

Investigation into the Death of Michael Crosby
at the Chittenden Regional Correctional Facility
on August 26, 2009



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DRVT is the Protection & Advocacy System for the State of Vermont

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I. EXECUTIVE SUMMARY

This report presents the results of an investigation conducted by Disability Rights Vermont (DRVT) into the death of Mr. Michael Crosby on August 26, 2009 at the Chittenden Regional Correctional Facility (CRCF) in South Burlington, Vermont. Mr. Crosby, a person living with disabilities, had been at the correctional facility for approximately ten and a half hours at the time he was found unresponsive in his cell. The Vermont Medical Examiner found the cause of Mr. Crosby's death to be acute mixed intoxication (Diazepam, Methadone, Oxycodone, Tramadol and Citalopram) with contributory factors of hypertensive and atherosclerotic cardiovascular disease, obesity, and chronic substance abuse. Mr. Crosby's manner of death was listed as "Accident (substance abuse; overdose of prescribed and non-prescribed medication)."

DRVT's investigation identified that a combination of policy violations and communication failures, most importantly the lack of any formal medical assessment of Mr. Crosby upon his incarceration on August 26, 2009, were likely contributing factors to Mr. Crosby's death. While individual Department of Corrections (DOC) and Prisoner Health Services (PHS) staff can be identified as having violated significant policies, directives and protocols, DRVT asserts that an overall environment lacking in oversight, quality assurance, and prompt and effective responses to identified errors must also be considered when reviewing this information and recommendations for future improvements.

DRVT provides this investigative report in furtherance of our federal mandate to protect and advance the rights of individuals with disabilities and in an effort to illuminate areas of concern and promote improvement in future services, policies, and responses to prisoners with disabilities throughout Vermont. DRVT wishes to acknowledge the cooperation received from Mr. Crosby's daughter and the Vermont Department of Corrections during the course of our investigation.

II. BACKGROUND

A. Michael Crosby

Michael Crosby was a 49 year old man with a history of depression, anxiety, attention deficit hyperactivity disorder, and poly-substance abuse. He had been receiving outpatient mental health, psychopharmacological, and substance abuse treatment services at the Howard Center for Human Services for several years. According to Burlington Community Corrections records, Mr. Crosby was engaged in weekly outpatient substance abuse counseling, regularly attended Alcoholics Anonymous meetings and was prescribed Celexa for anxiety/depression and Dextroamphet for ADHD. Mr. Crosby had previously been hospitalized at the Brattleboro Retreat in December 2008 for inpatient psychiatric and substance abuse treatment. Mr.

Crosby had a documented history of accidentally overdosing on medications in an attempt to get high. He had also intentionally made at least two serious suicide attempts, once in 2003 and again in 2007. Mr. Crosby had a sporadic work history and received Social Security Benefits as a result of his disabilities.

Mr. Crosby had several criminal convictions dating back to 1993 for charges including careless and negligent operation of a motor vehicle, retail theft, unlawful mischief, disorderly conduct by phone, violation of an abuse prevention order, simple assault, violations of conditions of release, sale of cocaine, conspiracy, and driving under the influence. He had been under the supervision of the Vermont Department of Corrections (DOC) since September 2001. He was incarcerated from October 2004 until April 2007 as part of a 30 month to 10 year sentence for sale of cocaine and conspiracy convictions and again in January 2009 for violations of conditions due to a high blood alcohol content reading and positive drug test. Mr. Crosby had reported to his parole officer that he had been drinking alcohol, taking Percocet pills and also expressed suicidal ideation at that time. Mr. Crosby was released in March 2009 onto conditional re-entry and tested positive for cocaine in April 2009. He admitted to his furlough officer that he had used opiates and methadone as well and was issued a graduated sanction. Mr. Crosby was issued another graduated sanction in July 2009 for admitting to the use of methadone.

On August 25, 2009 a detective from the Burlington Police Department contacted DOC community correctional officers and reported that the Burlington Police Drug Unit had completed two controlled drug purchases from Mr. Crosby as part of their investigation into the sale and possession of prescription drugs. During a search of Mr. Crosby's residence, 40 additional pills were found and noted to be the same as those sold during the controlled purchases. The detective advised the community correctional officers that Mr. Crosby would be issued a citation for the crimes of sale(s) of depressant/stimulant/narcotic drugs, possession of depressant/stimulant/narcotic drugs, and the sale(s) of depressant/stimulant/narcotic drugs abutting school property. Upon making telephone contact with Mr. Crosby, the DOC community correctional officers allowed 40 minutes for him to meet up with them and then took Mr. Crosby into custody on a notice of furlough suspension.

Mr. Crosby was lodged at the Chittenden Regional Correctional Facility at 12:30 a.m. on Wednesday August 26, 2009. At approximately 11:05 a.m. that same day Mr. Crosby was found unresponsive in his cell. Mr. Crosby was transported to Fletcher Allen Health Care (FAHC) after Prison Health Services medical staff attempted emergency resuscitation efforts with no success. Mr. Crosby was pronounced dead at Fletcher Allen Health Care on August 26, 2009 at 11:38 a.m.

