

INVESTIGATIVE REPORT
INTO
THE DEATHS OF SEVEN VERMONT INMATES
AND RELATED ISSUES

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Introduction

In December of 2003, the Vermont Agency of Human Services retained Michael Marks and Philip McLaughlin to conduct an investigation into the following:

1. [T]he circumstances surrounding the deaths of the following individuals: 1) Charles Palmer, Northern State Correctional Facility, 4/20/03; 2) Eva LaBounty, Dale Correctional Facility, 5/7/03; 3) Lawrence Bessette, Northern State Correctional Facility, 5/22/03; 4) James Quigley, Northwest State Correctional Facility, 10/7/03; 5) George Sumner, Northern State Correctional Facility, 2/14/03; 6) Neil Prentiss, [Lahey Clinic, Burlington Mass.], 11/25/02; and 7) Jeremy Garcia, private residence in Winooski, 9/30/03.

2. [A further investigation of]: 1) the practices of the facilities as they relate to these deaths including staff, supervisory and management responsibilities and actions; 2) the policies and implementation of policies, including the grievance process, of the Department of Corrections in connection with the deaths and the safety and health of inmates generally; 3) the provision of health and mental health services to inmates; and, 4) any related issues raised by facts that are uncovered during the course of the investigation.

Mr. McLaughlin and Mr. Marks retained Mr. Phil Stanley, the former Commissioner of the New Hampshire Department of Corrections and Mr. Walter Newcomb, former Superintendent of the Belknap County New Hampshire Department of Corrections to assist in their investigation and review of these issues.

The attorneys and investigators interviewed inmates, staff of the Department of Corrections and others. Mr. McLaughlin interviewed thirty-eight witnesses. Mr. Marks interviewed sixty witnesses. Mr. Newcomb interviewed fifty-eight witnesses. Mr. Stanley interviewed fifty witnesses. These totals do not reflect that they interviewed some witnesses on multiple occasions. Some witnesses were interviewed by more than one member of the team.

The attorneys and investigators inspected the correctional facilities in Newport, St. Albans, South Burlington and Waterbury. They reviewed documents, including correctional files, written complaints from inmates, and investigative reports. The documents fill several large boxes, and contain thousands of pages. The documents included State Police Reports and other investigations from the State with summaries of witness statements.

Executive Summary

The scope of the investigation was very broad. We were asked to investigate why seven people died and what those deaths said about the practices of the Corrections Department. We were also asked to address the issues that those deaths appeared to implicate. Those issues included the provision of medical service, mental health service, and the grievance process.

Our primary focus was to understand the circumstances of each of the deaths. We are fact finders. We are not policy makers. We are not management auditors. We are not personnel administrators. By addressing each of these deaths in a thorough manner we hope to provide a factual basis for the Department, the Agency of Human Services, and the Legislature to address policy and management issues.

At the start of this process, Mr. McLaughlin and Mr. Marks met with Commissioner Steven Gold and Deputy Commissioner Sister Janice Ryan. Commissioner Gold and Sister Janice Ryan are new to the Department. Mr. Gold became Commissioner on January 16, 2003. Sister Janice Ryan began work on August 4, 2003. Commissioner Gold and Sister Janice Ryan emphasized that they wanted an independent investigation that would be searching and accurate, regardless of the facts it uncovered. They also promised to provide access to all records of the Department and to secure the cooperation of all Corrections staff.

It was clear throughout this investigation that the Commissioner and Deputy Commissioner stayed true to their word. They consistently worked to assist the investigation in obtaining, sometimes on short notice, documents and information. We appreciate their cooperation.

We must also note the extraordinary assistance of Major Robert White and the Vermont State Police. The thorough, professional reports of the Vermont State Police were a great asset.

In the course of studying these deaths we learned a lot about the Department. It became clear to us that the Department faces tremendous stress. Its job is difficult. There has been a large increase in the inmate population. There has also been a large increase in the number of individuals on supervision by the Department outside of the inmate population. The issues that these inmates bring to Vermont's correctional system are increasingly complex, involving mental health and substance abuse problems that have only grown more severe through the years. And like many state agencies, the Department operates with substantial budgetary constraints.

During the course of our investigation we witnessed numerous examples of professional and caring work by the staff of the Department of Corrections. By its very nature this report will give insufficient emphasis to those efforts. We do not mean to slight the dedication and hard work of the staff by any failures that we note in this report.

It is clear to us that the Commissioner and the Deputy Commissioner are committed to learning from the deaths of these inmates and implementing meaningful responses. It is our intention in presenting this report to provide the factual basis for the Department, the Agency of Human Services and the Legislature to take appropriate actions.

We present detailed findings and conclusions in the body of this report. Among the more significant of these conclusions regarding the deaths of inmates are the following:

1. The placement of inmate James Quigley in administrative segregation and then close custody (i.e., a solitary cell with limited release time from that cell) for 118 days was not adequately supported and likely reflected retaliation against this inmate for the filing of grievances and lawsuits. Mr. Quigley committed suicide.

2. The response to requests for medical services by inmate Neil Prentiss was inadequate. Despite repeated requests, the inmate did not receive care in a timely manner. Mr. Prentiss subsequently died under circumstances that raise questions we cannot answer as to whether timely care would have prevented his death.

3. The Department provided significant mental health services to inmate Lawrence Bessette. The mental health care providers made reasonable professional judgments in providing those services. Their judgments and actions were not contributing factors in Mr. Bessette's death by suicide. There were errors in the transfer of Mr. Bessette's mental health records between facilities. These errors warrant correction but did not contribute to the cause of Mr. Bessette's death.

4. The Dale Correctional Facility failed to take adequate steps to assure that inmates would consume prescription drugs rather than hoard them for subsequent improper use. The availability of such drugs was a significant factor in the death of inmate Eva LaBounty by a drug overdose. In response to this death the Dale Correctional Facility has made extensive changes to correct failings in past practices and prevent a recurrence.

5. The Department invested intensive efforts to correct the drug abuse by Jeremy Garcia. The Department made appropriate decisions in the management of the conditional release of Jeremy Garcia. The Department's actions were not a contributing factor to his death from a drug overdose.

6. The Department provided humane care and support for inmate George Sumner, who died in custody from AIDS. The Department's actions were not a contributing factor in his death. The case raises unanswered questions concerning the treatment of terminally ill inmates which the Department should examine.

7. Inmate Charles Palmer died from a drug overdose. He obtained the drugs during a contact visit. The Department's actions were not a contributing factor in his death.

In addition to our conclusions concerning the deaths of inmates, we also make the following conclusions:

8. There are significant areas in which the Department should improve the provision of mental health services to inmates. The most critical of these is the implementation of an auditable system for quality assessment as required by the contract with the mental health care provider.

9. The State should consider ways to augment the capacity of the Prisoner's Rights Office as a mechanism for improving the grievance process.

10. The Department did not conduct adequate internal reviews of the inmate deaths. This is in part attributable to a culture within the Department that fails to embrace accountability. The Department needs to change this culture.

This report concludes with a set of recommendations for consideration by the Department, the Agency of Human Services and the Legislature.

INMATE DEATHS

James Quigley

Factual Findings

1. James Quigley died at the Northwest State Correctional Facility in St. Albans on October 7, 2003. Mr. Quigley committed suicide by hanging himself in his cell.

2. Mr. Quigley was serving a life sentence with a twenty-five year minimum for murder and attempted murder. Mr. Quigley came to the Vermont Correctional System through an exchange under the Interstate Prisoner Compact. Mr. Quigley committed his crime in Florida, and began his sentence in 1980. He transferred to Vermont on February 11, 2001.

Initial Time in Newport

3. Upon his arrival in Vermont, the Department classified Mr. Quigley as a medium security prisoner and assigned him to the Northern State Correctional Facility in Newport.

4. In March of 2001, a correctional officer intercepted mail addressed to Mr. Quigley and discovered detailed maps. The maps had been downloaded over the internet

from Map Quest depicting the route from the Newport prison to Florida. The maps included a detailed route to Mr. Quigley's home in Atlantic City, New Jersey. The maps also showed the driving distance and time.

5. When asked about these maps, Mr. Quigley stated that he had obtained them from an acquaintance from outside of the correctional system to document the distance between Newport and Florida. Mr. Quigley was citing that distance as the reason for a Florida court to provide him with additional filing time in connection with a post-conviction release petition.

6. Upon discovering these maps the Deputy Superintendent confronted Mr. Quigley. Mr. Quigley provided the explanation. The Deputy Superintendent found the explanation to be reasonable. He allowed Mr. Quigley to keep the portion of the Map Quest printout that listed the total mileage between Vermont and Florida. He confiscated the remainder of the maps. There is no record of any discipline for this event.

7. For some of the time that he was in Newport, Mr. Quigley served as the Law Librarian. He was removed from that position in August of 2002. Mr. Quigley unsuccessfully grieved his removal.

8. Mr. Quigley assisted a number of other inmates in preparing legal grievances and lawsuits. Mr. Quigley himself was the author of a number of grievances. Mr. Quigley filed thirty-six grievances between September 13 2001 and his departure from the Newport facility on July 17, 2003.

9. Mr. Quigley was a member of the inmate recreation committee. The committee allocates, with the approval of the superintendent, expenditures of funds for inmate recreation. In May of 2003, Mr. Quigley and another inmate rejected a proposal to purchase flowers from the fund. The Superintendent supported the proposal. The flowers were subsequently purchased.

10. The Superintendent removed Mr. Quigley from the committee in June of 2003. Mr. Quigley alleged that it was in retaliation for his refusal to approve use of inmate funds for the planting of flowers on the facility grounds. The articulated reasons for removing Mr. Quigley were: a) he had served on the committee for two years and other inmates should be given the chance to serve; and, b) the inmates from other states were not representing the interests of Vermont inmates.

Administrative Segregation in Newport

11. On June 10, 2003, Mr. Quigley had a parole hearing with the Florida Parole Board. The hearing was by telephone.

12. Following the hearing, Mr. Quigley's case worker at the Newport facility spoke with him and concluded that Mr. Quigley was upset with the outcome of the

hearing. The hearing established that the Florida Parole Commission would not consider Mr. Quigley for parole for another ten years.

13. Simultaneous with this, the deputy superintendent received information from an informant that Mr. Quigley had a “back-up plan”.

14. The deputy superintendent concluded that Mr. Quigley was a risk of escape and placed him in administrative segregation on June 10, 2003.

15. Administrative segregation places significant additional restrictions on inmates. Inmates in the general population share a cell with another inmate and may circulate through portions of the facility for part of the day. Inmates in administrative segregation are housed alone in a cell. They may leave their cell for one hour a day with strict limitations that do not allow them to leave the segregation unit.

16. Department of Corrections policies require hearings for administrative segregation placements. There must also be a finding, supported by evidence, of a violation of a Department policy.

17. A hearing officer within the facility conducted a hearing. On June 16, the hearing officer recommended the release of Mr. Quigley from administrative segregation because there was insufficient evidence to deem him an escape risk.

18. Shortly after this hearing the deputy superintendent searched the property taken from the cell Mr. Quigley had occupied prior to his placement in administrative segregation. He wrote the following email to Superintendent Lanman on June 16:

I spent time shaking down Quigley's property yesterday afternoon. I found maps of Vermont and all of the counties. There were all from the newspaper. I did not find any escape plan or anything suggesting he was putting anything together. What we do have is an interstate compact inmate who was just given information that he will more than likely serve another ten years prior to any consideration for parole. While it is difficult to tell if he did in fact have any thoughts of escape the information we did receive came from three sources. One officer received two of the tips but finds his sources reliable. Having the information come from several sources does suggest that something must have been said even if out of frustration at bad news. Approximately one year ago, could be longer, I was given some maps from Quigley's mail. They were from Map Quest. They were actual maps off the internet from the facility to Florida. When questioned James stated he did not know they were coming. Now an informant is stating that Quigley stated he had a backup plan when parole fell

through. I am recommending that we leave Quigley in SMU on open status. It is not close custody, he will remain medium. This will allow the facility to monitor his behavior until the final parole decision has been made. Something about he can appeal. Leave him there and review in thirty days.

19. Although this new information was not part of the record of the administrative segregation case, Superintendent Lanman considered the information and overrode that decision on June 17. She ordered that the Administrative Segregation status continue until a further review in fifteen days.

20. On June 17, Ms. Lanman also sent an email to Raymond Flum, who was in charge of classification and responsible for interstate prisoners, and Mr. McLiverty. The email states:

Ray, Quigley is an ISC from Florida. We AD SEG'd him last week because we received CI info that he would get out of here one way or another. We took this serious because he received information from Florida Parole that they would probably make him do ten more years and then consider him for parole. This obviously did not make him happy. He also has cost medical lost of money due shoulder injuries. We caught him on video in the gym using the weights and actually completed four sets. He's been told by Dr. Peterson not to go to they gym. He is being weaned from his medicine. Dave shook down his property yesterday and found a full map of Vermont and individual cutouts of each county of Vermont. At this point he is an escape risk. I'm requesting that he be sent back to Florida. I dealt with ISC as a CSS and LUS and know that they have to take him back if we request it. It's part of the ISC compact. AT this point nothing has been entered into case notes. Thanks, K

21. On June 18, Mr. Flum replied:

Kathleen, The ISC is a relationship piece. We can say take him back because we say so, and they can do the same with us. However, we try not to operate that way because generally the ones we send out are far worse for us than the ones we get in. In this particular case they have agreed to take [name deleted] and keep him in one of their close custody facilities, so it is not as simple as take him back because I say so.

With all that in mind, please provide me with any and all paperwork that you have on this guy and these situations that you refer to and I will work with Florida.

As far as the medical costs, these can be billed back to Florida if they are extraordinary, that is not reasonably included in normal maintenance. What brief info you supplied below might indicate that we could bill Florida for those costs. Have medical send me the information and I will work with Florida.

Thanks, Ray

22. On June 18, Mr. McLiverty replied:

If you can't move him florida, right off-send him to Northwest until you can.

23. Mr. Quigley appealed the administrative segregation decision to John Murphy, the Director of Grievances and Appeals. Mr. Murphy screens appeals from facilities to the Commissioner, which are Class 3 Grievances.

24. Mr. Murphy remanded the case to the Newport Facility for another hearing. Mr. Murphy concluded that the hearing record was inadequate to support that there was an escape risk because there may have been improper use of information from a confidential informant and consideration of information outside of the record.

25. On July 1, another hearing officer within the facility held a second hearing. The hearing officer considered the evidence from the search of Mr. Quigley's property. The hearing officer recommended that Mr. Quigley continue in administrative segregation. The superintendent approved this decision on July 2.

26. Mr. Quigley then appealed this decision to Mr. Murphy.

Transfer to St. Albans and Close Custody Status

27. While Mr. Quigley's appeal was pending, Mr. Murphy suggested to Ms. Lanman that Mr. Quigley should be transferred to the St. Albans Facility. Mr. Murphy observed that Superintendent Lanman considered Mr. Quigley to be an escape risk and Mr. Quigley had significant grievances with that superintendent. He thought it might make sense for Mr. Quigley to get a fresh start in a new facility. The St. Albans Facility is Vermont's most secure facility and therefore better equipped to deal with potential escape risks.

28. Department policies require the review of administrative segregation decisions within fifteen days. Unless there is evidence to support continued administrative segregation the inmate returns to his or her previous status. Mr. Quigley was scheduled for such a review on July 17, 2003.

29. On July 15, 2003, Messrs. Blanchard, Morley and Martinson of the Newport staff met to discuss Mr. Quigley. The case note describing the meeting reads in pertinent part: "Discussion was had in regards to placement of Mr. Quigley should the Administrative review allow him to return to general population and/or not. The plan from this group was for inquiry to movement to NWCF [the St. Albans facility] if the Due Process Hearing allows Mr. Quigley to return to general population status. If the decision is for continued Administrative status then he will be reviewed for continued placement in the SMU unit." Thus, regardless of the outcome of the review of Mr. Quigley's administrative segregation, the plan was to continue some form of restrictive custody.

30. Administrative segregation confinement and close custody confinement both occur in restricted areas with substantial limitations on inmates. Close custody inmates have some additional time out of their cells. Administrative segregation is a punishment that is subject to hearing and appeal. Close custody status is considered a classification decision and is not subject to appeal.

31. On July 17, the review of Mr. Quigley's administrative segregation occurred. The written review states: "Facility has no new evidence to present. Recommend remove from ad. seg. status." Superintendent Lanman concurred at 8:20 AM.

32. The case notes for July 17 read: "James Quigley has been reviewed by the Administrative Due Process this morning and the determination has been to discontinue the Administrative Segregation. The Superintendent has concurred with this decision. The case plan has now been reviewed and Mr. Quigley has been overridden to close custody and is currently being moved to the NWCF for close custody housing. Further case planning will be developed through the NWCF and be determined by Mr. Quigley's behavior."

33. There is no written evidence in Mr. Quigley's file documenting how the Newport Facility decided to change Mr. Quigley's custody status. The digital record of the Department documents that the change occurred on July 17; the record does not document the person who made the change. Generally, the Department's policy requires that classification occur through an assessment tool called the Conviction and Violation Summary. This tool generates a numeric score; higher scores correlate to greater risk and more restrictive custody. The custody level can be increased through an override of the score. The Department's written policies do not explain how these judgments should be made.

34. On July 17, Mr. Quigley transferred from the Newport Facility to the St. Albans Facility. Just prior to the transfer the staff at Newport told him that he was no longer on administrative segregation, but that his custody status had been changed to close custody.

35. Generally the transfer of inmates between facilities requires approval by the Department's Director of Classification or his deputy and written documentation of that approval. The record of Mr. Quigley's transfer does not document such approval. The transfer document indicates that David Ibey from the St. Albans facility and Marshall Rich from the Newport facility arranged the transportation. Superintendent Lanman signed the order for the transfer.

36. The only other written material concerning the transfer is a June 18, 2003 email from Lawrence McLiverty (quoted above in paragraph 22), the Department's Director of Security, to Kathleen Lanman and Raymond Flum, who was in charge of classification decisions.

