD refused to answer certain questions, including any about using alcohol and drugs, during the booking observation report conducted by Officer N. on 3/20/2020 at 2206. All of these facts make clear that getting MD's medical history was very difficult.

[2] Librium is also given to persons going through alcohol withdrawal.

dLCV's Report is particularly condemning regarding RRJ's required security inspections twice per hour at random intervals. Officer G's checks on MD did not coincide with the 15 minute checks logged on the Suicide Precaution Inmate Security and Observation Log. Officer G. admitted he logged observation checks every 15 minutes, but that he did not go to MD's door every 15 minutes given his other tasks such as medication pass, feeding lunch and dinner, and conducting regular security and observation rounds. However, as explained below, the fact that Officer G's checks did not match up to his logged times did not contribute to Inmate MD's death. Officer G completed his shift at 6:30 pm, the day before Inmate MD passed away. Inmate MD's health did not deteriorate until the shift *after* Officer Grant's shift. Video footage revealed Inmate MD was moving around in his cell after Officer G. completed his shift. Furthermore, during his shift, Officer G. checked on MD often when passing by his cell and completing other duties:

3/23/2020, 1004: LPC C. and Officer G. approached MD's cell (per Rapid Eye camera footage).

3/23/2020, 1012: Officer G. approached MD's cell and spoke to him (per Rapid Eye camera footage).

3/23/2020, 1019: Officer G. observed MD (per Rapid Eye camera footage).

3/23/2020, 1021: Officer G. received meal trays and stood in front of MD's cell (per Rapid Eye camera footage).

3/23/2020, 1044: Officer G. provided MD his meal tray (per Rapid Eye camera footage).

3/23/2020, 1104: Officer G. opened MD's cell door from the booth. Inmate attempted to exit his cell. Officer G. directed MD to return to his cell and door was secured (per Rapid Eye camera footage).

3/23/2020, 1122: Officer G. passed by MD's cell and observed MD standing in cell door (per Rapid Eye camera footage).

3/23/2020, 1150: Officer G. observed MD at his cell door (per Rapid Eye camera footage).

3/23/2020, 1200: Officer G. at MD's cell door (per Rapid Eye camera footage).

3/23/2020, 1212: Officer G. gave MD an additional drink from the cooler (per Rapid Eye camera footage).

3/23/2020, 1229: Officer G. gave MD another drink from the cooler (per Rapid Eye camera footage).

3/23/2020, 1240: Officer G. passed MD's cell and looked in the direction of the cell (per Rapid Eye camera footage).

3/23/2020, 1428: Officer G., after returning from lunch, accompanied Nurse B. into MD's cell (per Rapid Eye camera footage).

3/23/2020, 1437: Officer G. observed MD in his cell (per Rapid Eye camera footage).

3/23/2020, 1440: Watch Commander, Lt. J., entered Medical Housing Unit II and spoke with MD, accompanied by Officer G. (per Rapid Eye camera footage).

3/23/2020, 1444: Officer G. observed MD when passing by his cell (per Rapid Eye camera footage).

3/23/2020, 1515: Officer G. observed MD at his cell door (per Rapid Eye camera footage).

3/23/2020, 1529: Officer G. provided MD his meal, which MD retrieved through the tray slot (per Rapid Eye camera footage).

3/23/2020, 1533: Officer G. spoke with MD through the cell door (per Rapid Eye camera footage).

3/23/2020, 1534: Officer G. gave MD a drink from the cooler (per Rapid Eye camera footage).

3/23/2020, 1611: Lt. S. returned to MD's cell, accompanied by Officer G. Lt. S. retrieved trash from MD's cell and provided MD with a new suicide smock (per Rapid Eye camera footage).

3/23/2020, 1628: Officer G. observed MD through his cell window (per Rapid Eye camera footage).

3/23/2020, 1712: Officer G. passed by MD's cell, where MD was visible at the cell door (per Rapid Eye camera footage).

3/23/2020, 1728: Officer G. passed by MD's cell (per Rapid Eye camera footage).

3/23/2020, 1747: Officer G. conducted a security and observation round (per Rapid Eye camera footage).

3/23/2020, 1812: Officer G. conducted a security and observation round at MD's cell door (per Rapid Eye camera footage).

dLCV should consider Officer G's attentiveness to MD, speaking to him often, providing him multiple drinks from the cooler, and obtaining medical help for him. dLCV should also consider that MD was housed in medical housing where the cells have large windows, allowing an officer to see inside a cell from several feet away. While Officer G. may not have stood directly in front of MD's cell, he could easily see into his cell.

dLCV's report indicates that no corrective action was taken to ensure all security rounds are made. However, this year RRJ implemented a new state of the art system whereby rounds are recorded electronically. This will correct any issues regarding the capture of log times. Regardless, in this case, any incorrectly logged times did not contribute to Inmate MD's death.

dLCV also strongly and understandably emphasizes the falsification of any work-related records or making misleading entries with the intent to deceive. Officer M. only completed two security and observation rounds when she relieved Officer G. on his lunch break:

3/23/2020, 1307: Officer M. (who relieved Officer G.) conducted a security and observation round (per Rapid Eye camera footage).