B. Disability Rights Vermont

Disability Rights Vermont (formerly Vermont Protection & Advocacy, Inc.) is an independent, private, non-profit agency empowered by federal law to protect and advance the rights of

individuals with disabilities. See Protection and Advocacy for Individuals with Mental Illness Act, 42 U.S.C. § 10801 et seq; 42 C.F.R. Part 51 et seq; Protection and Advocacy of Individual Rights, 29 U.S.C. § 794(e) et seq, 34 C.F.R. Part 381 et seq. DRVT has the authority to investigate allegations of abuse and/or neglect involving individuals with disabilities if the incident is reported to DRVT or if DRVT believes there is probable cause that an incident of abuse and/or neglect occurred. Id. DRVT is the State of Vermont’s designated protection and advocacy system and is a member of the National Disability Rights Network (NDRN).

C. Chittenden Regional Correctional Facility

Chittenden Regional Correctional Facility (CRCF) is a minimum/medium security prison located in South Burlington, Vermont. CRCF is operated by the Vermont Department of Corrections (DOC), a part of the State of Vermont’s Agency of Human Services (AHS).

D. Prison Health Services

Prison Health Services (PHS) was the Department of Corrections’ contracted medical provider at CRCF at the time of Mr. Crosby’s death.

III. DISABILITY RIGHTS VERMONT INVESTIGATION

Pursuant to our federal mandates DRVT initiated an investigation into the death of Mr. Crosby which included the following:

- A. Review of Mr. Crosby’s Vermont Department of Corrections Burlington Community Corrections Field Services records;
- B. Review of Mr. Crosby’s Vermont Department of Corrections Chittenden Regional Correctional Facility core file;
- C. Review of Mr. Crosby’s Vermont Department of Corrections Chittenden Regional Correctional Facility medical and mental health records;
- D. Review of Vermont Department of Corrections Chittenden Regional Correctional Facility unit logs, end of shift reports, incident reports, special observation forms, unit and handheld videos¹;
- E. Review of email correspondence between Vermont Department of Corrections and Prison Health Services;
- F. Review of relevant Vermont Department of Corrections Directives, Policies, Procedures, and Post Orders;

¹ The Department of Corrections did not indicate that the video documentation time stamps on the video evidence DRVT was provided were inaccurate and DRVT’s findings based on our review of any video documentation provided by the Department includes the assumption that the time stamp was a reliable indicator of the actual time each recorded event took place.

- G. Review of relevant Prison Health Services Policies and Procedures;
- H. Review of Mr. Crosby's Fletcher Allen Health Care Emergency Department records;
- I. Review of the Vermont State Police Law Incident Table and Supplemental Narratives regarding Mr. Crosby's death;
- J. Review of the Vermont State Chief Medical Examiner's Final Report of Autopsy;
- K. Review of relevant DOC employees' personnel records (Confidential);
- L. Review of the Vermont Department of Corrections Administrative Review (Confidential);
- M. Review of the Vermont Department of Health Root Cause Analysis Final Report (Confidential);
- N. Review of the Prison Health Services Mortality Review (Confidential);
- O. Review of the Agency of Human Services Investigations Unit Death Investigation Report (Confidential).

IV. CHRONOLOGY OF EVENTS AND DISABILITY RIGHTS VERMONT FINDINGS

A. Pre-CRCF Admission Information

According to incident reports written by Burlington Community Corrections Field Services (CCFS) officers, on August 25, 2009 at approximately 6:10 p.m. a Community Correctional Officer (CCO 1) received a call from the Burlington Police Department (BPD) requesting CCO presence at a specific address in Burlington known to be Mr. Crosby's residence. BPD advised that they were executing a search warrant at the residence and informed CCO 1 and another CCO (CCO 2) that Mr. Crosby was going to be charged with two counts of sale of a regulated drug following two controlled purchases of prescription drugs. At approximately 7:40 p.m. a BPD Detective informed CCO 1 that an additional 40 pills were found in Mr. Crosby's residence and as a result he would be charged with possession of a regulated drug as well.

CCOs 1 and 2 attempted to make contact with Mr. Crosby at his residence at approximately 11:25 p.m. When Mr. Crosby did not respond to several loud knocks, CCO 2 placed a call to Mr. Crosby and left a voicemail message stating that he needed to call back or possibly face an escape charge. Ten minutes later Mr. Crosby called CCO 2 back and stated he did not wish to be charged with escape but he had "some stuff to take care of such as saying goodbye to his grandson and family and getting some telephone numbers together." CCO 2 advised Mr. Crosby to be at the Burlington CCFS office in less than 40 minutes or he would be placed on escape status.

Mr. Crosby met the CCOs at the Burlington CCFS at approximately 12:10 a.m. on August 26, 2009. He was accompanied by a female believed by CCO 2 to be Mr. Crosby's daughter and a male that was not identified in the records. CCO 2 informed Mr. Crosby that he was going to be charged by BPD with two counts of sale of a regulated drug as a result of the controlled drug purchases. CCO 2 wrote that Mr. Crosby "seemed surprised by this but did not deny it." While assisting Mr. Crosby with his seat belt in the back of the car, CCO 2 indicated "(t)his officer noticed Crosby was sweating quite a bit."

According to CCO 2's incident report, while on the way to pick up another furlougee who had turned himself in, he and CCO 1 "...spoke with Crosby quite a bit and he was in pretty good spirits. Crosby told us several jokes and we were all laughing at times. His speech was normal and not labored in any way." CCO 2 wrote that when they stopped to pick up the other furlougee, "Crosby was sweating enough so he asked this officer to wipe the sweat from his forehead. I found a few paper towels in the glove box and wiped his forehead. Crosby thanked this officer."