St. Albans—D-Wing

37. Upon arrival in the St. Albans Facility, the staff assigned Mr. Quigley to the D-Wing as a close custody inmate.

38. The D-Wing at St. Albans has two parts. The first part houses inmates with mental health problems and profound behavioral issues associated with them. The second part is a close custody unit. D-Wing is very high security, housing inmates in solitary cells.

39. The St. Albans Facility has a written policy governing D-Wing. It is called: "Close Management Program Delta-Unit Offender Manual." Mr. Quigley was a Level I inmate under this policy. According to the manual, Mr. Quigley was supposed to be out of his cell each day for one twenty minute phone call, shower, and two activity periods totaling between four and five hours.

40. According to the policy, inmates are not penalized for their past behavior. It reads:

The Close Management Program's primary purposes: Create an environment that is highly structured, allows graduated opportunities, closely monitors behavior & human interaction and supports offender efforts as **self-risk management**. Most offenders are assigned to the unit because of issues or problems that occurred in medium/open population. The Close Management Program offers offenders an opportunity at intervention: the chance to take a time out, reflect and learn to manage "risk" behaviors.

Regardless of the offenders (sic) incoming status, punishment is not the goal. Even if the offender arrives in the unit because of serious behavior resulting in a disciplinary report, the goal is the same: enter, serve

sanction, learn and leave better equipped to manage your own behavior.

41. The policy goes on to read:

Each offender who demonstrates progress and effort toward self-risk management will be continuously reviewed by the Close Management Team and offered the opportunity for increased privileges and will move ever closer to returning to medium custody/open population.

42. The policy goes on to read:

Level (1) is designed to be short-term -30-days in duration.

43. Mr. Quigley was on D-Wing for 82 days.

44. The weekly minutes for the D-Wing management team between July 21 and October 6 describe no misbehavior by Mr. Quigley. The regular descriptions for Mr. Quigley were: “quiet” and “no issues.”

45. The weekly minutes for the D-Wing management team between July 21 and October 6 describe a “movement list.” This was the list of inmates, in order of priority, who were next to move out of D-Wing. Prior to October 6, Mr. Quigley was never on this list.

46. Mr. David Ibey is the Living Unit Supervisor for D-Wing and was a member of the D-Wing Management Team. In two interviews Mr. Ibey explained his understanding of why Mr. Quigley remained in D-Wing. He said Mr. Quigley had an escape plan. He described Mr. Quigley as “a pain in the butt.” When asked if “pain in the butt” meant the filing of grievances, Mr. Ibey said “yes.” Mr. Ibey denied, however, that the filing of grievances had anything to do with Mr. Quigley remaining on D-Wing.

47. Mr. Steven Andrews was the Correctional Services Specialist at the St. Albans Facility who functioned as the caseworker on Mr. Quigley’s file. He also served on the D-Wing management team.

48. Both Mr. Andrews and Mr. Ibey stated that there was an understanding on the D-Wing management team that Mr. Quigley would stay in D-Wing until a transfer to Florida. Thus, the team would make no decision on reviewing Mr. Quigley’s custody status or moving him out of D-Wing. He would stay there indefinitely regardless of his good behavior.

49. The notes for the D-Wing management team for August 25, 2003, state the following concerning Mr. Quigley: "Security needs to review for medium placement. On Administrative Segregation status. Status should be reviewed. Quiet."

50. Mr. Quigley was not on administrative segregation; that would have required more hearings and appeals. He was on close custody. Inmates on close custody, according to policies, are allowed to leave their cells for up to five hours per day. If they are on administrative segregation, they are only allowed to leave their cell for one hour per day.

51. A review of the daily logs of the facility indicates that Mr. Quigley was not out of his cell for five hours a day. There are no records for fourteen days. Out of the other sixty-eight days he was on D-Wing, the records document that Mr. Quigley was out of his cell in the activity room for only twenty-one days. He may also have been out of his cell for a twenty-minute shower. It is possible that Mr. Quigley refused opportunities offered to be out of his cell. Mr. Quigley's correspondence contains complaints that he was not allowed out of his cell.

52. The conditions in D-Wing are much harsher than conditions for the general population. The inmates occupy solitary cells. Our inspection shows that windows in D-Wing are drafty. Mr. Quigley did not have access to standard items available to the general population, such as dental floss or standard toothbrushes. Mr. Quigley did not have access to standard writing implements. Mr. Quigley also complained that he did not have access to his full legal file; he had a post-conviction relief proceeding pending. Mr. Quigley did not have access to outside recreation or exercise.

Florida Transfer and Grievances

53. On July 22, the staff at the St. Albans facility printed a copy of the Conviction and Violation Summary review from the Department's data base and placed it in Mr. Quigley's file. There was no new review. The staff at St. Albans attached the staff notes from Newport to the review, and wrote "override---close" at the bottom of the page.

54. On July 22, Steve Andrews, the case worker on Mr. Quigley's file wrote the following email to Mr. Flum and several others:

Everybody-----

Inmate James Quigley was transferred from Newport to NWSCF on 7/17/03 as a higher degree of security was needed. Information revealed that inmate Quigley was considered to be an Escape Risk as he had local Vt. Maps in his possession and directions from MapQuest from Newport to Florida. Confidential information received was also used to place Quigley in

AD/SEG/increase his custody level/and eventually place him here at NWSCF. I'm unfamiliar with the ISC agreement/rational with Florida, but it appears to me that if this inmate requires more attention and a higher degree of security---why are we keeping him here in Vt??? Currently inmate Quigley is in "D" unit/Close Custody as he has been overridden by the Newport officials. Future plans for this inmate would be limited as he is currently considered a security risk. Why waste a Vt bed on an ISC inmate who we feel is a security/escape risk???? Can inmate Quigley be sent back to Florida for a swap if we still owe Florida????.

Direction requested---Thanks---SA

Note: Quigley is a ISC/Florida inmate serving a 25y to life for 1st Degree Murder--recently denied Parole--has been in Vt since 02/11/02.

55. That same day, Mr. Flum replied:

Steve and all,

When the information first came to light, I asked for any and all supporting documentation so that I could work with Florida. To date I have not received any material that I can work with Florida on.

Our swap with Florida is [inmate name]!

I will make the same request, get me any and all information that is relative to making him a high risk for escape and I will work on a new deal with Florida.

Thanks, Ray

56. Mr. Andrews immediately wrote back:

Ray---

Your request will be in the mail today---A conversation with Newport could also shed some light on this case. SA

57. Mr. Flum then replied:

Steve,

I wrote the e-mail the way I did, because I have already spoken to Mac and the NOSCF staff. My original request for information went to them. At the time, they were not real clear on the issues. Is there truly an escape attempt or do we simply want to get rid of him for other reasons?

I hope this helps? Ray

58. Mr. Andrews then replied that same day:

If the VT/DOC approves a Custody override up to Close and also approves a move to a more secure facility for an ISC person--obviously there is a concern. One questions if VT really needs to deal with this type of inmate. I known in past practice that if a ISC inmate sneezed wrong--he was headed back from which he came and generally our ISC inmates abided by our standards. ISC placement is a privilege and should be honored by the inmate to the fullest. Again several individuals obviously have some concerns or the inmate wouldn't be in Close Custody w/override and placed here. Return to Florida seems appropriate. SA

59. On July 21 and 22, Mr. Quigley grieved the changes in his custody level and the resulting placement in D-Wing. Mr. Quigley complained that his change in status by Ms. Lanman was retaliatory. Mr. David Ibey of St. Albans denied the grievances. Mr. Ibey wrote that he had consulted with Superintendent Lanman, and that his review of the core file showed the change was appropriate. Mr. Ibey wrote that Mr. Quigley would "have to earn his way out of close custody."

60. Superintendent Hatin reviewed the decision and concurred with Mr. Ibey. He wrote that Mr. Quigley could earn his way out of D-Wing and into the general population by "appropriate behavior" and "cooperation."

61. On July 27, Mr. Quigley filed a grievance requesting a soft toothbrush. There was a policy on D-Wing that only allowed inmates a miniature tooth brush. On July 28, Officer Mahoney denied the grievance stating: "Maintain appropriate behavior for movement out of Delta." Superintendent Hatin upheld this decision on July 31.

62. Superintendent Hatin states that he routinely uses terms such as "appropriate behavior" and "cooperation" in denying grievances.

63. When the grievances were denied, Mr. Quigley had no disciplinary record, no infractions, and no violations within the St. Albans Facility. Throughout his stay at the St. Albans Facility, he had no disciplinary record, no infractions and no violations. His disciplinary record at Newport included one disciplinary report, but was generally clean.

64. During his stay at St. Albans, no explanation was provided as to what Mr. Quigley needed to change so that his behavior would be appropriate or cooperative. The only apparent non-cooperation on Mr. Quigley's part was the filing of grievances and lawsuits.

65. Each week a management team reviewed the status of inmates on D-Wing. That team was supposed to initiate the process to move Level I inmates after thirty days if their behavior was good and they therefore met the criteria for movement. The team included David Ibey and Steve Andrews. The team never initiated that process.

66. Mr. Andrews wrote the case notes for Mr. Quigley's case while he was in the St. Albans facility. On July 28, Mr. Andrews wrote: "DMT[D-Wing Management Team]—Inmate Qiglet is a ISC [Interstate Compact] inmate who was transferred from Newport for Close Custody—overridden from medium—per Newport—Security issue—maps in his possession and informants stated that he was going to Escape. I have written Ray Flum and made a case that this inmate should return back to Florida as he is a security risk—no word back yet."

67. The last part of the case note written by Mr. Andrews reads: "This inmate likes to write tons of greivences (sic) over petty issues. Also a legal paperpusher."

68. On July 28, Mr. Andrews spoke with Mr. Quigley about writing grievances. Mr. Andrews stated that he asked Mr. Quigley if he was going to do the same thing here, meaning, to file many grievances. Mr. Quigley had no response. Mr. Andrews explained his comment by stating that he wished to have issues settled at initial stages. Mr. Quigley reported that the comment by Mr. Andrews was: "Why do you write so many grievances? Don't you like it here in Vermont?"

69. On August 22, Mr. Andrews again emailed Mr. Flum. The email reads:

Ray----

It's been 30 days since we had any communication regarding inmate Quigley and the request for his ISC return to Florida. Any progress relating to his possible return?? Inmate Quigley continues to occupy a valuable Close Custody bed and has done so since 7/20/03.

----Awaiting your response.

----SA

There is no record of any reply by Mr. Flum.

70. On September 2, 2003, Mr. Andrews sent another email to Mr. Flum and his deputy, Charles Remick. The email reads:

Ray/Charles

I hate to be a pain--but somebody needs to make a decision on this case. I may not know all the circumstances as to why Inmate Quigley is here via ISC; but during the past 60days Quigley has become a high

profile case. Again, in my opinion--this inmate should either return to Florida or another State.
-----SA

This resulted in the following exchange:

[Flum to Andrews]
My last conversation with your facility in regards to this case was a request for information. I was told that a package would be sent my way. I have not seen any package as of yet.

Ray

[Andrews to Flum]

Ray----

I sent the packet to you on 7/22/03

----SA

[Flum to Andrews]

Sorry to say, but no one in this office has seen it. Where did you send it, to who's attention was it sent?

St J address or Waterbury address?

Sorry

Ray

71. Mr. Flum's files contain a set of documents that Mr. Andrews apparently sent him at some point, although there is no cover letter. The set includes documentation concerning Mr. Quigley's administrative segregation hearings in Newport, the outcome of his parole, and his Florida conviction record. There is no new information concerning Mr. Quigley's risk of escape.

Review of D-Wing Placement and Classification by DOC

72. Mr. Quigley appealed the denial of his grievances questioning his placement in D-Wing and the conditions of his treatment there.

73. Faced with an accumulation of grievance appeals, John Murphy met with Mr. Quigley on September 10, 2003. The next day, Mr. Murphy prepared a memorandum that he gave to his immediate supervisor, Lawrence McLiverty, the Director of Security for the Department of Corrections.

74. The September 11 memo states: "The purpose of this memo is to apprise you of the possibility that Mr. Quigley is being retaliated against for his grievance activity." The memo reviews some of the history of Mr. Quigley's placement, his case notes and his grievances. The memo concludes: "Since some of his grievances speak to retaliation as the motivator behind his treatment at the hands of corrections management,

and the fact that his allegation gains credibility by the actual case note entered by Mr. Andrews on the day of the treatment team meeting, I believe that a determination needs to be made about the possible employee misconduct before I can craft a response to his most serious issues regarding retaliation. Please advise.”

75. In response to the memorandum, Mr. McLiverty instructed Mr. Murphy to immediately go to the Newport Facility to investigate the reliability of the assertion that Mr. Quigley was an escape risk.

76. On September 12, Mr. Murphy traveled to the Newport Facility. He learned that the confidential informant never said that Mr. Quigley was planning an escape. He had only stated that Mr. Quigley had a “plan B.”

77. Mr. Murphy knew that Mr. Quigley filed many legal proceedings, not only challenging conditions within the prison but also contesting his own incarceration. Mr. Murphy did not know that at that time Mr. Quigley had won a court case entitling him to an evidentiary hearing on a post-conviction relief proceeding. Thus, at that time, Mr. Quigley had a live legal proceeding challenging his conviction and his incarceration. Legal challenges to his incarceration could well have been the “plan B” referred to by the informant.

78. The maps that were the alleged basis for Mr. Quigley’s being declared an escape risk were from the Rutland Herald. They showed the State of Vermont, with some of its roads depicted and a numbered key showing the various locations of advertisers. Mr. Quigley also had county maps from a newspaper which apparently had been part of election coverage; they showed the political boundaries of various towns within Vermont counties.

79. The Rutland Herald and other papers that were routinely delivered to prisoners at Newport occasionally published similar maps. The library in the Newport Facility also maintained books with maps of Vermont containing comparable detail.

80. On September 12, Mr. David Martinson, the Deputy Superintendent at the Newport Facility made the following comment to Mr. Murphy: “The only reason that guy [Mr. Quigley] is in ad seg is he pissed off the superintendent.” Superintendent Lanman denies that she was angry at Mr. Quigley.

81. Following his visit to Newport, Mr. Murphy verbally reported back to Mr. McLiverty on September 12. He reported that there is more evidence that Mr. Quigley is currently in D-Wing in retaliation than because he is an escape risk.

82. On September 17 Mr. McLiverty sent an email to Mr. Hatin, the Superintendent at the St. Albans Facility. The email stated: “Quigley—what did Newport send you about this guys situation. I’m thinking that he doesn’t belong in D-block but wanted to review the materials that resulted in him being viewed as an escape risk.”

83. On September 19, Mr. McLiverty sent a three paragraph email to Mr. Hatin. The second paragraph reads: “Quigley and [another inmate name] don’t need to be housed in D block. These are thin cases of escape risk from Newport that I can staff with you. There probably are no DR’s [disciplinary reports] for escape.”

84. On September 25, 2003, Mr. McLiverty wrote Mr. Hatin a letter concerning Mr. Quigley and another inmate. The letter reads: “I would like the administrative segregation status of these two residents reviewed. I would like to be consulted about the findings of these reviews, when they are completed. Thank you.”

85. On September 29, Mr. Hatin replied in a letter that, in pertinent part, reads: “I have looked into your request and found the following: James Quigley—not on Administrative Segregation Status.”

86. On October 1st and 2nd, Mr. Murphy again went to the St. Albans Facility to investigate allegations that a correctional officer was mistreating inmates within the D-Wing. Mr. Murphy’s investigation documented that there was substantial evidence that a correctional officer was mistreating inmates in D-Wing. According to Mr. Murphy, the evidence did not indicate that Mr. Quigley himself was the subject of mistreatment. It indicated the mistreatment was directed towards inmates who had profound mental health disabilities.

87. Investigation after Mr. Quigley’s death has documented that inmates have alleged that the same correctional officer mistreated Mr. Quigley. The mistreatment included withholding showers, recreational time, and personal items. Mr. Quigley’s own correspondence documents that he believed he was being mistreated by this correctional officer.

88. One of the inmates said that Mr. Quigley complained to this officer about his food. The inmate reports that that this officer replied: “If you don’t like it, string up.” This expression means to commit suicide by hanging. The same inmate reports that this officer made this comment on many occasions. The officer denies making this comment. The correctional staff did not corroborate the complaints against this officer.

89. That Department reassigned that officer to a different post within the facility on October 13, 2003. The Department relieved the officer from duty with pay on November 13, 2003. The Department has not yet resolved the final status of this officer.

The Plan to Move Mr. Quigley from D-Wing

90. In September of 2003, Attorneys Paul Volk and Jason Sawyer were investigating whether to represent Mr. Quigley in a civil rights action for damages based upon his confinement in administrative segregation in Newport and then close custody in D-wing. Mr. Quigley had also filed a case in court questioning his confinement in D-Wing. Attorneys Volk and Sawyer did not represent Mr. Quigley in this case.

91. A day or two before October 2, 2003, Mr. Sawyer spoke with Robert Gagnon, an attorney from the Vermont Attorney General's office who was representing the Department in the defense of Mr. Quigley's court case. Mr. Sawyer stated that he thought Mr. Quigley had been placed in D-Wing as retaliation. He also objected to some of the conditions of confinement within D-Wing. Mr. Gagnon did not agree or disagree, but promised to get back to Mr. Sawyer.

92. Mr. Gagnon called Mr. Sawyer back on October 2. Mr. Sawyer understood Mr. Gagnon to indicate that there was a process in place to move Mr. Quigley to a list that would result in his transfer out of D-Wing. Mr. Sawyer called Mr. Quigley that day and gave him this news.

93. Mr. Gagnon organized a telephone conference on October 6, 2003. The other participants were Mr. Murphy, Superintendent Hatin, Mr. McLiverty, Mr. Flum, and Mathew Viens of the Attorney General's office.

94. In the telephone conference, Mr. Murphy laid out the reasons why he believed the placement of Mr. Quigley was unsupported. Mr. Hatin did not respond to the explanation in what Mr. Murphy regarded as a rational manner. Instead of dealing directly with the evidence that Mr. Quigley was not an escape risk, Superintendent Hatin commented that he was not going to allow a convicted murderer from Florida into his general population and then someday have to explain to a local selectman why that murderer had escaped.

