COMMONWEALTH OF VIRGINIA

Joint Subcommittee to Study
Mental Health Services in the 21st Century
April 19, 2016

Investigation of Critical Incident at Hampton Roads Regional Jail

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OFFICE OF THE STATE INSPECTOR GENERAL

Background

August 24, 2015

OSIG received a complaint regarding an individual found dead in jail cell at HRRJ (August 19, 2015) while awaiting transfer to Eastern State Hospital for Restoration to Competency.

Background

Complainant believed the death to be related to loss of significant amount of weight due to refusal to eat in four months spent in jail.

Background

- **OSIG began its investigation into this event August 25, 2015, acting under our authority as defined in the Code of Virginia.**
- **OSIG's investigation included a review of the DBHDS investigation as part of our report.**

Background

OSIG's investigation included multiple entities and a four-month timeline that crossed:

DBHDS

ESH

HRRJ

Portsmouth Department of Behavioral Healthcare Services

Portsmouth General District Court

NaphCare Inc.

Bon Secours Maryview Medical Center

OSIG Objectives

- **Examine sequence of events surrounding the death of this individual at HRRJ**
- **Review referral & admission processes between HRRJ & Eastern State Hospital**
- **Review DBHDS's Office of Internal Audit Investigation Report released to OSIG March 16, 2016**

OSIG Goals

OSIG's goals were to:

- **Identify potential risk points in the referral and admission processes**
- **Recommend systemic improvements in order to prevent similar events in the future**

OSIG Observation No. 1

- **Transfer processes from HRJJ to ESH had multiple decision & risk points.**
- **Numerous opportunities for variation, unanticipated, & negative outcomes.**
- **No existing regional protocol relevant to jail transfers.**

OSIG Observation No. 2

The impact of the 2014 safety net law did not limit the availability of a bed on the male jail transfer unit at ESH when this individual needed it.

OSIG Observation No. 2

- **Following this event, ESH revised the structure of the admissions office and communication.**
- **The process for developing and ensuring the accuracy of the Jail Transfer Waiting List was not addressed.**

OSIG Observation No. 3

The DBHDS Transformation Team for the Justice Involved made several substantive recommendations in the spring and fall of 2015 that have yet to be acted upon to advance the quality of care for these individuals.

OSIG Observation No. 4

- **DBHDS Office of Internal Audit Investigation Report did not identify possible root causes of this event.**
- **Recommendations not tied to root causes have little chance of achieving the goal of preventing similar events in the future.**

OSIG Observation No. 5

HRRJ has a direct responsibility to provide quality medical & mental health care for those in custody.

OSIG Observation No. 5 (continued)

NaphCare records provided were incomplete & inconsistent and evidenced little action related to the individual's psychiatric or medical symptoms outside of prescribing psychiatric medications.

OSIG Recommendations

OSIG Recommendation No. 1

DBHDS should develop a regional protocol relevant to the management of individuals in HRRJ with mental illness to include:

- **Clearly identified responsible parties**
- **Timelines**
- **Process flows**

OSIG Recommendation No. 2

ESH should revise the process surrounding the Jail Transfer Waiting List & create a system for consistently reviewing the list that includes all parties.

OSIG Recommendation No. 3

Recommendations of the DBHDS Transformation Team for the Justice Involved should be implemented immediately.

OSIG Recommendation No. 4

Investigations of critical events should:

- **Be conducted:**
  - **Independently**
  - **By trained professionals with behavioral health experience**
- **Include:**
  - **All relevant risk points**
  - **Analysis of root causes**
  - **Recommendations that address root causes**

OSIG Recommendation No. 5

- **HRRJ has responsibility to provide quality medical & mental health care for those in custody.**
- **HRRJ should revise the process for overseeing the quality and outcomes of any contract agency that provides medical and mental health care in their jail.**

Commonwealth of Virginia

Questions?

Office of the State Inspector General

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FY 2017 OSIG Work Plan

Office of the State Inspector General