CCO 2 wrote that they arrived at CRCF approximately fifteen minutes after first taking Mr. Crosby into custody and that he asked Mr. Crosby why he was sweating so much. Mr. Crosby responded by saying that he is "big guy" and "not in very good shape." CCO 2 reported that "[t]his officer looked into Crosby's eyes and his pupils were not pinned, typical of someone under the influence of opiate based drugs, nor were they dilated, which is typical of someone under the influence of cocaine." According to CCO 2's incident report, Mr. Crosby was taken into CRCF by the Correctional Facility Shift Supervisor (CFSS 1) and two float officers and was strip searched without incident.

CCO 1 also completed an incident report outlining a similar chronology of events and documenting the following: "As we pulled into the booking garage, I heard Mr. Crosby identify [CO 1], referring to the booking officer. [Prisoner 1] and Mr. Crosby were brought into the sally port to await admission. [Prisoner 1] was taken first. While waiting for Mr. Crosby to be brought in, I pointed out that he was sweating a lot. Mr. Crosby indicated that this was normal for him and pointed out that he is a big guy. Mr. Crosby was searched by CCFS [1] and a float officer and then brought in to the booking area where he was then brought into the strip search room. Present in the booking area were CCFS [1], two floats, one who appeared to be a trainee, the booking officer, [CO 1], and one of the facility nurses. Mr. Crosby was booked into CRCF on August 26, 2009 at 0035 hours. After CCFS [1] came out of the strip room, we discussed whether or not Mr. Crosby was under the influence of any substance. CCFS [1] stated that he believed he may be. It should be noted that during our interactions with Mr. Crosby, he was coherent, spoke normal and held conversations with us. He was also walking under his own power. Mr. Crosby was placed in booking cell HC-2 by CRCF staff prior to our departure from the facility."

Of note, according to their interview on August 26, 2009, the Vermont State Police investigation identified that the prisoner who was transported to booking along with Mr. Crosby observed that Mr. Crosby looked "a little messed up and drunk" at the time of admission to the facility.

There is no documentation that the DOC staff who transported Mr. Crosby to CRCF adequately conveyed to facility correctional or medical staff the critical information they had regarding Mr. Crosby's recent history of drug use or his pending drug charges. While some discussion may have occurred with facility staff, clearly no documentation, and most importantly, no effective action occurred at the time of admission. All of the above information supports a conclusion that DOC staff and contracted medical providers were or should have been in possession of sufficient information to have caused a prompt and professional medical evaluation, including a

determination of what if any withdrawal/detoxification protocols should have been instituted, at the time of Mr. Crosby's admission to CRCF. Despite this information, no qualified medical personnel were asked by CRCF staff to perform an immediate health assessment of Mr. Crosby nor was one done prior to his death.

DRVT concludes that the failure of DOC staff to specifically refer Mr. Crosby to medical staff for evaluation due to withdrawal concerns was a violation of **DOC Protocol 361.01.08 Management of Chemical Dependency and Withdrawal, Effective Date 8/20/97:**

V. Protocol

A. Management of Inmates who are Intoxicated

1. Inmates who are suspected to be experiencing symptoms of drug or alcohol withdrawal will be referred to the health care unit for evaluation of their symptoms.

2. Officer training shall include recognition of signs and symptoms of recent ingestion and the appropriate course of action to follow

B. Management of Inmates who are Experiencing Acute Withdrawal

1. Inmates experiencing severe withdrawal

a. An inmate suspected of experiencing any degree of withdrawal from alcohol or other drugs shall be referred immediately for medical attention...

c. Withdrawal syndromes in certain groups (including psychotics, geriatrics, epileptics, pregnant inmates, juveniles, and inmates otherwise medically ill) may require special attention and should be monitored more closely.

B. Admission information and DOC/PHS Response

1. Review of PHS Staff Actions

According to the documentation provided, LPN 1 was the nurse who had contact with Mr. Crosby when he arrived at CRCF admissions. While there were other nurses on site during the morning shift while Mr. Crosby was at CRCF, no other nurse documented contact with him (prior to their attempts to resuscitate him). DRVT notes that LPN 1 was a Licensed Practical Nurse (LPN), which is a credential that does not allow the holder to be responsible for assessing patients. While an LPN's scope of practice may include "contributing to the assessment of the health status of individuals" pursuant to 26 V.S. A. § 1572 (3)(A)(i), a Registered Nurse (RN)'s

scope of practice actually includes “assessing the health status of individuals” pursuant to 26 V.S.A. § 1572 (2)(A).

In a PHS Progress Note completed by LPN 1, on August 27, 2009 at 2300, entitled “Late entry from 8/26/10 0025”, LPN 1 acknowledged that she was present in the booking area at the time of Mr. Crosby’s admission and did have some interaction with him. LPN 1 wrote:

As this inmate is well known to this writer from previous incarcerations, I waited until he was brought into the booking area. He came into booking and greeted the booking officer by name. The officer and I both briefly spoke to the IM. I didn’t notice any difference in these interactions from any previous interactions. IM appeared alert and oriented and was ambulating on his own. His speech appeared slightly slurred, as one would hear if the person had a couple of drinks, but he did not appear to be intoxicated. IM was noted to be a bit sweaty, but I attributed this to his considerable weight gain and the circumstances of being returned to jail. IM was pleasant and spoke to the booking officer by name at least twice. This writer noted no s/s [signs/symptoms] of distress. Nothing in the interaction struck me as out of the ordinary or different from any previous incarceration.