95. At the conclusion of the telephone conference, Mr. McLiverty's recollection is that he ordered Mr. Quigley to be moved out of D-Wing as soon as possible. Mr. Murphy's recollection is that the telephone conference was inconclusive. Mr. Hatin's recollection is that it was decided to move Mr. Quigley to E-Wing.

96. Mr. Gagnon's recollection and his notes indicate that it was decided that Quigley would be moved from D-Wing to E-Wing, another close custody unit but with fewer restrictions, as soon as possible. Mr. Gagnon's notes document that there would be a review of the close custody status in the next week. There would also be a review of whether to return Mr. Quigley to Florida. He also recalls a decision that there would be an immediate response to some of Mr. Quigley's grievances over his living conditions.

97. Mr. Gagnon called Mr. Sawyer immediately after this conference call. He described the decisions that had been made. Mr. Sawyer described this as significant progress and said that Mr. Quigley would be pleased.

Mr. Quigley's Death

98. There was no communication between Mr. Sawyer and Mr. Quigley on October 6.

99. There was a management team meeting for D-Wing on October 6, 2003. The notes from that meeting concerning Mr. Quigley state: "Per Super/Hatin inmate Quigley is to be placed in E unit ASAP/ this week." There is no evidence to indicate that anyone in the Department of Corrections communicated this information to Mr. Quigley.

100. Mr. Quigley wrote three letters during the last two days of his life. All three were delivered after his death. On October 5 he wrote a letter to attorney Jason Sawyer. The letter reads:

10-5-03

Dear Mr. Sawyer:

Now that the confusion has clear, the best I can do is roughly \$11,000. Since that is well short of retainer quoted to me on Thursday please return the unused balance to my mother.

It's too bad the philistines will win by default. Even though I am the unfortunate principal, this case would have been academically interesting for a number of reasons, and it could have set some sorely needed standards for Vermont corrections.

Oh well, they have won the battle, but the war will continue. The tactics will necessarily have to change.

Sincerely
James Quigley

101. On October 6, he wrote a letter to attorney Paul Volk. The letter reads:

10-6-03

Dear Mr. Volk:

When we spoke on Thursday, I believe you state that AAG Gagnon advised you that I "was on the list." Although you did not specify precisely which "list" I was supposedly on, I assumed it was the list to be released from D-Wing to the general population.

As it turned out, [inmate name deleted], who has been down here 6-weeks, was released yesterday. Today

Steve Andrews made a new list of five, and two were released today. I am not, and have never been, on any list.

I suspect these officials are lying to the department's lawyers, but of course, you probably don't find this surprising.

Sincerely,
James Quigley

102. On October 5, Mr. Quigley wrote his mother. The letter reads:

10-5-03

Dear Mom,

A letter from you arrived here last week, along with one from Aunt E. I read neither.

On Thursday, I spoke with Paul Volk and Jason Sawyer. They want \$25,000 to take the case. Obviously, this is beyond my reach so I have instructed them to return the unused balance of the retainer to you.

A month ago I asked RJ to send them \$2,500 and assuming this would be done, I had instructed Sawyer to refund the \$2,500 that you had sent. For some reason my request of RJ was not honored.

Perhaps the reason was set forth in his letters of Sept. 8, 11 and 13, but I did not read them. In any event, it's irrelevant now.

Nothing has change (sic) here. Although Paul Volk says that assistant attorney general Gagnon claims I am "on the list." I'm not entirely sure just what "list" I'm supposedly "on," and in any case, it's irrelevant.

Tomorrow a brand new prison opens in southern Vermont. It looks like a torture joint. No free-world clothing (they supply everything), and 24-hour cell lights (pure torture). They probably think they're sending me there.

Two weeks ago, I got 4 injections in my back. They helped somewhat, but other than that, I've received no health care, in spite of numerous requests. There is still chronic pain, which has recently been exacerbated because it's been cold and rainy, and there is no heat whatsoever.

Yesterday there was a 30 mph wind to boot, and the windows in my cell won't close all the way, so it's been extremely cold (mid 40's) and damp. There is nothing to do but retreat under the covers and tremble because they won't provide us with adequate clothing or allow us to have our own clothing.

John Murphy was here last Wednesday, supposedly investigating someone's complaint that "conditions on D-Wing are barbaric." My reaction was, "they're the worst I've ever seen."

They're all full of crap. Spin is everything to these prison officials. It's all a front. In reality they are utterly evil and abusive. [DOC staff member] is a perfect example. [DOC staff member] is another. [DOC staff member] may be the worst of all. Too bad they win by default.

Love,

Jim

103. In the early morning hours of October 7, Mr. Quigley committed suicide in his cell.

104. His cell was L-shaped. There was a 37 by 40 inch toilet area in the back corner of the cell that could not be seen from the observation window in the door to the cell. Near the ceiling in this area, there was a metal grate. Mr. Quigley attached a portion of his bed sheet to this grate and hanged himself.

105. The policies governing D-Wing required that the guard on overnight duty check each inmate's cell every thirty minutes and make sure to see the inmate's skin. The purpose of this policy is to assure that the inmate is actually sleeping in bed. The policy protects against inmates placing objects under their sheets to simulate a sleeping person and then hurting or killing themselves in another part of the cell.

106. The night he died, Mr. Quigley had placed books underneath his covers to simulate a sleeping person. Mr. Quigley had gone to the corner of the cell that could not

be seen from the window and hung himself. The guard who was assigned to check his cell did not follow the policy requiring that he see Mr. Quigley's skin.

107. Mr. Quigley died on the 82nd day of his confinement in D-Wing. He died on the 118th day of his confinement in either administrative segregation or close custody.

Conclusions

The primary responsibility of any correctional facility is to maintain security. This requires protecting the public from inmates who have committed serious crimes and preventing their escape. This task requires difficult decisions that ought not to be second-guessed lightly.

In performing this task, the Department of Corrections has detailed standards, policies and guidelines that it is supposed to follow. Restrictions such as administrative segregation and close custody status are substantially more difficult for inmates than placement in the general population. If appropriate and warranted, they must be employed. If not required, Department policies are designed to assure that inmates are not subjected to these restrictions without an adequate basis.

This system failed in the case of Mr. Quigley.

The initial decision to remove Mr. Quigley from the general population was reasonable. It was reasonable for the Newport staff to be cautious and to take no risk of escape until there was time to conduct an investigation. But a reasonable investigation--such as that conducted by Mr. Murphy on a single day in September when the issue became prominent to him--should have disclosed that Mr. Quigley did not pose an unusual or heightened risk of escape.

There is no evidence of any behavior by Mr. Quigley in St. Albans that would have justified the conclusion that Mr. Quigley was an escape risk. Nor is there any evidence of any behavior that would have justified keeping Mr. Quigley in D-Wing beyond his initial thirty days there. The record establishes that the staff in St. Albans was determined to keep Mr. Quigley in D-wing until Vermont would transfer him back to Florida.

Mr. Quigley's correspondence in the last days prior to his death documents profound dissatisfaction with his circumstances. His condition deteriorated markedly during the 118 consecutive days he spent in segregated or close custody status.

We have concluded that Mr. Quigley's continued placement on D-Wing was not justified. If the system had worked correctly, it should have moved Mr. Quigley from D-Wing long before his death.

The correctional staff responsible for Mr. Quigley's placement denied that they had any conscious intent to retaliate against Mr. Quigley. Some of these denials are

credible and sincere. Others are not credible. Distinguishing which individuals were consciously retaliating from those who were indifferent or ineffective would not affect our ultimate conclusion: Vermont's correctional system treated Mr. Quigley differently because he had filed grievances and objected to institutional practices. We can discern no good reason for that different treatment.

A review of Mr. Quigley's grievance file shows that many of his grievances are unwarranted and unsupported. It is easy to understand why these repeated filings would annoy some. That is not, however, a sufficient basis for the treatment that Mr. Quigley received.

Retaliation for the filing of grievances is a significant mistake. It not only penalizes the inmate for an activity that is protected by the Department's rules, policies and the law itself, but it also prevents or inhibits an important auditing system for the Department. The system receives many frivolous grievances. But the valid grievances provide the system with an opportunity to correct its own errors. Retaliating against inmates for filing grievances undermines this basic safety net.

It is also significant that on the night of his death there was a violation of the regulations requiring the guard to check inmate cells every thirty minutes and see the inmate's skin. The guard should have conducted further investigation once he could not see Mr. Quigley's skin. It is impossible to say whether adherence to this policy would have prevented Mr. Quigley's death. There is no way of knowing whether Mr. Quigley took his life just after a thirty minute check and would have been dead by the next check even if the guard had made the check and observed his skin. We do know that this failure lost a potential opportunity for preventing his death.

Neil Prentiss

Factual Findings

1. Neil Prentiss, DOB: 11/14/54, was 48 years old when he died at the Lahey Clinic in Burlington, Massachusetts on November 23, 2002.

2. Mr. Prentiss for several years before his death had been an inmate in the Vermont Prison System and had been housed at various facilities in the State and in a Virginia facility. He had most recently been transferred to Chittenden on or about October 17, 2002. He left the Facility by emergency ambulance on October 31, 2002, was transported to the Fletcher Allen Medical Center in Burlington and, on or about November 12, 2002, was transferred from Fletcher Allen to the Lahey Clinic in Burlington, Massachusetts, where he died.

3. When he arrived for his last confinement at Chittenden, Mr. Prentiss had an institutionally well-documented history of serious illness, including but not limited to hepatitis B, hepatitis C, abdominal hernia, peripheral vascular disease and a traumatic brain injury.

4. The Chittenden Facility, like other Correctional Facilities in the State of Vermont, has an established methodology to communicate inmate requests for health care to facility health staff. The process involves the requirement that the inmate deposit into a designated facility mailbox a written request for healthcare entitled, "Correctional Medical Services Health Services Request Form."

5. Douglas Dinsmore, now a case worker trainee at the Chittenden Facility, was a correction officer at the time of Mr. Prentiss' 2002 incarceration at Chittenden. Officer Dinsmore worked second shift. He became aware that Mr. Prentiss made repeated written requests for health care. He believes that Mr. Prentiss' requests were properly deposited in the mailbox. Deposited requests for medical services are normally collected daily.

6. Medical request forms have two parts, an upper part of the form that contains the inmate's request, date and signature lines and a lower part that provides for the response of the health care worker, "Health Care Documentation."

7. Mr. Prentiss' sequential requests for care follow:

A. On **October 14, 2002**, Mr. Prentiss deposited a request. He identified the nature of his problem as severe head and leg pain. The lower left portion of the health form records that Mr. Prentiss was seen by a nurse on October 15, 2002, at 10:30 a.m. At that time a health care worker reported that Mr. Prentiss' legs hurt, **". . . real bad. I have a circulation problem for a long time."** The examining nurse noted, among other things, that Mr. Prentiss complained of "severe pain," but did not have any obvious limp. The treatment plan was to medicate with Tylenol for discomfort and refer Mr. Prentiss to a physician.

B. On **October 17, 2002**, Mr. Prentiss made another request. Mr. Prentiss reported his problem and request as follows: **"Head leg pain severe. Hernia in stomach stick out need to be seen – no medical treatment since I left VA 10-9-02 No meds with me Thank you."**¹ Mr. Prentiss' request was stamped as received on October 18, 2002. There is no evidence of medical follow up nor nurse notation on the request form.

C. On **October 18, 2002**, Mr. Prentiss made another request, stating **"Severe Head leg pain Hernia _____ stomach Second Request to be seen Came From VA. And have none of my Meds Must see doctor Thank you."** The request was received October 21, 2002. There is a nurse's note (on a form entitled "Interdisciplinary Progress Notes") on October 21, 2002, at 8:00 p.m., indicating that Mr. Prentiss was, **"Seen in H.C. VS✓ _____ placement. BP 130/90, P 72, R 16, T**

¹ Note: Quotations of the content of Mr. Prentiss' health care requests are as accurate as possible. Frequently, Mr. Prentiss' requests are fragmented. In addition, quotation of nurses' or doctors' notes are subject to the interpretation of symbols and shorthand. Copies of actual individual notes are available for inspection.

97.6 Ø c/o's @ this time. Refer for chart review." There is no note of any kind on the lower portion of the October 18th request form.

D. On **October 21, 2002**, the same day (no time indicated) on which he was apparently seen by a nurse, Mr. Prentiss again sought health services and stated, **"Severe head leg pain – Hernia in stomach None of my Meds came with me From Virginia must be seen Third request Thank you."** On the upper left-hand corner of this request, there is a hand-written notation, **"rec 10/23/02 w."** There is no evidence of medical follow up nor nurse notation on the request form.

E. On **October 22, 2002**, Mr. Prentiss made another request stating that, **"Been in jail over 7 yrs strait those are not made up illnesses in fact have got more need to be seen by doctor please this is my Fourth Request!"**. The request was received on 10/26/02. There is no evidence of medical follow up nor nurse notation on the request form.

F. On **October 28, 2002**, Mr. Prentiss made another request and specifically identified on the date line, **"10-28-02 plus 5 others."** His **October 28, 2002**, request stated that, **"Head – leg – Hernia chronic illnesses been in 7½ years strait am I going to be seen by the doctor Thank you."** This request was stamped as received on October 31, 2002. The request form contained no nurse notation.

8. Around mid October, **Douglas Dinsmore** spoke with Mr. Prentiss. He reports that Mr. Prentiss told him that he was not feeling well and that the medical staff was not seeing him and that he needed to be seen. Officer Dinsmore suggested that Mr. Prentiss put in a slip and believes that Prentiss did so. Officer Dinsmore does not know which in the sequence of slips Mr. Prentiss put in after this discussion of his complaints. Officer Dinsmore brought Mr. Prentiss' requests to the attention of medical staff. It appears that Officer Dinsmore's initiative contributed to Mr. Prentiss' being seen and examined to the extent reported in the "Interdisciplinary Progress Note" of October 21, 2002.

9. Officer Dinsmore reports that a nurse, ". . . actually had him (Prentiss) come down and checked him out. And then she had him sent back up to the unit. The status she sent him back up as, I can't remember, but to me it seemed like the common cold. I'm no medical professional, that's why it took a few days for me to actually call the nurse, cuz that's against our procedure. Under most circumstances, they fill out a request form and then the med staff would see them."

10. As the days passed, in Officer Dinsmore's opinion, Mr. Prentiss did not improve. Toward the end of October, on or about October 29 and October 30, Officer Dinsmore, working second shift, observed that Mr. Prentiss had been lying in bed for two days. "I can't remember the duration, it was like a couple days. And then I called down." It had become clear to Officer Dinsmore that Mr. Prentiss was having increasing difficulty. Officer Dinsmore's willingness to act outside the scope of the system's medical request policy appears to have been instrumental in the attention that Mr.

Prentiss received on October 30. There is an "Interdisciplinary Progress Note" dated October 30, 2002, at 10:40 p.m. which states that, ". . . ____ 2 calls from c/o Densmore regarding I/M. States I/M has been in bed X2 straight days, has had bloody diarrhea and appears ill."

11. On the note of October 30, the examining health care worker, among other observations, records that:

**I/M appears weak and does appear to be ill.
Continues to C/O ↑ abd pain ____ episodes of watery stools that had blood in them.**

**States appetite is poor and is not eating or drinking well.
C/O nausea _____ vomiting.
Return to unit.
See practitioner in AM.
Advised C/O and I/M to call for worsening symptoms.**

12. The "Unit Log for Supervising Officer" of October 30, 2002, records that Mr. Prentiss was "out to health center" at 10:30 p.m. and was "back into unit" at 10:41 p.m.

13. There is an additional note signed by a medical staff person under a "Late Note 11-5-02" that states as follows: "This paper was handed to PA @ clinic visit 10/31."

14. The note, on plain white lined paper, states as follows:

"Need something done today can't sleep hard to breath walk need help can't sleep.

"Legs two pair old man socks left there only have one need two more sets suppose to keep elevated was in infirmary 8 days _____ case I get _____."

"Tell these people I can't take tylenol. Haven't got my self co-pay cards for my _____ again along with socks. I _____ them."

"Was getting 4 Darvocet a day in VA. Can I get those back again. _____ takes the edge off head + leg pain so I can sleep."

“Does any know where my _____ is was turned in to nurse when I left back to VA and I’ve put a form in a month or so ago.”

15. A nursing note on October 31, 2002, at 3:24 p.m. relates that:

“Pt. well known, multiple medical problems. Had cough, flu-cough “mostly resolved”. C/O abdominal pain, swollen tense abdomen. ↑ past few days. Maroon diarrhea yesterday today ↓ diarrhea. ⊕ vomiting ⊕ epigastric pain ∅ vomiting.”

16. Then, after the report of vital signs, the nurse goes on to report:

“. . . unable to speak in complete sentences. States ‘winded.’”

17. After additional medical commentary, the report continues:

**(A) abdominal pain, dyspnea
(P) Discussed w/Dr. Werner. Since pt. has multiple med probs, sig. physical findings and _____ vitals will send to ER.**

**VHAP Papers faxed, confirmatory call made.
No officers or transport vehicles available – will send to ER via ambulance.**

18. A “consultation request” seeking emergency room treatment dated 10/31/02 in a section requesting a description of signs and symptoms, states as follows: **“Swollen painful belly x5 day. Pain in R groin. Diarrhea – maroon yesterday, today “clear” ⊕ nausea ∅ vomiting, short of breath, weak.”**

19. An inter-agency e-mail dated Tuesday, November 12, 2002, sheds light on Mr. Prentiss’ condition at that time. The e-mail reports that, **“Dr. Werner informs me that Neil Prentiss needs to be transported to Boston. Prentiss is being assessed for a liver transplant. He is currently on life support and a ventilator.”**

20. The last note in the Vermont DOC medical file, under the heading, **“Interdisciplinary Progress Notes,”** reports on 11/25/02 at 13:35, **“Died @ Leahy Clinic in Burlington, MA on Sat. 11/23/02.”**

21. It is standard practice, upon receiving a prisoner at a facility to conduct an interview and to medically in-process the inmate. There is evidence, corroborated by Assistant Chittenden Superintendent Jay Simons, that at the time during which Mr. Prentiss was seeking medical care, the in-processing of inmates was backed up. Mr.