3/23/2020, 1342: Officer M. observed Inmate at his cell door (per Rapid Eye camera footage).

3/23/2020, 1415: Officer M. conducted a security and observation round (per Rapid Eye camera footage).

Officer M. should have performed two additional checks. However, these improperly recorded log times occurred the day before Inmate MD passed away and, therefore, did not contribute to Inmate MD's death.

The dLCV Report indicates that no corrective action was taken with regard to this issue. However, as a result of the RRJ internal investigation, Officer M. received a written reprimand for improperly logging suicide watch checks. Even so, MD was alive and moving in his cell during this time period. MD's health did not begin to deteriorate until the following shift.

As records confirm, MD was seen by medical care providers at least 21 times during his four day period at RRJ. There is no indication that MD requested additional care, or that any care he may have requested was not provided. When MD's situation became emergent, medical staff performed CPR and EMS was called.

State regulations require a receiving and medical screening of inmates which screens for current illnesses, health problems and conditions, past history of communicable diseases, as well as current symptoms of inmate's mental health, dental problems, allergies, present medications, dietary requirements, and symptoms of venereal disease. The screening should also inquire into substance abuse, mental health status, and skin conditions. MD received a Receiving Screening by LPN C. on 3/20/2020, which met all of these requirements.

State regulations require inmates be informed, at the time of their admission, of the procedures for gaining access to medical services. MD was educated both orally and in writing of the procedures to gain access to medical during his Receiving Assessment on 3/20/2020, as indicated by the Receiving Assessment instrument. Information regarding medical services, as well as information to gain access to the Inmate Handbook on the kiosk, were also provided to Inmate MD during orientation, as indicated by the orientation documentation. This orientation is provided pursuant to RRJ Policy 20.1.006, § 1.2.3. The Inmate Handbook also contains information on how to access medical services.

State regulations require a health evaluation by a qualified health care professional[3] to collect additional data, after reviewing the Receiving Screening, to complete an inmate's health history, including following up on any positive findings obtained during the receiving screening and subsequent encounters. Positive findings are integrated into the inmate's initial problem list.

[3] Qualified healthcare professionals can include nurses, certified nursing assistants, and mental health professionals, among others.

LPN C. performed the Receiving Screening on MD. Thereafter, she followed up on MD's positive mental health findings by contacting his group home in Petersburg to verify MD's medications and his medication compliance. Additionally, a Behavioral Health Initial Evaluation of Inmate MD was performed by a Qualified Mental Health Professional. Thereafter RN H. also followed up with MD's group home to inquire about his anxiety. Later, Dr. T. conducted a medication renewal review and an Initial Psychiatric Evaluation on 3/21/2020. Documentation in MD's file shows his problem list was updated to include cerebral palsy and intellectual disability, which were added to the list and marked assessed after Dr. T. completed her initial psychiatric evaluation. Schizoaffective disorder and hypertension were already listed from a previous incarceration in 2016. As described above, Dr. T. conducted a medication review and evaluation, and updated his problem list.

V. Conclusions

MD's death was the result of pneumonia which he likely had before he came to RRJ. Medical staff did not ignore or mistreat MD. To the contrary, they checked on him often, noting signs of anxiety, for which he received medication. He complained once about difficulty breathing, and security staff had a nurse check on him. The nurse did not observe any breathing difficulties. Security and medical staff continued to check on MD often. MD's deterioration, when it began, was rapid. When he stopped moving around as he had been, he was evaluated, and appropriate emergency measures were taken. The conduct alleged by dLCV in its Report did not cause or contribute to MD's death. Nor did any of RRJ's actions amount to deliberate indifference or gross negligence. MD was observed, assessed, or treated by medical staff 21 times in the four day period he was incarcerated at RRJ.

MD's death is unfortunate, and RRJ does not want to minimize the tragedy of any person dying while incarcerated. However, it was not the result of RRJ's or its medical provider's actions or inactions. Nonetheless, since the time of MD's death, RRJ has taken significant steps to improve the medical care it provides inmates and to enhance security staff performance and accountability. Changing the medical provider has yielded positive results as evidenced by RRJ's recent NCCHC accreditation. RRJ deployed an electronic security checks system this year, which will enhance performance and accountability in staff security rounds. The Standards Compliance Officer position has been in effect since the end of September. The SCO is assessing performance on all relevant standards, both medical and security, on a daily, weekly and monthly basis and the Superintendent is implementing any needed corrective action as soon as it is identified by the SCO. Regular quality assurance meetings are taking place between RRJ staff and its medical provider, Corizon Health, in order to quickly and systematically identify and correct any shortcomings or discrepancies in the care of inmates. RRJ's Board has increased staff compensation significantly in the last year in order to better recruit and retain qualified, professional staff, and has similarly appropriated additional resources to its medical provider contract to ensure they are able to do the same. Even though RRJ does not agree with some of the conclusions in dLCV's report, RRJ is deeply invested in doing what it can to ensure appropriate medical and behavioral heath care is provided to inmates in its charge. To that end, RRJ welcomes further discussions with dLCV about

RRJ specifically and correctional health care generally. RRJ is always looking to improve the services and care it provides, particularly to vulnerable populations, which often include individuals who should never have been incarcerated.