LPN 1 identified that Mr. Crosby was slurring his speech and was “a bit sweaty” and recorded that she considered his condition to be that of one who may be under the influence of not anything more than a couple of drinks. LPN 1’s informal assessment failed to trigger any further evaluation in the medical unit by a nurse in accordance with **PHS Health Services Policy P-G-06, Intoxication and Withdrawal, Procedure #1** that states:

If an inmate appears to be intoxicated or going through withdrawal he is evaluated in the Medical unit by the nurse. 2. The physician is called and the detoxification protocol is initiated. The protocol is a guide, not standing orders. Individual detoxification orders are given by the physician specific to the need of the inmate.

DRVT obtained no evidence demonstrating either that LPN 1 had the appropriate training and experience to make the determination that Mr. Crosby was not within the detoxification/withdrawal protocols or that if qualified she actually performed an adequate evaluation to make such a determination.

In addition, LPN 1 failed to document her informal assessment of Mr. Crosby until approximately 22.5 hours after the encounter. This conduct appears to be in violation of **PHS Health Services Policy & Procedures Manual, PH-01 Health Record Format and Contents, Procedure #5** that states, “[T]he medical record is to be complete with all findings and interventions recorded at the time of service delivery.”

DRVT was provided with a **PHS CRCF Health Center Intake/Night Shift** document (no date or author noted) that stated:

[S]econdary to security, all non-critical intakes will be deferred to day and evening shifts. In the event that there is a critical admission, re; fragile diabetic etc, a complete intake will be completed on paper at time of booking in the A/C area. For inmates that may be detoxing, a CIWA/COWS will be initiated and the patient will be monitored on 15 min checks. All interactions will be documented in a progress note as part of the medical record.

Perhaps due in part to the lack of attention to the INS and admissions medical screening that is discussed in the next section, Mr. Crosby was not identified as a “critical” or “detoxing” patient requiring prompt medical evaluation. According to DOC/PHS email correspondence dated July 1, 2009 with the subject line “Detox”, sent by the DOC Medical Director to PHS Managers, if Mr. Crosby had been accurately identified as a person with detox/withdrawal concerns that would have required “notification to the on-call provider at the time of their intake and that nurses were not to wait for symptoms to develop. The provider would then give specific orders as to how that inmate was to be monitored and when he/she should be notified as far as changes in their status.” This notification to the on-call provider did not occur.

A PHS staff person, presumably LPN 1, documented on a reporting sheet entitled “BOOKING” that she performed nursing rounds in booking at CRCF on August 26, 2009 at 0000, 0050, 0205, 0245, 0455, and 0455 (noted twice). A different staff person with illegible initials documented on the same booking sheet that s/he performed rounds in booking at CRCF on August 26, 2009 at 0729, 0806, 0902, 1105, 1222, and 1334. This documentation was apparently in response to a June 10, 2009 email sent by the PHS District Manager to PHS staff, DOC Facility Superintendents, DOC Medical Director, Chief Mental Health Officer and others at DOC, regarding intake/transfers. This email stated:

This is a reminder to all sites. Please print and post, ask all staff to read and sign. Nursing staff should be making rounds in booking every two hours and documenting that the rounds are done either by signing the booking officer’s log, or by a log that medical has sent up. Part of this procedure is to let you know if anyone has come in that needs to have either a[n] intake or receiving (transfer) screen done. Screens are supposed to be done asap, but within 12 hours of arriving at the facility.

A review of the booking unit video documentation provided by DOC demonstrates that nursing rounds in booking were not consistently performed within the two hours required and other time references in the nursing documentation were inconsistent with the video time indications.

DRVT was also provided with an August 20, 2009 email from a PHS Regional Administrator to all nursing and medical staff regarding the intake process. This email stated:

This is an important reminder to all staff regarding patient assessment at the time of intake where the first patient interface takes place. The on call MD must be notified by the nursing staff **any time** an inmate arrives at the facility with a positive medical history, recent hospitalization, and/or states they are taking medications (prescribed or not), or medication assisted therapy such as Suboxone or Subutex – **regardless of whether or not the medications have been verified**. As always continue to exercise sound nursing judgment and notify the on call MD if an inmate presents with **any** concerning appearance or behavior and has none of the above in their history.

DRVT found no evidence that this directive was appropriately followed by PHS staff in connection with Mr. Crosby's death.

DRVT identified an apparent conflict between the DOC/PHS Contract # 10962 Amendment #4 (starting date: 1/29/2007; ending date: 1/31/2010) and the above noted August 20, 2009 PHS memorandum and June 10, 2009 emailed protocols regarding when the medical screening should take place and what should be documented for such an encounter. Section II. A. of the DOC/PHS Contract states in relevant part:

II. Health Care Services A. Intake Screening

Contractor shall conduct a receiving screening on all new commitments (including transfers) **immediately upon the inmate's arrival at the DOC facility** [emphasis added] and before the inmate enters the general population of the facility. A qualified health care professional shall:

1) Inquire into, and document current and past illnesses, health conditions, and special requirements including...