Simons and the correctional staff at Chittenden were generally aware of backlogs in processing medical reviews.

22. On October 23, 2002, Mr. Simons had occasion, as he often did, to walk through the facility to check on conditions and talk with offenders. Mr. Simons saw prisoner TH. Mr. Simons, while he was a correctional officer in Newport, had known TH and noticed that TH was lying in his bed, was badly bruised and apparently ill. He inquired. TH said he was “dope sick.” He said that he was supposed to be getting a medication which he had not received for four or five days. That concerned Mr. Simons who immediately went to the infirmary. On his way to the infirmary he saw Mr. Prentiss, whom he had known as an inmate in Newport. At that time, Mr. Prentiss did not complain of illness. Mr. Prentiss looked and sounded “okay.” Mr. Simons went to the infirmary, strongly expressed his concern about TH who had been without care and at that time learned that the infirmary was “. . . 70, some 70 intakes behind, which at that time happened.” Mr. Simons reported his findings and his concerns to the Regional Director of CMS and to DOC Clinical Director Tom Powell.

23. Chittenden at the present time has a population cap, as a consequence of Court order, of 197 inmates. Last year Chittenden processed about 7,000 prisoners, an average of about 20 a day. Chittenden processes more inmates on a daily basis than any other Vermont correctional facility. The rate of processing creates great stress on the facility and its capacity to attend to the physical and mental health needs of its inmate population. It also creates great personal stress on correctional staff and on health care and mental health staff.

24. Before Mr. Prentiss’ death, on April 23, 2002, a group of senior departmental staff met at Chittenden to discuss medical concerns which included, at that time, the concerns of the Superintendent and Assistant Superintendent that there was inadequate medical staff to properly run the health center; they expressed a concern that inadequate staff would lead to significant medical problems and errors in medication administration. Following that meeting, Clinical Director Tom Powell sent a formal letter, based upon the consensus of senior staff, to Correctional Medical Services. Dr. Powell commented that CMS should declare a staffing emergency at Chittenden. He further commented that, “I hope this conveys to your St. Louis office the urgency of this matter and the need for appropriately drastic measures to insure contract compliance.” Dr. Powell reports that CMS did take action in an attempt to address staff shortages at Chittenden and that circumstances associated with shortages have since been resolved and that staffing is reasonably stable at the present time.

25. Both Superintendent Susan Blair and Assistant Superintendent Jay Simond, and other staff, were cooperative and responsive in providing information.

26. It does not appear that any investigation was undertaken nor any report rendered by the Central Office at DOC regarding the facts and circumstances surrounding the incarceration of Mr. Prentiss; his repeated requests for health care; the quality of responses to his requests; the facts and circumstances associated with Mr. Prentiss’

apparently rapidly declining medical condition, his emergency transfer from Chittenden to Fletcher Allen Hospital or from Fletcher Allen to The Lahey Clinic where Mr. Prentiss died.

Conclusion

Mr. Prentiss made repeated requests for health care. He expressed urgency. He provided detail to support urgency.

We are not physicians. We do not know if the quality of response to Mr. Prentiss' requests was a factor which contributed to his death. We do know that it raises substantial questions.

Setting aside the potential causal connection between the care rendered to Mr. Prentiss and his death, we conclude that Chittenden did not adequately respond to Mr. Prentiss' requests. We have not found any satisfactory explanation for the quality and timeliness of care provided to Mr. Prentiss.

We have found no written report from any governmental authority regarding Mr. Prentiss' death. In the absence of the Department's critically and objectively examining the care received by Mr. Prentiss, and reporting the results publicly, there is no adequate basis for the system to self-criticize and self-correct. It is our conclusion that in Mr. Prentiss' case, and in the case of all deaths within the Vermont prison system, the government owes a duty of candor and transparency to investigate, to report, to accept criticism, to learn, to improve, to move on.

Lawrence Bessette

Factual Findings

1. Lawrence Bessette died in the Northern State Correctional Facility in Newport, Vermont on May 22, 2003. The autopsy reports and State Police investigation document that Mr. Bessette died of suicide. Mr. Bessette hung himself in his cell.
2. Mr. Bessette had a long and history of substance abuse. He was a cocaine addict.

Mr. Bessette's Treatment at Chittenden

3. On March 15, 2003, Mr. Bessette entered the Chittenden Regional Correctional Facility. He was a detainee facing a charge of first degree aggravated domestic assault against a woman with whom he had been involved for a long period of time.
4. A staff person completed an "Initial Needs Survey" designed to screen for mental health concerns requiring quick attention, such as the threat for suicide. Mr.

Bessette denied receiving any medications for mental health. He denied receiving recent treatment for mental health. He denied having thoughts of killing himself.

5. Mr. Bessette left the Chittenden Facility on March 17, 2003. He was released on bail.

6. Mr. Bessette again became a detainee in the Chittenden Facility on April 30, 2003.

7. Mr. Bessette did not cooperate with the booking process on April 30. He refused to answer the Initial Needs Survey. Although Mr. Bessette provided no information to indicate that he was suicidal, the shift supervisor placed Mr. Bessette on fifteen-minute checks.

8. Under Department policy, once an inmate is placed on fifteen-minute checks staff can not remove the inmate from the checks. Only the mental health staff can make that decision.

9. On May 1, a mental health clinician conducted a mental health evaluation. The evaluation records that Mr. Bessette described that he “almost made a suicide attempt” in 2002. He reported seeing a doctor who prescribed neurontin; he discontinued that after few weeks and resumed abuse of cocaine. Mr. Bessette denied current suicidal thoughts. He denied any thought or plan to harm himself with these words: “I don’t have the balls to kill myself.”

10. The chart note shows that the clinician first wrote: “Remove from fifteen minute [checks]. Can contact as needed. He agreed to this plan.” The clinician then crossed through this note and wrote: “However, even after being cooperative [with] me, he is still refusing to be booked. Will leave on 15 min [checks] until the behavior stabilizes.”

11. The clinician wrote a treatment plan. The plan described Mr. Bessette’s problem as: “angry, uncooperative, refuses to be booked, oppositional, maybe unpredictable.” The goal was: “improve conduct, become more cooperative.”

12. On May 2, Mr. Bessette answered the Initial Needs Survey. His answers were different from his March 15 responses. He now responded that he had thoughts about hurting or killing himself, and he had attempted to take his own life.

13. The mental health clinician saw Mr. Bessette again on May 2. He denied any thought or intent of suicide. The clinician noted that Mr. Bessette was now cooperating with booking. She removed Mr. Bessette from fifteen-minute checks.

14. The clinician saw Mr. Bessette on May 5. The note reads in part: “Inmate anxious, reports suicidal thoughts & plan last p.m., such thoughts come ‘on and off’ today but denies plans to act on them. The clinician placed Mr. Bessette on fifteen-

minute checks because of ongoing suicidal ideation and his fragile state. She referred him to the mental health treatment team.

15. On May 6, Mr. Bessette saw a different mental health clinician. In this meeting, Mr. Bessette described his legal and family situation which he reported had caused his suicidal ideation. The note states that Mr. Bessette was receptive to counseling, future oriented, and had strong deterrents to suicide. The note states that Mr. Bessette contracted for safety. The clinician concluded: "Apparent low risk for harm today."

16. On May 7, a nurse spoke with Mr. Bessette to complete a medical screening. He denied any history of receiving psychotropic medications. He talked about suicide, but denied having a plan. While leaving the appointment, he saw an acquaintance and said: "I'm going to string myself up in twenty minutes." The nurse placed Mr. Bessette on fifteen-minute checks and notified mental health.

17. On May 8, Mr. Bessette met with the mental health clinician who had counseled him on May 1, 2 and 5. He reported that if he were to kill himself he would not have to deal with a long sentence, but that his sons would be disappointed and harmed. He described his suicidal thoughts as intense, but that they come and go. The clinician reminded Mr. Bessette that his mood was more depressed because he was withdrawing from cocaine abuse. The clinician noted that in about one month he should notice improvement. The clinician continued the fifteen minute checks and planned to discuss the case in the May 19 treatment team meeting. The clinician observed that by May 19 Mr. Bessette would be detoxed and that would allow a clearer diagnostic picture.

18. On May 9, the clinician again met Mr. Bessette. The clinician noted that Mr. Bessette's suicidal thoughts were increasing. He contracted to not harm himself. The clinician decided to refer Mr. Bessette to see a psychiatrist on May 13 to evaluate whether he should receive anti depressants.

Transfer to Newport

19. On May 11, the Department of Corrections transferred Mr. Bessette from the Chittenden Facility to the Newport Facility. The transfer had nothing to do with Mr. Bessette's behavior or treatment at the Chittenden Facility. The cause of the transfer was overcrowding at the Chittenden Facility and the availability of a space in the Newport facility.

20. As a result of the transfer, Mr. Bessette did not see the psychiatrist as scheduled on May 13.

21. As part of every transfer the sending and receiving facilities complete a Health Services Transfer Form. The side of the form completed by the Chittenden Facility stated that there was no mental health history. The form left blank the space for

listing mental health concerns. The form indicated that Mr. Bessette's last mental health assessment was on May 6, but that he was not on the mental health roster.

22. Along with the Health Services Transfer Form, Mr. Bessette's mental health related records followed Mr. Bessette to the Newport Facility. We obtained those records from the internal files of the Newport Facility.

23. It is unclear whether the notes of Mr. Bessette's visits with clinicians on May 8 and 9 were part of the record at the time of transfer, or sent to the facility separately. The nurse who completed the form at the Chittenden Facility noted the last mental health assessment as May 6. The notes for May 8 and 9 may have been added to the file at the Chittenden Facility after the completion of the form but prior to the transfer. The notes may have been sent later to the Newport Facility.

Treatment at Newport

24. Mr. Bessette arrived at Newport on Sunday, May 11. Mr. Bessette completed another Initial Needs Survey. Mr. Bessette denied any thoughts of killing himself. He reported that he had previously attempted suicide, and did not have anything to look forward to. Based on the screening, the shift supervisor placed Mr. Bessette on fifteen minute checks.

25. The primary mental health clinician at Newport reviewed the Initial Needs Survey on Monday, May 12. He immediately scheduled an appointment for Mr. Bessette.

26. On May 13, Mr. Bessette met with the clinician. The clinician met with Mr. Bessette for about thirty minutes. Mr. Bessette stated: "have thoughts of suicide, but I have my boys."

27. The clinician is certain that he reviewed Mr. Bessette's mental health records from the Chittenden Facility prior to seeing Mr. Bessette on May 13. He recalls reviewing the notes of treatment from both clinicians who saw Mr. Bessette at the Chittenden Facility. He is unsure whether the records included the notes from the May 8 and 9 sessions at the Chittenden Facility. He observed that notes sometimes are not placed in files immediately, and that it is possible these notes were not yet at the Newport Facility when he met with Mr. Bessette on May 13. The clinician believes that the May 8 and 9 notes are consistent with the remainder of Mr. Bessette's file and that they would not change his assessment.

28. As a result of his file review and meeting with Mr. Bessette, the clinician's assessment was that Mr. Bessette was a heavy cocaine user with sporadic suicidal thoughts. He noted the depressive symptoms, but wrote that they could be associated with cocaine use. He concluded that Mr. Bessette appeared to be stable with a low risk of self harm. The clinician intended to obtain Mr. Bessette's records of

treatment outside the facility. The clinician decided to place Mr. Bessette on thirty minute checks for a twenty-four hour period, and then to discontinue the checks.

29. The clinician discussed Mr. Bessette's case with the Mental Health Treatment Team for the Newport Facility. The clinician reviewed Mr. Bessette's treatment history at the Chittenden Facility. The clinician discussed with the Team that Mr. Bessette's depression appeared to be secondary to his history of cocaine abuse. He said he did not think Mr. Bessette needed to be on checks. The Team concurred.

30. After May 14, there were no special suicide checks on Mr. Bessette at the Newport Facility.

31. On a form dated May 16, Mr. Bessette submitted a written request for mental health services. The request stated: "I am having a breakdown, and I need to talk to a counselor."

32. Mr. Bessette used the wrong form. He used a generic "inmate request form." He did not use the medical request form.

33. It is unclear why Mr. Bessette used the wrong request form. On May 8, while at the Chittenden Facility, Mr. Bessette had written a request for medical services for chest pain. He wrote the request on a blank sheet of paper and added: "There are no medical request forms in the A-unit." He did not place such an explanation on his May 16 form.

34. Inmates were supposed to deliver these written requests to a box in the dining hall, which was checked on a daily basis. We do not know where Mr. Bessette delivered the request, or when he actually delivered it. The most likely explanation is that Mr. Bessette gave the form to a staff person who routed it to the medical office through inter office mail.

35. The nurse at the Newport Facility's medical unit specifically recalls that she received the form through inter-office mail on May 21. She immediately gave the form to the mental health office.

36. The clinician for Mr. Bessette noted on the form that he received the form on May 21. He scheduled an appointment with Mr. Bessette for the next day.

37. On, May 22, the mental health clinician met with Mr. Bessette. Mr. Bessette reported that he had submitted the request to see the clinician because he "just needed to talk to someone." Mr. Bessette stated that his sentence would be shorter than he had feared; this was great news. He was optimistic. He said he would change his life style and deal with his addiction. He said he wanted to reconnect with his family.

38. The clinician made this assessment: "Patient with narcissistic trait and substance abuse reports futuristic thinking, hopeful about release and spending time with

his wife and children. No need to ascertain records due to patient increased affect, outlook, and possible release in 60 days. Stable, no suicidal ideation or homicidal ideation.” The meeting ended at 12:30 P.M.

Mr. Bessette's Suicide

39. Following this meeting, Mr. Bessette had a lengthy telephone call with the woman who was the victim of the pending assault charge. She also was the mother of two children fathered by Mr. Bessette. Mr. Bessette had been involved with the woman for many years. We have listened to the tape recording and reviewed a transcript of the telephone call.

40. The woman told Mr. Bessette that she would be with another man and she would not marry Mr. Bessette. Mr. Bessette tried to persuade the woman to change her mind. She refused. Mr. Bessette threatened to kill the woman during the call.

41. Mr. Bessette also said he would kill himself several times during the call. A portion of the transcript reads:

WOMAN: I think you're going to kill yourself.

MR. BESSETTE: I'm gonna.

WOMAN: No you're not.

MR. BESSETTE: You wait. I ain't f----- livin' without you [name of woman], and that is all there is to it. I f----- didn't dedicate 8 years of my life to just lose you.

42. Mr. Bessette returned to his cell. According to the correctional officer on duty, the officer locked Mr. Bessette into his cell at 3:07 PM.

43. Mr. Bessette then put a sign over the window in the door to his cell stating that he was using the toilet. This sign covered approximately the bottom 3/4th of the window into the cell.

44. Sometime between 3:07 PM and 3:54 PM on May 22, Mr. Bessette hung himself in his cell.

45. Mr. Bessette's roommate returned to the cell from the outside recreation yard, looked over the sign and saw Mr. Bessette's body suspended from a belt tied to the bunk bed. The roommate alerted the correctional staff at around 3:57 PM.

46. The staff immediately called for medical assistance. The staff attempted to revive Mr. Bessette without success.

Conclusions

Vermont Protection and Advocacy has questioned the adequacy of the mental health care provided to Mr. Bessette. Vermont Protection and Advocacy released a report on February 12, 2004. We have carefully considered their report on this death. We have reached different conclusions.

It is not our role to engage in debates with anyone. It is our role to find the facts and make assessments. We have the advantage of additional evidence that may have been unavailable to Vermont Protection and Advocacy. We have concluded that the record does not establish material failures in the care of Mr. Bessette that had an impact on his suicide.

Mr. Bessette received intensive attention and care during his incarceration. During his twelve days at the Chittenden Facility, the mental health staff saw Mr. Bessette six times. During his eleven days at the Newport Facility the mental health staff saw Mr. Bessette twice. The last meeting with Mr. Bessette was just hours before he died.

The question, therefore, is not whether there was enough attention paid to Mr. Bessette. The question is whether his treatment was appropriate, and whether his treatment was a factor that contributed to his death.

The critical link in this chain is his treatment in the Newport Facility. When Mr. Bessette died, there were no fifteen-minute checks in place. Had the checks been in place, the likelihood that he could have ended his life the way he did would have been substantially lower. The reasonableness of the decision to remove those checks is the key fact in this case.

We do not see a basis for our disagreeing with this critical decision. The clinician at the Newport Facility met with Mr. Bessette and personally assessed him. He considered the history of treatment at the Chittenden Facility. That history established, as the clinician noted, changes in Mr. Bessette. Some days he more strongly expressed suicidal ideation. Some days he improved. Some days the Chittenden Facility had Mr. Bessette on suicide checks. Some days it did not.

The clinician did not make this decision in isolation. He reviewed this decision with the mental health team. They concurred in his judgment. Between May 14 (the date that checks ended) and May 22 (the date of his death) there do not appear to be any incidents involving Mr. Bessette that would provide a basis for questioning this decision.

Mr. Bessette apparently completed an inmate request form on May 16. That form did not arrive in the mental health office until five days later. But there is no evidence to conclude that this delay was attributable to a failure by the Department. The most likely explanation is that Mr. Bessette used the wrong form and did not place it in the designated box.

Once the clinician received Mr. Bessette's inmate request form on May 21 he immediately responded. The next day, Mr. Bessette had a positive meeting with the mental health clinician. The notes of that meeting document that one of the major sources of anxiety for Mr. Bessette—his fear of a long sentence—appeared to have ended. The notes also show improvement in Mr. Bessette's intention for dealing with his cocaine addiction. Nothing in Mr. Bessette's presentation that day appears to have indicated any reason for reinstating the suicide checks.

To conclude that clinical misjudgments caused Mr. Bessette's death, one would have to conclude that Mr. Bessette's presentation at this meeting would have caused a reasonable clinician to reinstate suicide checks. We have concluded that the clinician's actions in response to this meeting appear to have been reasonable.

The clinician and the mental health team made informed, professional judgments. Subsequent events were tragic. That does not make those judgments wrong.