- past or current mental illness, including hospitalizations;
- current or past receipt of, or eligibility for Community Rehabilitation and Treatment (CRT) programs;
- history of, or current suicidal ideation;
- medications taken (including last dose), name of prescriber and pharmacy;
- all inmates who are currently taking prescribed medication upon intake will be medically evaluated and, if medically indicated, those medications will be made available to the inmate in accordance with established protocols;...

- use of alcohol and other drugs (including last use), and any history of associated withdrawal symptoms, detoxification needs and stabilization services for a substance abuse disorder; and,

2) Observe and document the following...

- appearance (e.g., sweating, tremors, anxious, disheveled);
- behavior, (e.g., disorderly, appropriate, insensible);
- mental status (including state of consciousness, suicidal ideation, cognitive limitations), using forms developed in conjunction with the state;
- breathing (e.g., persistent cough, hyperventilation);
- skin (e.g., trauma markings, bruises, lesions, jaundice, rashes, scars, tattoos, infestations, and needle marks or other indications of drug abuse); and,
- other disability that may or may not require reasonable accommodation.

4) Document the findings, date and time the receiving screening is complete.

5) Print name and title and sign and date the screening form.

8) Identify all community providers and obtain release of information authorizing contact.

9) Observe the following timelines for all inmates:

- inmates with questionable health conditions will be medically cleared within twelve (12) hours of intake, and before being sent to the general population;
- inmates with non-emergent conditions will be referred to the general population with appropriate follow-up referrals established;
- inmates requiring immediate intervention will be referred to the appropriate health care staff for evaluation and treatment and will be seen within two (2) hours of intake;
- any referral of the inmate for special housing will be implemented in four (4) hours.
- any referral for emergency health services will be initiated immediately; and,
- referrals to additional medical specialists will be as appropriate, and timelines will be imposed with regard to the severity of medical need as determined by the referring physician.

While the contract identifies that screenings should occur “immediately” upon arrival at a DOC facility and includes a detailed list of what should be assessed and documented, the emails identified above indicate that PHS staff were not screening prisoners at admission and, in fact, were expected to do no more than two hour checks of booking rather than more immediate responses to newly admitted prisoners.

Also indicative of the confusion and lack of adherence to a requirement of immediate or as soon as possible medical screening at intake was **PHS “Health Assessment” Policy No. P-E-04, Effective Date: 2/1/05** which states under the “Procedure” section #1:

Inmates who have been booked into the facility are put on the list for an initial screening by the screening nurse for same day or as soon as possible, and on the physical exam list for PE by provider ASAP, but no later than 7 days after inmate arrives at the facility.

Also relevant was the CRCF Health Center form entitled “**Triaging Medical Intakes**” that stated:

During times of high volume with intakes, we must make certain we have a ‘face to face’ interaction with inmates awaiting medical intake. The medical staff will triage, reviewing the charts of all pending intakes, decide which intake they will do first and then go see the other several inmates waiting and check in for the following information:

- 1). Does he/she have any medical conditions?
- 2). Does he or she take any medications?
- 3). Does he or she have any pain/injuries?
- 4). Has he or she been hospitalized recently?

Then write a brief progress note with the date and time – stating you have asked the above information and actions taken – as well as noting how the inmate is acting IE: clear speech, ambulating well, Etc. – Vital signs are to be obtained and documented in the progress note. If there are issues identified, ask the health center nurse to see the I/M to expedite interventions.

There was no “triage” form for Mr. Crosby in the records provided to DRVT for review. Had there been high volume issues responsible for the failure of PHS staff to complete a timely medical screening of Mr. Crosby, DRVT would expect this form to have been utilized and available for review. Instead it is apparent that PHS staff had received various and conflicting information about when complete medical screenings should be done and what the process would be when delays in immediate screenings for new admissions. In addition, the lack of documentation of compliance with the various forms and directions noted above is also likely indicative of a work force that was not expecting careful oversight and prompt enforcement of requirements.

DRVT's investigation identified that there were at least five PHS nursing staff (3 RN's, 1 LNA, and 1 LPN) either on duty or in the facility at the time Mr. Crosby was found unresponsive in his cell. The only PHS staff that had documented contact with Mr. Crosby in the ten and a half hours he was in the facility (prior to resuscitation efforts) was LPN 1. Despite the availability of qualified staff, i.e. registered nurses whose duties include performing health assessments, no qualified medical provider administered a medical screening or medical evaluation of Mr. Crosby. It does not appear from the record that any RN or on-call medical doctor received or reviewed information available to DOC staff including Mr. Crosby's recent history of drug use and possession charges, his slurred speech and sweating condition, his past mental health and medical complications, and his acknowledged current ingestion of medications (as recorded on the Initial Needs Survey noted below). Had this information been made available to the appropriately qualified individuals, it is likely that additional augmented evaluation and observation would have ensued, potentially averting Mr. Crosby's death.

2. Review of DOC Staff Activities

Pursuant to **DOC Administrative Directive #362 Suicide Prevention & Intervention in Facilities, Effective Date: 11/09/05**, an Initial Needs Survey (INS) for Mr. Crosby was completed by CO 1. Of note CO 1 recorded the following responses and observations on the INS form at a documented time of 0035 hours:

7. "Have you ever been admitted to a mental hospital?" Y; "Are you taking any medications for your nerves which was [sic] prescribed to you by a doctor?" N; "Have you been to a mental health agency or a private counselor in the last six months?" Y "Howard M. Health"

8. "Have you ever gotten a DWI or DUI?" Y; "Have you ever received treatment or counseling for drug or alcohol problems?" Y; "Have drugs or alcohol ever caused problems for you such as losing your job, or fights with girl/boyfriend or spouse?" Y "Has anyone ever been upset by or complained about your alcohol or drug use?" Y

10. "Have you ever attempted to take your own life?" Y "3 years ago" *

12. "Do you have any drugs in your system that were not prescribed by a doctor?" Y

13. "What is the inmate's BAC?" 0.00

14. "Is the inmate showing signs of substance abuse or chemical withdrawal (e.g., slurring or speech, unstable gait, strong odor of alcohol, dazed look?" Y – [slurring was circled] *

17. "Does the inmate appear overly anxious, afraid or is raging (e.g., hand wringing, profuse sweating, panting, excessive fidgeting or pacing?" N

19. "Is the inmate behaving in a strange manner (e.g. not making sense, hearing, seeing or smelling things that aren't there; disorientation; or extreme withdrawal)?" N.

The INS form states:

(i)f you checked any of the non-shaded boxes which contained a *, notify the Shift Supervisor immediately. These are critical items for which immediate attention is warranted.

CO 1 documented that the total number of check marks in the non-shaded Yes/No columns was 5. CO 1 also wrote and circled "2*" next to the number 5, indicating that 2 of the items checked in the non-shaded Yes/No columns were those requiring immediate notification to the Shift Supervisor. The Yes/No box requiring documentation of Shift Supervisor notification was left blank, as were the comments section and the entire Shift Supervisor Action section. Additionally, there was no Shift Supervisor name printed, no Shift Supervisor signature, and no date or time documented by a Shift Supervisor.

DRVT reviewed booking unit video provided by DOC as part of our review of the circumstances surrounding Mr. Crosby's death. On the booking unit video there is no evidence that CO 1 completed an INS with Mr. Crosby at 0035 as documented on the INS. At 0035 the CRCF booking unit video shows that Mr. Crosby was standing at the booking desk engaged in conversation with various CCOs. In addition, CO 1 did not identify on the INS Mr. Crosby's profuse sweating that was documented by the CCOs just prior to his admission and was apparent on the DOC unit video upon his admission. The video does demonstrate that CO 1 called Mr. Crosby out of his cell to the booking desk from 0408 through 0420 later that morning. There was no sound on the video provided to DRVT during this time, and there is no picture from 0410 through 0420, but at 0408 through 0410 it appears that Mr. Crosby is standing at the booking desk and speaking with someone who was out of camera sight but presumed to be CO 1 as she was the only staff person shown on the video at the time. When the video resumed at 0420, Mr. Crosby walked with CO 1 back to his cell from another part of the booking unit that was off camera. Based on this information DRVT suggests it is possible that the INS was actually completed during this time period and not at 0035 as noted by CO 1.

Given the apparent delay of approximately three and a half hours between booking and completion of the INS form, as well as the lack of documentation demonstrating that the Shift Supervisor was notified of the flagged items as required or that nursing staff was notified of either Mr. Crosby's admission or of issues of concern identified on the INS, DRVT concludes **Administrative Directive #362** was violated. Specific requirements that were not adhered to include:

1.b DOC staff will administer and sign the *Initial Needs Survey* for all inmates entering DOC facilities at the time of their arrival.

- Staff should not rely exclusively on an inmate's denial that they are suicidal and/or have a history of mental illness and suicidal behavior.
- Previous confinement in the facility must be recorded.
- Any behaviors or actions that are worrisome must be recorded and health services staff notified.

c. Upon completion of the *INS* forms (parts 1 and 2) and/or the intake process, the Booking Officer will notify a qualified health care professional of every admission.

d. The Booking Officer will complete the intake screening process, including the *INS* forms, on all inmates prior to housing assignment, **except** under the following circumstances:

- 1) The inmate refuses to comply with the process;
- 2) The inmate is severely intoxicated or otherwise incapacitated;
- 3) The inmate is violent or otherwise belligerent.

Additionally, DRVT concluded the following DOC Protocol **361.01.01 Mental Health Receiving Screening, Effective Date: 8/20/97** was also violated. The specific sections violated include:

II. Purpose: Inmates will be screened upon arrival to identify urgent mental health and medical needs requiring immediate evaluation and treatment. Early identification of inmates with serious mental illness or in need of medical or mental health services require an expedited referral to the appropriate clinical staff for further evaluation, crisis services, psychological consultation, special housing and/or a full mental health evaluation.

V. Inmates entering DOC facilities will receive health and mental health screening by health, mental health, and/or correctional and booking staff immediately upon arrival as part of the booking process.

C. Disposition:

a. If the Total Score exceeds the designated cutoff, or if one of the (*) items is marked [2 were], the Shift Supervisor must be notified and any action must be documented in the appropriate section of the Scoring and Action Sheet...

c. If notified by the Screening Officer, the Shift Supervisor must complete the designated section of the Scoring and Action Sheet (supervision or observation instituted and documentation of those notified).

d. All notified parties must follow-up with the inmate and document their actions in the inmate's medical chart.