The telephone call changed Mr. Bessette's positive outlook. In that call, one hears the change. Mr. Bessette's reaction to this call was the precipitating factor in his death. And while some of his records generally describe stress over family situations, nowhere do they foreshadow this event.

There are other questions less central to the cause of Mr. Bessette's death that warrant discussion. Because of his transfer, Mr. Bessette did not see a psychiatrist on May 13. Part of the purpose of the referral was to consider whether Mr. Bessette should receive medications. Mr. Bessette missed the appointment and did not receive medications.

It is at best unclear, however, whether the psychiatrist would have prescribed medications. Mr. Bessette had severe and long-term cocaine addiction. His record documented that it was reasonable to detoxify Mr. Bessette prior to providing medication. Most important, the clinician and the mental health treatment team at Newport considered Mr. Bessette's case and did not pursue medication. We do not have a basis to question their professional judgment in making this decision.

It is true that the Department did not obtain Mr. Bessette's records of mental health treatment for the period prior to his incarceration. Several facts explain this. Mr. Bessette denied a history of mental health treatment or medications on several occasions. He apparently told a clinician at the Chittenden Facility that he at one time had a prescription for neurontin, but he also said that he only took this for a few weeks before returning to cocaine abuse. Most important, the clinician in Newport noted in his first meeting that he would obtain the records. Mr. Bessette then reported in their second meeting that he would receive a short sentence. He presented himself positively. It was then that the clinician decided to not obtain the records.

The most significant failure in the handling of Mr. Bessette's case is the inaccuracy in the Transfer Form. It failed to note the most recent history of Mr. Bessette's mental health treatment at the Chittenden Facility. This mistake created the risks that Mr. Bessette would not be seen by a mental health clinician and that the mental health clinician would not be aware of the full extent of the treatment at the Chittenden Facility.

This error did not affect Mr. Bessette's care; the mental health clinician reviewed his file and saw him quickly. In another case, this error could have a serious impact. The Department should review whether it needs to change its protocols to prevent such an error.

Eva LaBounty

Factual Findings

1. Eva LaBounty died in the Dale Correctional Center on May 7th of 2003 of a drug overdose.

2. The Department incarcerated Ms. LaBounty on November 6, 2002, for escape from furlough. She was serving a sentence of one year to five years and four months on the following charges: aggravated assault, petty larceny, and violation of conditions of release.

3. Ms. LaBounty's record describes a long history of drug addiction prior to this incarceration.

Ms. LaBounty's Mental Health Treatments and Medications

4. Initially the Department placed Ms. LaBounty in the Chittenden Correctional Facility. On her intake form on November 6, 2002, Ms. LaBounty reported that she was not taking medications. She also reported that she was depressed. She did not report suicidal intentions.

5. On November 7, 2002, Ms. LaBounty filed a request for medical services. She stated that she could not sleep and was stressed that she had just lost her kids. She stated that she was having a hard time dealing with it.

6. On November 11, a mental health clinician saw Ms. LaBounty. She reported that Ms. LaBounty was suffering depression and anxiety. Ms. LaBounty did not report suicidal intentions. The clinician recommended medication and support. She decided to refer Ms. LaBounty to a psychiatrist in two or three weeks to allow time for Ms. LaBounty to detoxify.

7. On November 19, Ms. LaBounty again requested mental health assistance because she was experiencing a high level of anxiety and not sleeping.

8. On November 21, a clinician saw Ms. LaBounty and confirmed that a psychiatrist would see her soon.

9. On November 23, a psychiatrist examined Ms. LaBounty. He noted Ms. LaBounty's concern with the potential loss of her children. Ms. LaBounty denied any thoughts of suicide. The doctor prescribed amitriptyline, a psychoactive drug.

10. On November 29, Ms. LaBounty reported that she was experiencing a lot of anxiety and nightmares at nights.

11. On December 16, Ms. LaBounty reported that she was experiencing anxiety attacks and sleep problems, and that she was waiting to be examined.

12. On January 17, 2003, a psychiatrist again saw Ms. LaBounty. He noted that since the last time he had seen Ms. LaBounty, someone at the facility had discontinued the administration of amitriptyline after it was reported that Ms. LaBounty had opiates in her urine. He noted that this report was inaccurate and again prescribed amitriptyline. He increased the dosage to 150 mg per day. He also noted that Ms. LaBounty denied suicidal intentions.

13. On February 7, 2003, the Department transferred Ms. LaBounty to the Dale Facility in Waterbury.

14. On February 13, a psychiatric nurse practitioner examined Ms. LaBounty. She noted Ms. LaBounty's anxiety over the potential loss of her children. She prescribed buspar, apparently to help address the anxiety.

15. Ms. LaBounty met with the psychiatric nurse practitioner or mental health therapist at the Dale Facility four times between February 17 and March 13. The notes describe Ms. LaBounty's continued anxiety over the potential loss of her children. None of the notes indicate that Ms. LaBounty expressed any intention of self harm or suicide.

16. The March 13 notes describe increases in the dosage of buspar to 45 mg per day. The notes describe an increase in the dosage for amitriptyline to 200 mg per day. The notes describe a prescription for wellbutrin, apparently to treat depression, on March 13, 2003. Wellbutrin and buspar are psychoactive drugs.

17. On April 2, 2003, Ms. LaBounty submitted a request for health care. A nurse saw her and noted that Ms. LaBounty was experiencing a lot of stress. There is no indication of any intention of self harm or suicide.

18. On April 9, 2003, Ms. LaBounty submitted a request for health care. She stated that the wellbutrin was helping; that she remembered being told that the dosage could be increased to 300 mg per day; and, that she would like the medication to be increased.

19. On April 10, 2003, the psychiatric nurse practitioner increased Ms. LaBounty's dosage of wellbutrin to 300 mg per day.

20. On April 21, 2003, Ms. LaBounty saw a mental health therapist and described her grief and loss prompted by recently seeing her children and knowing that her parental rights would soon be terminated. The mental health therapist noted that Ms. LaBounty was not suicidal.

21. On April 24, 2003, Ms. LaBounty saw the psychiatric nurse practitioner. She again described her pain at losing her children. She gave no indication of suicidal thoughts.

22. On May 1, 2003, Ms. LaBounty again met the psychiatric nurse practitioner. They talked about how much pain she was experiencing. She expressed no suicidal thoughts.

23. On May 1, 2003, the psychiatric nurse practitioner increased the dosage for amitriptyline to 250 mg per day, and maintained the dosage on the wellbutrin at 300 mg per day. She decreased the dosage on the buspar from 30 to 15 mg per day.

24. Generally, a nurse would provide Ms. LaBounty with her medications. A correctional officer would supply the medications at bed time. Ms. LaBounty took some of her medications at bed time when there was no nurse present. The protocol for administering the medications was that a nurse or staff officer would hand Ms. LaBounty the medication and Ms. LaBounty was supposed to swallow the medication immediately.

25. There was no protocol for either the nurse or the staff to inspect the mouth of Ms. LaBounty to assure that she swallowed the medication.

26. In December of 2002, an inmate at the Dale Facility had an overdose of medications that had been prescribed and administered in the facility but not consumed by the inmate. The inmate survived the overdose. In response, the Dale Facility crushed some medications for some inmates prior to giving the medications to the inmate. This policy was not uniform. The Dale Facility applied this policy to medications and inmates the staff believed to be prone to abuse.

27. Ms. LaBounty's medication was in pill form. The staff did not crush the medication before giving it to Ms. LaBounty.

Dale Facility Care for Ms. LaBounty

28. Ms. LaBounty was at the Dale Facility for approximately the last three months of her life. The record documents intensive efforts by the Dale Facility Staff to provide Ms. LaBounty with services and support.

29. Ms. LaBounty was a participant in a program entitled “Cognitive Self Change.” This is an intensive group program that required two group sessions a week and the completion of assignments outside of the group.

30. Ms. LaBounty worked with substance abuse counselors at the Dale Facility.

31. The Dale Facility has a mental health treatment team. It meets regularly, reviews the cases of inmates, and discusses options for providing services for inmates. The Superintendent, the mental health therapist, psychiatric nurse practitioner, and case worker for Ms. LaBounty would all participate in these meetings.

32. We have not found any notes of these meetings. Participants recall several discussions of Ms. LaBounty. The team discussed the impact of the termination of parental rights on Ms. LaBounty.

33. Ms. LaBounty was reluctant to have formal counseling with the mental health therapist. We have already described her two formal meetings with the mental health therapist at Dale. In addition to these formal meetings, there were numerous informal discussions. The therapist made it a point to circulate around the facility and talk with inmates on an informal basis. She regularly spoke with Ms. LaBounty and provided her with support.

34. Ms. LaBounty’s caseworker was very attentive to Ms. LaBounty’s needs. In addition to working with Ms. LaBounty in the Cognitive Self Change group, the caseworker frequently spoke with Ms. LaBounty. The case notes document that the case worker regularly tried to help Ms. LaBounty with the issues related to the termination of Ms. LaBounty’s parental rights.

35. On May 5, 2003, Ms. LaBounty met with her case worker at the Dale Facility for thirty minutes. Ms. LaBounty was emotional and tearful, because she was about to go to a court hearing at which she expected the termination of her parental rights to her two children. The case worker offered her assistance.

36. On May 5, 2003, Ms. LaBounty appeared in court at a hearing. The court terminated all of her parental rights to her two children.

37. On May 6, 2003, Ms. LaBounty met with her case worker for twenty minutes. Ms. LaBounty was again emotional and tearful. She said the loss of her children was the hardest thing she had ever gone through, and she had to do it without abusing substances. The case worker talked with Ms. LaBounty about her needs and the support she would receive. Ms. LaBounty said there were people she could talk to if needed.

38. The case worker considered whether to place Ms. LaBounty on a schedule of checks every fifteen minutes for suicide. The case worker decided this was not necessary and potentially counterproductive.

39. The case worker knew Ms. LaBounty well. Ms. LaBounty was distressed, but was also oriented toward her future. The case worker knew that Ms. LaBounty had not expressed any suicidal thoughts. In response to the suicide of a former inmate six weeks before, Ms. LaBounty had said that she could not understand how this former inmate could take her own life knowing the hurt it would cause.

40. The case worker knew that Ms. LaBounty had an assault conviction and was working on anger issues in her group. The case worker feared that fifteen minute checks would be perceived by Ms. LaBounty as an unnecessary restriction and might provoke a response in anger. Because she did not perceive a risk of suicide, the case worker did not place Ms. LaBounty on fifteen minute checks.

41. On May 6, the mental health therapist was away on vacation. There were backup services available, but no interim replacement on site. Thus, no mental health professional saw Ms. LaBounty on the day of the termination hearing or the next day. Ms. LaBounty did not request mental health counseling.

Ms. LaBounty's Death

42. Ms. LaBounty went to bed at about midnight on Tuesday night, May 6. She was found dead in her bed the following day, Wednesday May 7.

43. At about 5:45 AM on May 7, one of Ms. LaBounty's three roommates tried to waken her. The roommate could not rouse Ms. LaBounty or detect a pulse. She then ran to get a guard.

44. The guard allowed all of the roommates to stay in the room. While the Dale Facility does not have locks on the bedroom doors for inmates, it does have a policy that requires inmates to return to their room after the announcement of a lockdown. The guard did not call for a facility lockdown.

45. Word of Ms. LaBounty's situation quickly spread among the inmates on this floor. There was concern, distress and confusion.

46. Medical services arrived. Another inmate came into the room during the attempt to revive Ms. LaBounty. During this time, one of the inmates removed an address book and letters from Ms. LaBounty's armoire and hid them. It is unclear whether the inmates removed any other items.

47. The state police officer investigating Ms. LaBounty's death concluded that Ms. LaBounty had consumed medications that she had been prescribed and hoarded, and other medications that were prescribed to other inmates. Ms. LaBounty probably

consumed all of the medications that she had hoarded, but some medications may have been removed from her room by inmates after her death because of a failure to secure the room.

48. One of the inmates who remained in the room during the initial attempt to treat Ms. LaBounty subsequently admitted to providing Ms. LaBounty with Valium two days before the death. The toxicology report did not indicate that Valium was a factor in Ms. LaBounty's death.

49. One of the inmates stated that prior to her death Ms. LaBounty had saved a quantity of medications that she had been prescribed.

50. Ms. LaBounty died of an overdose of amitriptyline, bupropion (i.e., wellbutrin) and methadone. The amitriptyline was in a concentration approximately four times the lethal range. In addition to these substances, the toxicology report showed elevated levels of nortriptyline, diazepam and desmethyldiazepam.

51. Two of the three substances that caused Ms. LaBounty's death—amitriptyline and wellbutrin—were prescribed to her by the staff at the Dale facility. One of Ms. LaBounty's roommates was prescribed methadone.

52. The State Police Officer who investigated this death concluded that it was likely Ms. LaBounty committed suicide. He noted that Ms. LaBounty was an experienced substance abuser, and that the concentration in her blood stream was such that Ms. LaBounty would likely have realized that it would be lethal.

53. The staff at the Dale Facility is unsure of her intentions, but believe it is more likely that Ms. LaBounty unintentionally overdosed. They note that Ms. LaBounty likely did not have long experience with abusing amitriptyline. They note that amitriptyline is a very lethal drug when overdosed. They also observe that Ms. LaBounty seemed oriented toward her future and did not express suicidal thoughts.

54. The investigation by the Vermont State Police documented that many inmates at the Dale Facility did not actually consume their medication. Instead, they would hide the medication in the cheek, and retain the medication for their later use in dosages sufficient to achieve intoxication or for sale to other inmates.

55. Dr. Jeffery Metzner provided a report in August of 2003. The report documents that in March of 2003, a few weeks before the death of Ms. LaBounty, 68.8% of the inmates at the Dale Facility were receiving psychotropic medications. Other Vermont institutions had percentages ranging from 20.2 to 47.9. Dr. Metzner commented that the statewide percentages were very high. He did not comment specifically on the percentage at the Dale Facility.

56. Medication rates for women are generally higher than men. The mental health therapist—who was not responsible for the prescribing decisions at the Dale

Facility, but was very familiar with the population—believes that the prescription rates were appropriate.

Response of the Dale Facility to Ms. LaBounty's Death

57. Superintendent Rowe concluded that the Dale Facility made errors in Ms. LaBounty's case. She instituted changes to correct these errors and improve the practices of the facility.

58. Superintendent Rowe concluded that there needed to be a better system to assure that inmates actually consumed prescribed medications. Superintendent Rowe instituted a policy that required an officer to be present during the administration of all medications. The nursing staff must check the mouths and the hands of the inmate to prevent the hoarding of medications. The inmate must open her mouth and wag her tongue as part of this process.

59. Superintendent Rowe concluded that correctional staff should not administer medications. Superintendent Rowe established a policy requiring that only the nursing staff could administer medications.

60. Superintendent Rowe concluded that amitriptyline should not be prescribed because it is a lethal drug if overdosed. She persuaded the mental health care provider to remove amitriptyline from the list of approved drugs for the Dale Facility.

61. Superintendent Rowe concluded that there should be mandatory fifteen minute checks for inmates whose parental rights are terminated. Under Department policy, only a mental health professional who has examined the inmate can discontinue those checks.

62. Superintendent Rowe concluded that there should be more programmatic support for inmates who suffer the termination of parental rights. Superintendent Rowe was instrumental in establishing a program with Vermont Children's Aid to provide these services.

63. Superintendent Rowe concluded that the staff at the Dale Facility should receive more training in the need to secure areas of the facility that become crime scenes for police investigation. Superintendent Rowe has provided this training.

Conclusions

We do not know whether Ms. LaBounty committed suicide or died from an overdose of drugs that she had intended to be intoxicating. The absence of any expression of suicidal intention prior to her death makes it more likely in our judgment that the death was accidental. But we cannot reach a firm conclusion on this point.

Regardless of her intention, Ms. LaBounty placed herself at significant risk with substances that she and other inmates obtained through prescriptions from facility staff. This overdose occurred on the night after the termination of her parental rights to her children.

The Dale staff was very responsive to Ms. LaBounty. They provided her with extensive counseling and support. Their concern for Ms. LaBounty and their grief at her death were apparent. The staff's empathy and effort warrant acknowledgement.

This case also presents two failures on the part of the Dale staff. Prior to Ms. LaBounty's death, the Dale Facility lacked adequate protocols to assure that medications would actually be consumed by inmates. Drugs were widely available in the facility. They did not arrive through smuggling. The drugs originally were prescribed as medication but were hoarded by the inmates for use as intoxicants. The facility failed by not having adequate protocols to prevent this practice.

The Dale Facility staff erred by failing to control access to Ms. LaBounty's room after the discovery of her body. This failure impeded the investigation by the State Police. The investigating officer documented that at least some cleansing of the scene occurred by inmates. There is no way for us to know the full extent of the lost evidence.

There are other issues that do not yield a simple or clear resolution. Dr. Metzner commented that the overall medication rates for Vermont were high; the rates for the Dale Facility were by far the highest. He was concerned with this medication rate. Credible observers have given good explanations for the rate. Without a systematic audit of the records by a medical expert, no one can reach a definitive conclusion. Based on the information available to us, we cannot conclude that the prescription rate in general, or the prescriptions given any particular inmate, were improper.

After carefully thinking through the issue, the case worker made a decision not to place Ms. LaBounty on fifteen minute checks. That decision cannot be fairly evaluated unless one considers the information and policies available to the case worker at that time. She spent significant time with Ms. LaBounty. As documented by the extensive mental health history, Ms. LaBounty had never indicated that she was suicidal. With the benefit of hindsight, one might make a different decision. But the evidence documents that the case worker was thoughtful and thorough. She made a reasonable decision under the circumstances.

We believe the new policy of the facility to require fifteen minute checks is sound. It addresses the potential for an inmate to believe that she is being treated arbitrarily and the associated need for caseworkers to make what could be difficult judgments.

This case also describes exactly how a correctional facility should respond to the death of an inmate under clouded circumstances. The Dale Facility made errors. Those errors made it easier for Ms. LaBounty to obtain the drugs that killed her. Those errors

made it harder for the State Police to effectively investigate this incident. The Superintendent responded appropriately to the errors. She provided strong leadership. She evaluated the death. She did not look for excuses. She tried to discover what went wrong. She then made responsive, effective changes.