2. The disposition and any action taken (whether an immediate referral to an advanced clinical provider or mental health professional, transport to an outside medical facility or routine processing) will be documented in the inmate's medical chart.

There is also no documentation that **CRCF Policy 362.00.01, Potential Suicides, Effective Date 4/27/2009 Section 1.c** was followed in that it required staff to “[A]dvice Shift Supervisor of high scores, asterisks, and those under the influence who cannot be tested...” Specifically, DRVT could find no indication that CO 1 advised the Shift Supervisor of the two questions with asterisks on the INS that were answered affirmatively by Mr. Crosby (#10 and #14). CRCF Policy 362.00.01, Section 1. e. also requires the Booking/Admissions Officer to “[i]nform medical when forms are completed.” Had these important notification procedures been followed, more appropriate evaluation and observation may have ensued, potentially averting Mr. Crosby’s death.

At a time not documented on August 26, 2009, CO 1 completed an Intake Medical Screening (IMS) form with Mr. Crosby per DOC Protocol 361.01.01, DOC Directive 315.01, Intake and Bail, Effective Date 03/03/97, and DOC Policy 351 Health Care Services, Effective Date 2/10/86. Of note CO 1 documented the following:

1. “Are you allergic to any medications?” Yes; “If yes, what are they?” “Anti-inflammatory” was handwritten in that section.

3. “Are you currently taking any medications?” Yes was marked affirmatively and the words “Can’t remember” were handwritten in that section. “If yes, fill out Pre-Existing Medications form on reverse side.” The Pre-Existing Medications form was blank.

6. “Do you have any current or past medical problems that we should be aware of?” Yes was marked affirmatively; “If yes, what are they?” That section was left blank.

“Do you have any of the following?” Asthma, Hepatitis, Mental Illness, Fever, and Night Sweats were all marked affirmatively.

8. “Have you used alcohol in the past 24 hours?” No

9. “Have you used street drugs within the last 3 days?” No

10. “Do you have any problems that occur after stopping the use of drugs or alcohol?” No

- “NOTE THE FOLLOWING BY OBSERVATION. (NOTIFY SUPERVISOR OF ANY POSITIVE ITEMS)” Slurred speech and sweating were marked affirmatively.

Although the IMS form was signed by CO 1, the comment section on this form was left blank as were the date, the time, and the Supervisor’s Signature, in addition to the Pre-Existing Medications section on page 2 as noted above. Also as noted above in the discussion of the INS form filled out by CO 1, the booking unit video documentation provided by DOC appears to

demonstrate that CO 1 also likely completed the IMS with Mr. Crosby more than three and a half hours after he arrived at the facility, in violation of **DOC Policy 351 Health Care Services Section 4.6.1.3.1** which states in part that “[u]pon admission an Intake Medical History will be recorded regarding each inmate prior to his/her being given living arrangements...” As with the INS procedure, violations of DOC policy regarding the IMS include that there is no documentation to demonstrate that CO1 notified the Shift Supervisor as directed on the Intake Medical Form regarding her observations that Mr. Crosby was sweating and had slurred speech, there is no record of what time she completed the Intake Medical Screening Form, and there is no indication in either DOC or PHS records that she made any referral to medical staff pursuant to **DOC Policy 351 Health Care Services 4.6.1.3.1 Admissions Officer/Supervisor, Effective Date 2/10/86** which states in part: “[a]ny abnormalities will be referred immediately to medical staff... Any evidence of or report of the use of medication or drug by admittee is to be reported to medical services staff.”

CO 1 also noted that she completed an “Authorization of Special Observation” form regarding Mr. Crosby at 0035 on August 26, 2009. On this form she noted:

Type of Observation: Mental Health; Reason for Observation: High INS – previous attempt; Level of Watch: Close: physical checks at staggered intervals not to exceed every 15 minutes; documentation as observation occurs; Location of Observation: Holding Cell 2.

CO 1 also completed a “Special Observation Monitoring Sheet” on August 26, 2009 which documented the following:

Type of Observation: Suicide Watch [checked] Mental Health [checked] Physical Health [checked] Security [checked]; Start Date: 8.26.09; Start Time: 0035; Cell Location: BK2; Discontinuation Date/Time: [blank]; Observation Conditions: Close Observation: Physical checks at staggered intervals not to exceed 15 minutes [checked]; Special Observation [checked].

Handwritten in the same box was “15’s until booked” with the “until booked” crossed off and written underneath “(M/H – previous attempt).” Also written in corner of the box was “NOS”. The Supervisor Approval signature, date, and time section was blank.

As noted above, DRVT questions accuracy of the time documented by CO 1 on the Authorization of Special Observation form as it is apparent from video documentation provided by DOC that the reason for close observation, noted as a “High INS”, could not have been identified prior to the actual INS being completed. It is notable that CO 1 was concerned enough about Mr. Crosby’s condition to place him on special observation at admission, yet failed to follow through on other basic documentation, reporting and communication requirements related to those concerns.