Jeremy Garcia

Factual Findings

1. Jeremy Garcia was on furlough status from the Department of Corrections when he died on September 30, 2003 of a drug overdose at an apartment in Winooski, Vermont. He was twenty-five years old.

2. At the time of his death, Mr. Garcia was on furlough status for a sentence with a minimum of nine months and a maximum of eight years. The sentence was for various charges, including driving under the influence, larceny, passing bad checks, possession of marijuana, and violating conditions of release.

3. Mr. Garcia was an opiate addict.

4. On December 2, 2002, the Department of Corrections released Mr. Garcia on conditional release/furlough status. While on conditional release, Mr. Garcia was under the supervision of the Burlington probation and parole office.

5. The basic components of Mr. Garcia's conditional release plan were: 1) a requirement to complete adequate treatment for substance abuse; 2) a requirement to hold gainful employment; 3) a requirement to obtain and maintain his own housing; and 4) a requirement to avoid substance abuse. Over the course of his conditional release, Mr. Garcia did not maintain a job, did not get his own housing, and repeatedly tested positive for drug use.

6. On December 27, 2002, Mr. Garcia entered Maple Leaf Farm for a residential drug treatment program. Maple Leaf Farm released him on January 9, 2003.

7. Part of the supervision of Mr. Garcia's conditional release involved drug testing. Between the start of his conditional release in December of 2002 and March of 2003, Mr. Garcia failed several drug tests. He also admitted the use of marijuana, oxycontin and other substances.

8. On March 28, 2003, the Department incarcerated Mr. Garcia for fifteen days as a sanction for his repeated failing of drug tests. The Department returned Mr. Garcia to his conditional release status on April 10, 2003.

9. The probation officer in charge of his case and her colleagues who worked with her were concerned with Mr. Garcia's repeated failures. The probation

officer and her colleagues concluded that Mr. Garcia's chances of success would improve if he had another living situation, as he repeatedly failed when living with his father.

10. On May 2, 2003, Mr. Garcia again tested positive for drugs. In a meeting with his probation officer, Mr. Garcia expressed the desire to move away from home. The probation officer agreed; she concluded that Mr. Garcia had to make a substantial change if he were to have any chance of avoiding further drug abuse. Following consultations with her colleagues, the probation officer approved Mr. Garcia's move from his father's home. This resulted in a change to Mr. Garcia's approved plan that required him to live at the new approved residence, and, therefore, prohibited him from living with his father.

11. On May 9, 2003, Mr. Garcia again tested positive for drugs. He admitted to using ocycontin. On recommendation of his probation officer, the Department again incarcerated Mr. Garcia.

12. The Department sent Mr. Garcia to the Northern State Correctional Facility in Newport. The Department determined that it would release Mr. Garcia to furlough status again only if Mr. Garcia immediately enrolled in an approved residential treatment program.

13. While he was in the Newport Facility, Mr. Garcia tested positive for the use of drugs and also was found guilty of a disciplinary violation for possession of drugs. Twice his release to a residential treatment program was cancelled because he had used or possessed drugs.

14. On September 29, 2003, the Department again placed Mr. Garcia on furlough so that he could be admitted to the Maple Leaf facility for treatment. He entered the Maple Leaf facility that afternoon.

15. On the evening of September 30, Mr. Garcia called the probation office at 8 PM and left a message on the answering machine stating that he felt threatened and wanted to leave. At about 9:15 PM, a probation officer called and spoke with Mr. Garcia. Mr. Garcia said that he wanted to leave. The probation officer told him he could not leave. Mr. Garcia agreed to stay.

16. Later that night, Mr. Garcia left the Maple Leaf Facility with acquaintances. Mr. Garcia obtained oxycodone. Sometime on October 1, 2003, he died of an overdose of oxycodone at an apartment in Winooski.

17. There were significant disagreements between Mr. Garcia's probation officer and the father of Mr. Garcia. Mr. Garcia's father questioned the appropriateness of numerous decisions made by the probation officer. The most serious of these disagreements concerned the determination that Mr. Garcia should not live at home with his father.

18. The case notes file between December of 2002 and Mr. Garcia's death documents dozens of meetings, phone calls, conferences and other efforts to address Mr. Garcia's drug abuse. The notes summarizing this work comprise thirty-nine pages. Over the course of Mr. Garcia's supervision by the probation office, the officers were attentive to his case. They worked professionally and diligently to structure responses to Mr. Garcia's behavior that would discourage substance abuse and encourage the steps required for Mr. Garcia to maintain sobriety.

Conclusions

Mr. Garcia's death depicts the destructive power of drug addiction. Extraordinary efforts by dedicated probation officers were unsuccessful. A stay in a residential treatment center with a good reputation was unsuccessful. Incarceration did not deter further abuse, even within the walls of prison. The threat of further incarceration did not deter Mr. Garcia from leaving the Maple Leaf facility one day after arrival and taking the drugs that cost him his life.

We are sympathetic to the pain of Mr. Garcia's father. The father asserts that had the probation officer and the Department been more responsive to the father's efforts to help his son and also allowed him to remain at his home, more effective treatment for Mr. Garcia could have occurred. We disagree with this assertion.

The probation office made extraordinary efforts to reverse Mr. Garcia's abuse. While he was on conditional release, Mr. Garcia repeatedly abused drugs. Faced with a pattern of abuse, it was reasonable for the office to encourage Mr. Garcia to change his living situation. Given the failures by Jeremy Garcia to maintain employment, stay sober and make progress toward independence, something had to change. The decision to incarcerate Mr. Garcia followed at least twelve failed drug tests, a four month period in which he could not maintain employment and other violations of his conditional release.

This case demonstrates that Mr. Garcia's access to drugs continued while he was in the general population at the Newport Facility. The source of these drugs is unknown. Mr. Garcia was able to obtain such drugs within a matter of days after being placed in the general population.

In a subsequent section of this report, we will review the efforts to control the flow of drugs into prison facilities and make recommendations for additional steps.

George Sumner

Factual Findings

1. George Sumner, DOB: February 25, 1972, was 30 years old when he died in Newport at the Northeast State Correctional Facility on February 14, 2003. He had been confined in Vermont facilities and at the infirmary in Newport for more than a year before he died.

2. The inmate in-take process in Vermont Correctional Facilities includes the completion by an inmate of a questionnaire designed to alert the receiving facility to physical and mental health issues which an inmate presents.

3. The in-take process does not automatically involve diagnostic blood tests to screen for blood borne diseases. However, blood testing might occur at time of in-take if an inmate's questionnaire discloses at-risk activities.

4. Mr. Sumner's responses to health related questions on questionnaires which he completed at in-take at Vermont correctional facilities did not alert officials to the necessity of any further testing.

5. On January 9, 2002, Mr. Sumner presented to medical staff that he had not been feeling well and had over a two month period sustained a twenty pound weight loss. His complaints were followed by further testing. Mr. Sumner was diagnosed with AIDS.

6. Mr. Sumner was soon transferred to the infirmary at Newport which has medical and nursing staff to care for ill inmates.

7. The medical record at Newport indicates that Mr. Sumner was followed closely by medical and nursing staff. On several occasions, medical staff sought consultations with specialists. Consultations were provided and, from time to time, Mr. Sumner was transported outside the Newport facility for testing and stabilization.

8. With the passage of time, Mr. Sumner's condition deteriorated. He lost weight. He developed and was treated for other ailments brought on by his immune deficiency.

9. As his condition continued to deteriorate, infirmary staff raised questions about the suitability of his continued confinement in the infirmary. Options for transfer were considered. There is a record of e-mail correspondence that pre-dates Mr. Sumner's death by two weeks in which the suitability of his placement is raised by the infirmary's head nurse, but decisions were reaffirmed to honor Mr. Sumner's request to remain at the Newport infirmary.

10. Medical records report that Mr. Sumner expressly stated that he did not wish to be moved from Newport. The record reveals that Mr. Sumner was aware that his condition was terminal and that he expressed a desire to die among people whom he perceived as caring for him. It appears that infirmary staff were very attentive to Mr. Sumner and provided him not only with medical care but empathetic and supportive personal attention.

11. Mr. Sumner's condition continued to deteriorate during January and early February of 2003. At approximately 5:30 a.m. on February 14, 2003, an infirmary nurse

checked on Mr. Sumner and found that he had no vital signs. Emergency resuscitation was begun with the assistance of both medical and corrections staff. Departmental policy requires that correction staff, when confronted with a medical emergency, not make assumptions about an inmate's condition which would result in the failure to provide resuscitation.

12. The shift nurse phoned the supervising physician, presented Mr. Sumner's vital information, and the supervising physician directed the cessation of resuscitative efforts and transport of Mr. Sumner to the North Country Hospital.

13. An emergency ambulance was called, and despite the fact that resuscitative efforts had ceased and despite the fact that Mr. Sumner was dead, he was transported by ambulance to North Country Hospital in Newport. The emergency room physician in Newport did not wish to receive Mr. Sumner's body. The physician expressed anger with the decision to transport Mr. Sumner's body to the emergency room. He observed Mr. Sumner's body in the back of the ambulance outside the emergency room and confirmed the obvious fact that Mr. Sumner was dead. Mr. Sumner's body was then transported by ambulance to a Newport funeral home. Official notification was made by the prison, and a correction officer, who remained for several hours with Mr. Sumner's body, was finally relieved of that duty after State investigators arrived to examine the circumstances of Mr. Sumner's death.

14. State police investigative reports concerning Mr. Sumner's death suggest that some staff commented with regard to the transport of Mr. Sumner's body to the hospital that, "Nobody dies in a Vermont prison."

15. Departmental policy requires that inmates being transported outside the prison be restrained. For that reason, Mr. Sumner's leg was shackled to a gurney despite the fact that he was obviously dead. His body remained shackled at the funeral home for several hours and until the accompanying correction officer was relieved. The correction officer was dutiful in following his instructions.

16. The Newport Facility's retention of Mr. Sumner, a general awareness of his diagnosis and the continuing decline in his physical condition were topics of discussion and concern among some individuals at the facility. In part to address the concerns and in part out of personal empathy, Kathy Lanman, the Superintendent of the Facility, visited with Mr. Sumner and occasionally took lunch with him. She and other members of her staff appear to have performed acts of kindness which, absent this investigation, would not have received the recognition which they deserve.

17. Mr. Sumner's mother visited with him at Newport as did other family members. She confirms Mr. Sumner's desire to die in Newport. The last family visit occurred five days before Mr. Sumner's death. He requested pizza. Correction staff ordered-out for him. Everyone realized Mr. Sumner could not chew or digest. Mr. Sumner's mother reports that her son "just smelled the pizza and smiled." She praises the

Newport staff members for their care and compassion. As a gesture of appreciation she sent a note to Superintendent Lanman and a fruit basket to the staff.

Conclusion

The Sumner investigation did not disclose evidence of improper conduct regarding the care given to Mr. Sumner during his life. On the contrary, infirmary staff appear to have given competent and compassionate care. That said, our inquiry suggests issues which we believe that Corrections Central Office should further investigate and resolve to its satisfaction. They follow:

A. Are departmental custodial and health care policies and procedures current and adequate to govern the treatment plan, medication regimen, placement and associated complexities required to provide humane care to terminally ill inmates?

B. What is the rationale for requiring correctional officers to shackle and transport a patently dead inmate, with a communicable blood borne disease, to a hospital emergency room?

C. “Nobody dies in a Vermont prison.” The comment requires further inquiry by DOC central office regarding policy, procedures and practices concerning the management of inmates’ deaths in Vermont prison facilities.

Charles Palmer

Factual Findings

1. Charles Palmer was an inmate at the Northern State Correctional Facility in Newport. He died on April 20, 2003.

2. Mr. Palmer was a detainee awaiting trial on charges of sexual assault, burglary, grand larceny and aggravated domestic assault. Mr. Palmer was incarcerated at the Marble State Correctional Facility in Rutland on August 22, 2002. He transferred to the Northern State Correctional Facility in Newport on February 21, 2003.

3. Mr. Palmer died of a drug overdose. The overdose occurred after he ingested a bag with drugs that had probably been smuggled into the facility by a visitor during a contact visit. Mr. Palmer later tried to regurgitate the bag for his own use. At least some of the bag remained in his system. The bag leaked or burst in his system, resulting in the release of the drugs. Mr. Palmer died of a massive overdose.

4. Mr. Palmer’s case is still the subject of an active criminal investigation and potential prosecution.

Conclusions

We have written few findings on this case because there is a pending criminal investigation. We do not want to hinder that investigation or any potential prosecution by releasing details prematurely. Our review does not indicate that this case raises issues of misconduct or errors on the part of the Department of Corrections.

The circumstances that led to Mr. Palmer's death—the smuggling of drugs into the prison system—are apparently common. The inmates we interviewed generally confirmed that drugs are widely available in at least some Vermont prisons. While no one can provide a precise estimate of the number of inmates who are regularly using drugs within the correctional system, anecdotal evidence strongly indicates that drugs are available to and abused by a large number of inmates.

This is a common problem in prison systems throughout America.

Limiting the availability of drugs within prison is important. Many inmates have substance abuse problems; effective detoxification and treatment requires the interdiction of drugs. Drugs threaten the safety of inmates (both users and non-users) and staff.

Recently, the Department of Corrections undertook a review of its policies for preventing the importation of and use of drugs within its facility. The review recommended several steps, such as the use of uniforms for some inmates, additional searches and testing.

With the help of our consultants we have reviewed the new policy. We believe that the new policy is an improvement. We are also recommending the consideration of additional steps to interdict drugs before they reach correctional institutions. We describe those recommendations in the last section of this report.

ISSUES RELATED TO INMATE DEATHS

Provision of Mental Health and Medical Services

Factual Findings

1. Phil Stanley, the former Commissioner of the New Hampshire Department of Corrections, conducted a review of the provision of mental health services and related issues. His review is an appendix to this report.

2. Mr. Stanley did not conduct a comprehensive audit. His time and budget did not provide the resources for an audit. He visited several facilities, interviewed witnesses and reviewed some of the more important background documents.

3. The Department of Corrections provides mental health services to its inmates through a contract with Dr. Paul Cotton. Dr. Cotton was a principal in Matrix Health Systems, which was the named contracting party prior to October of 2003.

4. The report of Mr. Stanley concludes that there are significant areas of the contract that are being met. These areas include crisis intervention and coordination of mental health emergency services; mental health treatment team meetings; psychopharmacy services and some degree of consultation to the institution treatment programs.

5. The report of Mr. Stanley also noted some general areas that warrant improvement. These included: A) Policies and procedures are in need of revision to provide guidance to facility staff who support the mental health practitioners. B) Staff training could be significantly improved. C) There is lack of teamwork between contract staff and facility staff in some areas of providing mental health to inmates. D) There is some degree of strained working relations between central office and its field superintendents.

6. Mr. Stanley's report describes some specific problems. These included: A) The failure to meet the contract's requirement for group therapy. B) A lack of formal training by the mental health contractor for the correctional staff. C) A failure to provide all hours and services stated under the contract at the Dale Facility. D) The failure to implement the mandated quality assessment and quality improvement program. E) Failure to adequately collaborate with facility superintendents.

Conclusions

We did not have the time or resources to provide a comprehensive audit of mental health services in the Vermont system. We focused our review through two distinct paths. First, we wanted to understand the relationship of mental health issues to our primary responsibility, which was to assess the deaths of seven inmates. Second, we asked an experienced correctional official to provide a general review of mental health services based on field observations.

Mr. Stanley's review identifies several areas in which the system can improve. We are most concerned with creating an auditable assessment system for quality assurance and quality improvement. Without it, no one can verify whether inmates are receiving adequate services or the performance of the outside contractor. The anecdotal evidence reveals complaints by inmates and advocacy organizations. The contract requires the implementation of a quality assessment system; it has not yet been implemented. Without a meaningful quality assessment system, it is difficult to effectively assess the performance of the system as a whole. Nor can it be effectively managed.

Implementation of Grievance Process

Factual Findings

1. The Department of Corrections has a three-tiered grievance process. Level One involves a grievance provided by an inmate to a direct supervisor or staff. Level Two involves review of that grievance and its initial resolution by the superintendent of each facility. Level Three involves appeals from the Superintendent to the Commissioner of Corrections.

2. There is a fifteen day deadline for resolving grievances within facilities. The Commissioner must decide grievances within a “reasonable” time.

3. We did not conduct a systematic audit of the timeliness or adequacy of grievance responses within the facilities or at the level of the Commissioner because of time and resource limitations.

4. Vermont Protection and Advocacy, an advocacy organization, has experienced delays in receiving responses to some of its grievances.

5. By law, the Defender General’s Prisoners’ Rights Office has responsibility for representing inmates in cases challenging the conditions of confinement.

6. The staff of the Defender General’s office is professional and respected by all relevant constituencies. Even Corrections Department officials who are nominally adverse to the Prisoners’ Rights office say that the Prisoners’ Rights office is professional and pragmatic in solving problems.

7. The Prisoners’ Rights Office has limited resources that make it difficult to adequately represent prisoners.

Conclusions

Vermont Protection and Advocacy has recently filed a series of grievances with the Commissioner. We are not sure whether it is a function of limited resources or some other reason, but the resolution of some of these grievances has languished. This delay undermines the grievance process.

If a grievance has substantive validity it should be acknowledged as such and the situation corrected in a timely manner. If a grievance does not have substantive validity it should be denied with a rational explanation. If resources or the complexity of the subject require more time to resolve the grievance there should be an explanation of that circumstance in a timely manner.

The ultimate check on the functioning of the grievance process for prisoners is the court system. The entity charged by law with the responsibility for representing

prisoners in actions challenging conditions of —confinement—the Prisoners’ Rights Office of the Vermont Defender General—faces substantial shortfalls in its resources. Those shortfalls limit its effectiveness.

One might think that a shortage of lawyers available to represent prisoners would simplify the life of the Department of Corrections. We suggest that the opposite may be true. Strengthened representation of prisoners may provide quicker and more reliable adjustment of Department errors. Moreover, good lawyers can resolve problems early through negotiation, thereby shortening or avoiding litigation.

We recognize the severe budget constraints affecting the State. It is beyond our role to recommend additional appropriations. We do think that the State should consider reallocation of resources that are currently devoted to corrections. In future budget cycles, the Department of Corrections may want to consider whether enhancing the resources of the Prisoners’ Rights Office would be cost effective for the Department because of the audit function it would provide to the Department. If that is not feasible, then the Department will need to consider other mechanisms to achieve the goal of maintaining an effective audit capacity to check and improve the Department’s performance.

General Department Issues

Factual Findings

1. The Department has a practice of preparing written reports responding to the untimely deaths of inmates.
2. The final reports on the deaths of inmates Bessette, Quigley, Palmer and LaBounty were not completed until several months after the deaths. They were provided to us on February 13, 2004. We received preliminary reports earlier on some of the deaths.
3. The reports themselves are inadequate. They do not begin to address in depth the circumstances that led to the deaths. They provide no basis for assessing or improving Department practices. They emphasize facts that would be favorable to the Department in subsequent litigation. They generally ignore potential errors that warrant correction.
4. The Department’s staff is frustrated by its inability to obtain police reports and autopsies for inmates who have died. Without this information, it is difficult to fully assess the circumstances of deaths and make appropriate changes.
5. The day-to-day operations of correctional facilities rest largely in the hands of superintendents. Superintendents, while nominally operating under the control of the Department’s main office in Waterbury, exercise a substantial degree of autonomy. Many of the superintendents express concern with their supervision and support.

6. There is a perception among superintendents that they are not consulted adequately on mental health and medical programs.

7. The only employees in the department who are exempt from the classification system for employees are the Commissioner and the Deputy Commissioner. Key management personnel, such as the remaining management staff in Waterbury and superintendents are classified employees who can only be dismissed for just cause.

Conclusions

The Vermont Department of Corrections faces enormous challenges. The budget is tight. The population has increased at a rate beyond the system's capacity. The inmate population presents high levels of substance abuse and mental illness. Inmate turnover prevents much of the system from fulfilling its mission. One superintendent told us that she processed 1900 inmates into her facility and 1700 out of the facility in a year. That superintendent said: "Do you think I know who they are, let alone tell you that I provide them corrections and rehabilitative services. I stash them until they are moved."

These and other problems will not magically disappear. It might even be unfair to expect the Department to respond to all of these problems with its limited resources. But some of the Departments wounds are self inflicted. And they directly arise out of what might be best described as cultural issues.

When inmates die prematurely a correctional system should try to understand why. That inquiry should be genuinely searching. If the death is connected with a failure by the system, that failure has to be understood to prevent a recurrence. The goal should be to learn from the experience and identify whether there are changes that should be made in the future.

The reports prepared by the Department in this case are lacking in that regard. This may in part be a function of limited resources. We perceive that it is in part at least the function of a culture that avoids rather than embraces accountability.

We are concerned that litigation management techniques are trumping the needs of sound institutional management. Corrections management practices require timely, unsparing critiques and the intelligent acknowledgement of failure. Liability issues are best managed by competent managers who find and report and act on facts, not by those whose mission is judgment avoidance. The Department is not a private entity. It is the government. First and foremost, it needs to correct its errors. It has a duty of accountability.

The actions of the Commissioner and Deputy Commissioner in supporting this investigation, Superintendent Rowe in responding to the death of Ms. LaBounty and Mr. Murphy in reviewing the confinement of Mr. Quigley stand in sharp contrast. Their actions are models of the culture the Department should try to create.

The Department also should have access to hard data if it is to assess inmate deaths. We obtained Vermont State Police reports for the inmates who died in Vermont. We also had access to autopsy and toxicology reports for some of the deaths. This information was essential to our review. The Department needs access to that information if it is to make a meaningful review.

RECOMMENDATIONS FOR FURTHER CONSIDERATION

We are making a series of recommendations for further consideration. In view of the time and effort that we spent on this project, we thought it necessary that we share our impressions of what would be appropriate changes. While we have consulted with experts, we caution that we are not authorities in the correctional field. Nor have we reviewed the Department of Corrections in a comprehensive manner. Considerations that are beyond the scope of this investigation and our expertise will likely affect whether it is advisable to implement these recommendations. We present the recommendations for further consideration by the cognizant managers and policy makers.

1. The Department should revise its policies to assure that no inmate remains in a segregated cell for a period of longer than fifteen consecutive days without review and approval by a facility superintendent and a senior Department official based outside of the facility. That status should be reviewed again at least every fifteen days, and the review should be documented.

2. The Department should revise its policies and practices to assure that no inmate is transferred without the immediate delivery of all health and medical records to the inmate's new facility.

3. The Department should review whether the recent revisions to its practices are adequate to assure that medications will not be hoarded for later abuse. The Department should then revise its policies and train its staff to implement the policy.

4. The Department should regularly audit the percentage of inmates receiving psychotropic drugs in each facility and conduct detailed reviews of prescribing practices when those percentages exceed established norms.

5. The Department should establish a procedure to promptly identify facilities that have a backlog of medical care requests and procedures to remedy any backlog. The Department should also establish a procedure to audit the reasonableness of its contractor's responses to requests for health care.

6. The Department should establish an audit process independent from its medical contractor to review at least a statistically significant percentage of health care cases on a regular basis to assure adequate care.

7. The Department should establish an auditable quality assurance review process for mental health care treatment as required by its contract for mental health services.

8. The Department should change its policy to require that it respond to level three grievances within thirty days. In extraordinary cases in which further time is truly necessary, the Department should delay a final response no more than an additional thirty days following written notice to the grievant.

10. The Department should consider the following steps to improve the interdiction of drugs from its facilities: These are:

- A. Limit the availability of contact visits for inmates who have tested positive for drugs. Contact visits appear to be the chief means for smuggling drugs into prison.
- B. Contact visits should be monitored more closely by the reassignment of staff and videotaping. The facilities we visited all had monitoring systems and programs. We recommend intensifying the existing programs and making them more visible to visitors.
- C. Consider more effective screening of visitors. In particular, we believe that the use of dogs trained to detect drugs should be used and prominently warned to visitors.
- D. Consider more prominent and aggressive written and verbal warnings to all visitors of its screening methods and the potential for prosecution prior to their entry into each facility.
- E. The Vermont Attorney General should work with State Attorneys and make it a priority to prosecute those who introduce drugs into prison.
- F. The Vermont Attorney General and State's Attorneys should also consider prosecutions of inmates who sell drugs within prison. Currently, these offenses are generally dealt with through discipline within the correctional system.
- G. The Department should publicize all of the steps that it implements. The goal of these recommendations is to increase deterrence of those who would introduce drugs into prisons and thereby diminish the supply.

11. The Department should attempt to reorganize its inmate population to separate long-term offenders from detainees and short-term offenders.

12. The Department should discontinue the practice of housing mental health inmates and close custody inmates together at D wing in St. Albans.

13. The Department should assign and train senior staff to prepare truly evaluative reports of future inmate deaths or other extraordinary events and require the

completion of such reports in a timely manner. The reports should be prepared by staff who did not participate in the underlying events that are the subject of investigation.

14. The Department should be allowed access to police reports and autopsies in the deaths of its inmates to allow the preparation of adequate reports.

15. The Department should update its policies and procedures on a regular cycle.

March 15, 2004

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REPORT BY PHIL STANLEY
ON MENTAL HEALTH SERVICES
AND RELATED ISSUES IN
VERMONT DEPARTMENT OF CORRECTIONS

Introduction

During the week of February 8-12, 2004 I traveled to Vermont and interviewed a variety of staff, both state and contract, related to provision of mental health and grievance services to inmates of the Vermont Department of Corrections. Interviews were also conducted with selected inmates at two of the prison facilities. Part of my trip included tours of the Northern Correctional Facility in Newport, the Dale Correctional Facility in Waterbury, and the Northwest Correctional Facility in Swanton. Interviews were held at the facilities, in DOC central office, and over the phone.

The current performance of the Department with regard to mental health services was my primary focus. The responsiveness of all whom I talked with was much appreciated. Documents that I reviewed prior to and during my visit were: the contract between Dr. Paul Cotton and DOC; the report provided to the Vermont DOC by Dr. Jeffrey Metzner in August 2003; DOC mental health policy and procedures; and various correspondence from DOC staff, advocacy group members and legislators pertaining to the provision of mental health to prisoners.

This report will note that, in various ways, the contract for mental health services is not being met.

- Policies and procedures are in need of revision to provide guidance to facility staff who support the mental health practitioners.
- Staff training could be significantly improved.
- Leadership is needed for critical parts of the prison system.
- There is lack of teamwork between contract staff and facility staff in some areas of providing mental health to inmates. This is particularly true at the upper levels of the organization.
- There is some degree of strained working relations between central office and its field superintendents.

- Communication on mental health issues must be improved between central office and the field prison facilities.

Rather than indicate that problem issues are predominant, it should be noted that the Vermont DOC staff and contract staff are providing for initial intervention to deal with mental health concerns, and basic crises needs of offenders. There are very dedicated staff who work for the DOC and contractors.

Prison System Issues

Conflicting Missions

The prison system is straining to provide basic services across the board due to the fact that it holds arrestees, short-term jail prisoners and long-term felony offenders in the same facilities. Vermont is a combined system in this respect. Most states require their local jurisdictions, cities and counties, to provide services for arrestees and short-term jail prisoners, leaving long-term incarceration to the state. But in Vermont, a detainee (not yet adjudicated) may be housed in the cell next to an inmate serving 20-30 years.

There is a great deal of pressure on these facilities to provide programs and structure for these diverse populations. The concern is that Vermont is running both a jail system and a prison system within the same facilities, leaving one to wonder if they are doing an adequate job of either. In addition, because of the large number of prisoners, Vermont has had to find prison space for hundreds of its most compliant, long-term prisoners out of state. This leaves the most sophisticated, most ill, most mentally ill, most problematic inmates inhabiting the same prison space as someone who recently was picked up for petty larceny and who may not even have a court appearance scheduled. This can be a devastating experience for a “new” offender, but it can also be disturbing to the long-term inmate who may “just want to do my time.” The large number of short-term offenders in the system means that there is significant turnover of prison populations.

This situation can create many issues related to the stable operation of a prison. Programs in this environment can be fragmented. There may be an effort to include short-term offenders, who can be disruptive, into programs. Or, the more likely scenario is that short-term offenders will be excluded from some prison programming, creating a sense of isolation or anger on the part of the excluded. Often the short-term offender will attempt to undermine the program involvement of longer term prisoners.

One of the primary management issues in a prison is the amount and types of “property” permitted for inmates. This is typically a combination of items allowed from the community, such as personal clothes and items that inmates purchase once they are in prison, commonly referred to as store or canteen items, such as food. The current mixture

of short and long-term prisoners puts enormous pressure on the short-term inmates to turn over items to longer term inmates. This is called pressuring or “strong arming.” It is a behavioral issue that most prisons face but is exacerbated in Vermont due to the mixture of these two distinct populations.

Doing Your Time

Providing mental health programs in this setting presents similar issues. Where do the mental health staff concentrate their efforts? The short-term detainees require quick assessment, continuation or changing of medication regimens from the community, intensive counseling around their sudden loss of freedom, observation for signals of severe mental health issues, including suicide. The longer term offender presents some of these same issues but in addition they must deal with the issues of adjustment to the grinding routine of a prison, with few freedoms, the long-term estrangement from significant relationships in the community and the pressure to find your niche to do your “time” quietly. For these longer term inmates, anger management, communication skills, life skills, medication management are but a few of the mental health subjects around which there should be quality programming if the prison is to accomplish its goal of “correction” and break the cycle of recidivism.

Redefining Prisons

Vermont DOC should give thought to defining prison space for discrete population groups. It appears that with the opening of the Springfield prison for the mentally ill and designating the Dale facility for short-term female incarceration and Windsor for long-term female incarceration, there is a move in this direction. But can this approach be taken further? The DOC should consider whether the Northern Correctional Facility should be designated for longer term incarceration because of its facility design and distance from major population centers. The two hour or more drive to this location from most of Vermont’s other facilities make this an impractical site for short-term inmates. Prisons closer to the larger population centers should be designated for short-term incarceration and detainees. There needs to be more separation of the short and long-term populations to ensure a more consistent approach to program delivery, including mental health.

Mental Health Contract Compliance

To determine effectiveness of the mental health program for inmates, a starting point is the contract for services between Dr. Paul Cotton and Vermont DOC.

There are significant areas of the contract that are being met. These are: crisis intervention and coordination of mental health emergency services; mental health treatment team meetings; and psychopharmacy services.

Immediate Care

Both contract staff and state staff responded that the immediate mental health needs of inmates are attended to in a variety of ways. An Initial Needs Survey is filled out on each inmate, typically by correctional staff, and if there are mental health concerns at the start of incarceration or at time of transfer, proper attention is focused. It was also evident that when line staff had any concern about an inmate's mental health, contract staff were responsive to deal with any perceived crisis.

Psychopharmacy

Psychopharmacy services is an important component, because new inmates may have been taking a specific type of medication on the street and an evaluation needs to be made to determine whether to continue or change medications. Most of the state staff described that mental health providers, including the prescribing nurse practitioner were providing these services. There is some degree of concern that drug regimens being practiced on the street were too quickly terminated upon entry to the prisons.

I could find no definitive answer to this issue. Inmates and some staff complain about the ending of "helpful" medication. The contractor and some state staff say that the current practice is reasonable, that some medicines are continued, some discontinued, and some substitutions are prescribed. But, they say that all of this is done within a prudent case assessment process to provide for the best individual treatment. Dr. Metzner's report has more specific recommendations regarding medication monitoring issues. His recommendations should be followed.

Treatment Teams

Weekly treatment team meetings were being held and both contract and state staff felt the meetings were an excellent vehicle for maintaining a united approach to an inmate's mental health needs. It is recommended that some consideration be given to permitting some degree of correctional officer involvement in the treatment team meetings. While there are concerns around confidentiality, officers can be trained in these issues. They are the front line observers of inmate behavior.

Contract Delivery Concerns

There are also important areas where the contract is not being performed. These are: Provision of Group therapy; training for staff; quality assessment; and consultation with the facility superintendent each month.

Group Therapy

There was no indication, at the Northern Correctional Facility or Northwest Correctional Facility that group therapy was being provided. The contract states such therapy should focus on symptom reduction, stress management, positive adjustment,

coping skills, interpersonal skills development and mental hygiene. There was no indication that groups with these subjects were being conducted. There were comments that at some time in the past, there had been anger management groups, but due to staff changes, primarily state mental health staff vacancies, there had been none of these classes for some time. This area of the contract should be reviewed and either be revised or brought into compliance.

Staff Training

The contract describes the importance of education and training for state staff. The contract states “education and training of staff will improve services and insure good utilization of resources. The Contractor will maximize effectiveness by providing training and support to State staff, with emphasis on correctional officers who work directly with the inmates.” In my discussions with correctional officers, it was clear that this was not occurring. All training for new and experienced officers is done by state staff. After the initial academy, each officer receives two hours of suicide prevention training annually from other state staff, not contract staff. While the suicide prevention training is required annually, it would be helpful for officers to receive an additional hour or two of training each year in basic mental health issues. As state mental hospital systems have moved to a stronger community orientation, a significant number of the inmate population across the country exhibit increasing mental health issues and this is certainly true in Vermont. It should also be noted that the primary trainer and curriculum developer for suicide prevention for the DOC no longer works for DOC. Development of primary trainers on this issue should occur immediately, either under the contract (as required) or with state staff.

Dialectical Behavioral Therapy (Dale)

The contract for mental health services specifically requires Dialectical Behavioral Therapy at the Dale Correctional Facility. The contract is being performed in this regard, as there are two group therapy sessions per week, dealing with the issues of stress management, mental hygiene, coping skills and behavioral skills. The contract requires Family Meetings to ease transition to the community but this service is not being provided. Since female offenders are often the primary parent when they return to the community, these services should be developed, as described in the contract.

The contract also requires that specialized services be provided for women dealing with loss of parental rights. While the contract with Dr. Cotton is not providing this service, another contractor, Vermont Children’s Aid, is providing the service. Vermont Children’s Aid is a separate community provider, under contract to the Vermont DOC for this service. The Vermont DOC should complete a contract amendment to deal with this issue. One other issue of concern with the Dale Correctional Facility is the contract requires forty hours per week and the Superintendent indicates that they are receiving only thirty hours per week on a regular basis. The contract either requires adherence or amendment.

Quality Assessment and Improvement

The mental health contract describes an ambitious quality assessment and improvement program that, at this point, has not been implemented. While discussing this issue, I was provided a draft of the proposed quality improvement program. I was advised that the same contract, with the same language, had existed with the previous contractor, Matrix. Therefore the lack of full implementation of the quality assessment and improvement program is a significant concern. While I do not think that the quality assessment component should be eliminated, it is certainly at a point where the contractor should deliver the service or alternative means of assessment should be explored. While there is a reasonable time factor for development of the assessment format, the delay, to this point, is not acceptable. An additional concern is that the contract staff will perform the data collection on indicators that they have proposed. Central office should be the monitor of contract compliance, as measured by the quality assessment. As the quality assessment process is developed, the role of oversight by central office will need clear definition if the assessment process is to have integrity.

I heard repeated concerns from the field facilities (3) that there was little coordinated effort to communicate around mental health issues. Planning and implementation appears to be mostly a matter for central office and the contractor. When I inquired whether they had seen the draft of the quality assessment program proposal, it did not appear that facility superintendents and their administrative teams had an opportunity to comment and make recommendations on the proposed quality indicators. Since the activities to be measured, as part of the quality improvement program, will occur in their prisons, it makes sense to consult with the superintendents and their administrative teams. I would suggest that, in addition to mental health staff, prison administrative teams are primary facilitators for the success of a mental health program and must be consulted. Table 2 of the proposed quality improvement plan should include an objective such as “Develop quality indicators in collaboration with facility superintendents and their administrative teams to ensure support for the overall mental health program. Subsequent collaboration will include quarterly review of quality indicators and discussion to develop local facility action plans for improvement.”

Superintendent Collaboration

This subject, of coordination of mental health programming is referenced in the contract. Specifically, the contractor is to provide “Consultation to the institutions treatment programs, quality assurance and utilization review, including monthly meetings with the facility superintendent to discuss quality improvement issues.” When asked if there were formal monthly meetings between the superintendents and the contractors, I received mixed responses. One location said that it occurred but apparently not at the other two locations. This portion of the contract alludes to a substantive discussion between the superintendent and the contractor and I am not convinced that it occurs.

These meetings are critical for many reasons. The superintendent must keep the contractor advised of recent activities within the prison, to include security issues and the

contractor has a responsibility to keep the superintendent informed of current mental health issues within their prisons. While it is recognized that weekly treatment team meetings occur, this does not take the place of the need for superintendent meetings. Some superintendents had not seen a copy of the contract, and rely on feedback from subordinate staff about the operation of the mental health program in their institutions. It is recommended that formal monthly meetings be scheduled between the contractor and the superintendent or that this contract requirement be deleted.

Licensure

The contract provides “All mental health and clinical staff providing services shall have at least a master’s degree in counseling, psychology or a related mental health profession, unless otherwise exempted and approved by the State. Licensure or certification is required, unless otherwise exempted by the State.” While I did not ask providers whether they were or were not licensed, it was obvious that this was a significant issue of concern with superintendents and other members of their administrative teams. The situation should be clarified by central office, regarding who is licensed and who is not. And if they are not licensed, how are they exempted.

One superintendent told me that on two recent occasions unlicensed providers were proposed to work at the prison, and when the superintendent objected, the individuals were withdrawn from consideration. While it was certainly appropriate to consult with the superintendent, it was not acceptable to propose a practitioner who did not meet the requirements without sufficient explanation. The superintendent stated that one of these unlicensed practitioners then was sent to work at another facility, where he is currently employed.

The selection of mental health practitioners is typically made without consultation with the superintendent. The response was summed up by one superintendent who said “you get who they send you.” At one of the facilities, the superintendent was not pleased with the performance of one of the practitioners, had communicated their concern to central office, but was not getting a response. While at the facility, I had a short interview with this practitioner. This individual did not appear to have the self-assurance necessary to operate in a prison environment. The superintendent must have the authority to have input over the staffing at their facility. Without the support of a superintendent, practitioners may not be effective, and may, in fact, adversely affect the overall operation.

Correctional Facility Observations

Dale Correctional Facility

The Dale Correctional Facility appears to be a well run operation. The facility was clean. The building is old, a part of the old state hospital, but there was an obvious effort to maintain its appearance. The interaction between staff and inmates seemed appropriate. When inmates made a reasonable request to staff, the issue was acted upon. I

talked with two correctional officers who indicated they receive suicide prevention training but would appreciate more training in dealing with mental health issues. The inmates were preparing to eat the evening meal, and there were no apparent complaints. Medical staff were on duty at the time. It appeared as though medical issues were receiving attention.

The layout of the building is somewhat problematic, with three stories for staff and inmates to navigate. The stairwells are enclosed, with no visibility between floor levels. This makes coverage and sight lines for staff to observe inmate behavior difficult. As part of the old hospital, there is not much that can be done about these features. But, observing behavior, such as a potential suicide, is more difficult in this type of structure rather than one that is more open or possibly confined to one level. If there are two levels, the two floors should be connected by a short stairway, to permit rapid officer response. The stairs at Dale are considerable, going three levels within a stairwell, adding to the concern about sight lines.

Northern Correctional Facility

This is a fairly new prison in a remote part of Vermont. The facility was clean, there appeared to be fresh paint in a number of areas. Staff obviously took pride in the appearance of the facility. I observed the medical/mental health area of the institution. It was well laid out, providing medical staff close proximity to mental health staff. In the living units, the structure is typical two story construction with good sight lines for correctional staff observation.

As indicated, this facility would operate better without the constant turnover of its short-term population. Transporting these offenders over long distances is costly to the department, and makes productive programming at the facility difficult. The facility started as a long-term facility for medium custody inmates, but is currently about half short-term offenders, or even those who have not yet been convicted.

When discussing mental health issues with correctional officers, they indicated that the suicide prevention training was helpful but they wanted more information on mental health issues. I learned that correctional officers were excluded from treatment team meeting for reasons of confidentiality. While correctional officers certainly need to maintain confidentiality, they can certainly be advised of major mental health issues and behavior cues in the management of the mentally ill inmate. It is recommended that correctional officers be permitted to attend treatment team meetings to better facilitate their management of these inmates.

As part of my visit, I had a short discussion with an inmate receiving mental health services and he appeared pleased with mental health services provided by the contract staff.

Staff at the Northern facility were not impressed with the quality of mental health staff provided under the mental health contract. They would have appreciated a more collaborative approach to staff selection, which did not occur.

Northwest Correctional Facility

This prison has been built in stages, often without maintaining consistency of architectural style. Therefore it has the feel of a hodge podge of building styles, with the individual living units trying to serve many purposes. Because of the successive building projects that have resulted in the current layout, there are poor sight lines for correctional staff to observe inmate behavior.

The area of most concern was D unit, where one wing is segregation and the other wing is mental health. I cannot stress enough that this concept should be reviewed and considered for immediate change. Housing a wing of mentally ill inmates next to a wing of segregated inmates is not good correctional practice. In fact, it was acknowledged that, at times, when there are empty beds on either side, mentally ill inmates may be housed on the segregation wing and vice versa. This practice should never occur. These populations should be kept entirely separate because of their significant difference. The mental health wing should be an environment where staff and inmates interact as much as possible. The mentally ill inmate should be out of the cell, participating in therapeutic programming. There should be as much interaction with staff as possible. Granted, with some of the most severely mentally ill inmates this can be problematic and staff intensive. But, the segregation unit is serving a far different purpose. Inmates on this wing are locked up much of the day, and programming is minimal. They are serving segregation time for negative behavior, not mental illness. The current situation on D unit requires the same correctional staff manage these two divergent populations, and that can be difficult. Correctional staff on the mental health side need additional training to deal with this acute population. The handling of segregation inmates requires a different set of skills.

In addition, I found the unit to be poorly maintained. This unit requires new paint and better daily maintenance. Glass in a number of cell doors was badly etched, obscuring visibility, and should be replaced. Food service was a positive aspect of this prison operation. I talked with two inmates on this unit, one said his mental health needs were being met and another who was sufficiently mentally incapacitated to be unable to respond to simple questions.

To be fair to the staff at Northwest, it is obvious that they are given the most problematic inmates in the Vermont system to deal with. In talking with one inmate in his cell, I found pornography taped to the wall. This is a practice that should be stopped. It is no longer acceptable. Correctional officer staff felt they had a good working relationship with mental health practitioners. They felt that if they observed problem behavior, mental health staff were responsive. There was no evidence that group therapy, required under the contract, was occurring. The Superintendent felt that this was due to a decrease of mental health practitioner coverage, by nearly half of what his institution previously received.

Policies and Procedures

Prisons are, by nature, tightly regimented environments that operate on a predictable routine, where each day is structured much like the day before. To manage such an environment, policies outlining broad principles of facility management are critical. Procedures or protocols providing detailed instruction on how to implement the policy are equally necessary and must be easily understandable for a large spectrum of staff. The policies and protocols are the road maps that provide staff the necessary authority to enforce the routine activities within a prison. Inconsistency in the policy area can lead to unintended consequences, as staff search for guidance in dealing with prisoners.

In the mental health area, I found some concerns that lead me to recommend that Vermont DOC begin an immediate effort to bring its policies, directives, and protocols up to date. The primary policies for mental health and suicide prevention included in policy manuals in the facility superintendent's offices are dated 1982. There is no reasonable explanation for a policy to be this far out of date. Even if the information in the policy reflects current management's approach, it may simply need to be updated.

The directives and protocols are more current, dating from 1997, but I would even argue that is too lengthy a time between reviews and that they may not reflect current practice. In fact, in discussing this issue with one of the superintendents, they indicated that until a few months ago the facility they managed had only the 1982 policy to provide direction to staff. The superintendent only received a copy of the 1997 directive and protocol by asking a contract staff member for a copy. I was also provided a copy of a memo dated March 6, 1998 from Clinical Director, Tom Powell on the subject of Suicide Watch procedures. This document, for all practical purposes was the current direction on suicide watches and should have been incorporated into a newly published policy and directive within a reasonable period, no more than a year later. But this did not happen. Tom Powell's memo did not indicate that it superseded the 1982 policy or the 1997 protocol. This creates a potential situation where in the event of a suicide, staff would have to describe that they were following either a 1982 policy, a 1997 directive, or a 1998 memo, all of which purport to guide staff on suicide watches for inmates. And, at least at one facility, the staff clearly did not have the 1997 directives and protocols until recently.

This is unacceptable and needs immediate attention. One individual needs to be designated as the policy manager for the department. All policies should be updated on a schedule not to exceed three years. Best correctional practice, in the area of prison mental health, would be that policies should be updated every year or two at the latest.

Grievance Process

Due to my short visit, time did not permit me to thoroughly review the entire grievance process. However, I was able to review the grievance processes that were followed with the Vermont Protection and Advocacy grievances. I am impressed with the

volume of effort and the responsiveness to the grievances given by the DOC. The VP&A may not agree with the outcomes, but the department certainly appears, on paper, to take the process seriously and correct situations as much as possible. The most immediate issue that emerged concerning some grievances was the substantial lag in response time. This issue needs attention in order to retain a credible grievance program. I did not hear from any staff within the prisons who was critical of the grievance process, with the exception of a concern that the VP&A grievance requests were too detailed. Responses to these grievances required extensive staff time. The Vermont DOC grievance process, which requires a facility response before requiring a central office review and response is fairly standard correctional practice.

I had a discussion with John Murphy, Hearings Administrator, who is responsible for the grievance process. He felt that some facility superintendents were more responsive than others. He also felt that there could be more local resolution of issues, so that some grievances need not rise to the third level (central office-Commissioner). Mr. Murphy indicated that some upper level administrators within central office could be quicker to respond when they are asked to investigate on behalf of the Commissioner. He cited a recent situation in which he raised the issue of possible retaliation against inmate Quigley at the Northwest Correctional Facility. Mr. Murphy did not feel that the response was timely. A quality grievance process must have commitment at all levels of an organization to demonstrate credibility and responsiveness.

Central Office vs. Prisons

In any correctional organization it is not unusual that there will be tension between central office and the prisons. The challenge is to manage that tension and generate energy towards quality operation of the prison environment, including mental health programs. Often, the difference between central office and prison operations is a matter of serving a variety of constituencies. Central office manages numerous external stakeholders. For the most part prisons manage internal stakeholders, primarily staff and inmates. Central office must do what it can to support the operation of quality programs for inmates in the prisons. Central office must make it clear that is there to provide the support that the prisons need if they are to succeed. Too often that equation is reversed and the prisons feel that they are to do the bidding of central office.

In my analysis of the mental health area, I came away with the distinct impression that the mental health contract is expected to be facilitated by the prisons with no questions asked. The information they had about the contract was inconsistent. Furthermore, they are not consulted on personnel hired by the contractor. They feel that policy and directive is not clear or current concerning mental health. There are mixed, mostly negative, comments about the perceived arrogance of the contractor. I cannot confirm the validity of this perception, but its very existence is a problem. This entire dynamic is ripe for change. It is necessary for the mental health program to be seen by the superintendents and their staff as one of "their" programs since they deal with the inmate population.

There were also some negative comments about the lack of support shown by central office staff. Again, I cannot confirm the validity of this perception, but its very existence is a problem. There is a morale issue with the superintendents in this system, due to a perceived lack of attention from Central office. This seems to be a carryover from the previous Commissioner and his administration. Currently there is much hope that the new Commissioner and Deputy Commissioner will make needed changes and support the important work they do for the department. The teamwork ethic between Central office and the prisons that should be present, does not seem to exist.

Given the pressure on central office to deal with external stakeholders, it can be very difficult to clear the atmosphere, but that is what is needed. Not only will the mental health program be more successful, but other program areas will benefit as well. The Commissioner and Deputy Commissioner must pay close attention to the prison operations side of the DOC. The stress of dealing with a high population count, and rapid turnover of inmate populations means that the prisons are operating in a crisis mode most of the time.

Conclusion

It would be easy to conclude, with the above comments, that the Vermont DOC has grave problems and is in need of drastic measures. The reality is that the Vermont DOC is experiencing many of the same issues that face any state correctional organization. Budgets have been squeezed and correctional leaders have had to make difficult choices about funding for prison programming. Often the move is toward contracting out to save dollars and yet try to maintain accountability. Contracting for correctional services can be controversial. Strong oversight of contracts is necessary to ensure contract performance and cost containment. It would appear, against this backdrop, that Vermont DOC is having its struggles due to the enormous population pressures and significant inmate turnover that some of the facilities are experiencing.

It would also be convenient to recommend that more dollars and more staff, either contract or state, would resolve the above issues. However, all of the above recommendations for improvement can be accomplished without additional funding. I would suggest that the Vermont DOC engage itself in a process that would make quality and excellence of prison operations a core value of the organization. I have suggested specific remedies, but this is by no means an exhaustive list. There are many more concrete activities that Vermont DOC staff can define for itself, that would result in improved prison operation, including mental health. Improved mental health programming must be part of a larger effort to reform prison operations.

Phil Stanley

EDUCATION

MA, Public Administration

SEATTLE UNIVERSITY, Seattle, Washington, 1977

BA Sociology

UNIVERSITY OF WASHINGTON, Seattle, Washington, 1971

**CORRECTIONS
BACKGROUND**

SPECIAL AWARD - State of Washington

Governor's Distinguished Management Leadership Award, 1994

Department of Corrections

STATE of NEW HAMPSHIRE

2000 - 2003

Commissioner

- ❖ Reporting to the Governor and Executive Council, provide leadership for all staff and offenders under the authority of the Department of Corrections.
- ❖ Offender population consists of 2,515 inmates, and 6,100 offenders under probation or parole supervision.
- ❖ Appointing authority for 1,205 staff including direction to Wardens and Division Directors in the hiring, promotion, discipline, and termination of all employees within the Department.
- ❖ Fiscal management for a department with a \$84 million annual budget.
- ❖ Responsible for operation of four state prisons, three halfway houses, and eleven district probation and parole offices.
- ❖ Responsible for external agency relationships, including effective communication of agency priorities to the State Legislature and the Governor.
- ❖ Responsible as Superintendent of the Corrections Special School District #111 for staffing, budget, and setting educational priorities for inmate population.
- ❖ Responsible for oversight of contracts regarding corrections services for the department, including mental health services provided by Dartmouth Hitchcock.

Department of Corrections

STATE of WASHINGTON

1973 – 2000

Regional Administrator

NORTHWEST REGION, EVERETT, WASHINGTON 1977 - 2000

- ❖ Regional Administrator for one of five regions with oversight for Clallam Bay Correction Center, Olympic Correction Center, and Monroe Corrections Complex. Superintendents reported to me relative to those prison operations. In addition, eight community correction offices reported to me through a Field Administrator.
- ❖ Appointing authority for personnel; responsible for personnel management of 1,500 staff, including hiring, promotion, and corrective/disciplinary actions.
- ❖ Fiscal management for an annual regional budget of \$95 million.
- ❖ Plan, develop, and organize programs within the prisons and community corrections facilities in the region affecting 3,500 prison inmates and 10,000 community corrections offenders.
- ❖ Responsible for leadership within region for Offender Accountability Act implementation.

Superintendent

WASHINGTON CORRECTIONS CENTER, Shelton, Washington 1995-1997
SPECIAL OFFENDER CENTER, Monroe, Washington 1994-1995
COYOTE RIDGE CORRECTIONS CENTER, Connell, Washington 1992-1994.

- ❖ At the Washington Correction Center, Superintendent with responsibility for 1,705-bed, male adult prison that includes maximum, close, medium, and minimum custody inmates; lead and direct staff of 613 employees; plan and direct programming and security for prison operations.
- ❖ Appointing authority for personnel: responsible for personnel management, and direct supervision and management of associate Superintendents, business manager, health care manager, administrative assistant, and secretary.
- ❖ Plan, develop, and organize all institutional programs such as: Reception Center, intrastate transportation, Intensive Management Unit, and general population over 1,700 inmates; responsible for security, accountability of inmates, and inmate classification including records management.
- ❖ Maintain a fully trained, armed, and equipped Special Emergency Response team and Emergency Response Team.
- ❖ At the Special Offender Center, responsible for providing full mental health services for inmates with most severe psychiatric diagnoses. Developed suicide prevention strategies and critical incident response protocols in coordination with mental health professionals within the department and the University of Washington.

Associate Superintendent

TWIN RIVERS CORRECTIONS CENTER, Monroe, Washington 1987-1992

- ❖ Managed staff that provided inmate programs: education, inmate employment, volunteers, recreation, religion, library, records, living units, health services, sex offender treatment, and classification. Project assignment in 1988 to lead task force to complete revision of Inmate Classification system, which is currently in use in Washington DOC.

Correctional Program Manager, Work Release Supervisor, Parole Officer

STATE OF WASHINGTON 1973-1987

- ❖ Positions involved progressive levels of supervisory and managerial assignments and responsibilities in Division of Community Corrections and Division of Prisons. Beginning as Parole/Probation Officer, continued in State service with increasing responsibilities and commitment in areas of: classification, budget preparation, development of policies, personnel management, training, and case management.

*Additional
State Employment:*

Counselor

ECHO GLEN CHILDREN'S CENTER, Issaquah, Washington two years

**TRAINING
EXPERIENCE**

Taught periodically at the Criminal Justice Training Commission, Burien, Washington.
Extensive public speaking with community service groups, including college classes.
Adjunct Professor of Psychiatry, Dartmouth College 2002-2003

**COMMUNITY
INVOLVEMENT**

Commissioner, Kirkland Washington Planning Commission, 1999-2000 (volunteer)
Chairman, Board Member, Kirkland Parks and Recreation Board, 1985-1993 (volunteer)
Chairman, Kirkland Parks Bond Campaigns, 1984 and 1989 (volunteer)
Coach, Various Youth Teams, Kirkland, Washington, 1979 - 1993