DRVT reviewed documentation of the Special Observation checks made for Mr. Crosby. Of note is that, despite clear direction in the Special Observation Monitoring Sheet and training related to staggering fifteen minute checks, many of the checks were recorded as having occurred at regular intervals at the quarter hour. DOC staff documented the following on the Special Observation Monitoring Check Sheets:

0035 LOB (lying on bed/bunk); 0045 LOB; 0100 LOB; 0115 LOB; 0130 LOB; 0145 LOB; 0200 LOB; 0215 LOB; 0230 LOB; 0245 LOB; 0300 LOB; 0315 LOB; 0330 LOB; 0345 LOB; 0355 LOB; 0410 LOB; 0420 LOB; 0430 LOB; 0445 LOB; 0500 LOB; 0515 LOB; 0530 LOB; 0545 trays in; 0600 trays out; 0615 LOB; 0630 LOB; 0700 LOB; 0715 LOB; 0730 AA (appears asleep); 0759 AA ; 0809 AA; 0818 AA; 0832 AA; 0841 AA; 0852 AA; 0903 AA; 0913 AA; 0923 AA; 0932 AA; 0948 AA; 1000 AA; 1011 AA; 1025 AA; 1035 AA; 1047 AA; 1100 AA.

In a report written to SOS 1 and S1 on August 26, 2009 regarding Mr. Crosby, CO 2 noted that on that date at approximately 0730 he took over the post of booking from CO 1. CO 1 informed him that she had five prisoners in the cell and that three of them were going to court. CO 2 went on to report that, “[CO 1] showed me the confinement sheets and I then did a walk of the unit/checks of the guys in the cell at approx 0730. I then went and started doing a facility headcount and while doing this I did another check approx. 0745hrs and when it started to get busy with bravo guys going out I had CO [3] start checking my guys.” CO 2 reported that CO 3 continued to assist him in doing the checks on the prisoners in booking, and that CO 2 specifically recalled checking on Mr. Crosby at approximately 0930 when he appeared to be on his right side and asleep. On August 26, 2009 CO 3 wrote an Incident Report regarding Mr. Crosby that confirmed CO 2’s account and specified that on at least one occasion during his shift he had seen Mr. Crosby change sleeping positions while doing his checks. At approximately 1100 CO 4 came into the booking area to feed the prisoners in booking and holding cells 1 and 2. CO 4 found Mr. Crosby unconscious in his cell after attempting to get his attention regarding the food. Medical staff was called but they were unable to revive Mr. Crosby who was transported by ambulance to the hospital and pronounced dead at 1138. DRVT notes with appreciation that CO 4 took time to try to alert Mr. Crosby that his food tray had arrived and acted quickly in accordance with DOC policies upon the realization that Mr. Crosby was unresponsive and was not showing any signs of life.

Based upon a review of the video and documentation provided by DOC, DRVT concludes that in relation to the observations noted above, DOC staff did not comply with **CRCF Post Order Number 403.00.14, Booking Post, Effective Date 5/12/09**. That Order requires booking unit officers to:

15. Conduct special observation checks. While conducting special observation checks correctional officers will:
 - b. Look for signs of life (i.e. the rise and fall of the chest, movement, change in position, etc.);

- c. In cases where the signs of life are not readily observable the CO will employ one of the following strategies to elicit a response from the inmate: speak to the inmate and bang the cell door. At night the CO can also shine the flashlight in the inmate's face or turn on the overhead light in the cell;
- d. Should these strategies fail to elicit a response from the inmate the CO will notify the CFSS immediately;
- e. The use of any one of the strategies will be recorded in the unit log and any observation of the inmate will be noted on the special observation form;
- f. Record the actual time that the special observation check was conducted on the form. Correctional Officers will never fill in time blocks prior to conducting special observation checks;
- h. Special observation checks will vary in time however no check will exceed the time limit ordered on the special observation form.

Specifically, the video documentation demonstrated that CO 1 recorded inaccurate observations and inaccurate time entries on Mr. Crosby's special observation sheets. For instance, at 0035 CO 1 recorded that Mr. Crosby was "LOB" whereas the video showed that he was standing at the booking unit desk at that time, engaged in conversation with the CCO's. At 0410 CO 1 again recorded "LOB" while the video documentation showed Mr. Crosby exiting the cell at CO 1's request at 0408 and standing at the booking unit desk at 0410. He was out of the cell until 0420, at which time CO 1 again recorded that he was "LOB".

The video documentation also demonstrated at least three instances when the duration between checks was in excess of 15 minutes. According to the unit video CO 1 performed a check of HC2 at 0158 then not again until 0217, she performed another check of HC2 at 0240 then not again until 0258 and again performed a check of HC2 at 0600 then not again until 0617.

The video documentation provided did not capture any images from 1055 through 1104 therefore DRVT is unable to verify that the 1100 special observation checks documented by CO 3 were in fact performed as required.

In addition to the above noted inaccuracies and errors, the evidence demonstrates that DOC staff failed to perform checks, and to document that performance, in a manner that would ensure signs of life were obtained as required by the above noted Post Order. DOC records indicated that there were four prisoners in HC2 requiring checks, including Mr. Crosby, during a majority of the time under review. On numerous occasions, the video documentation showed the checks of prisoners in HC2 being performed from outside the cell door/window and lasting 1 to 5 seconds, with no indication that the COs actually looked for and identified signs of life for four different prisoners, some sleeping under covers in a darkened cell. Contrary to the Post

Order, no documentation of signs of life and efforts to obtain them was created. The evidence noted above demonstrates that the checks performed were often ineffective and proved to be of no value to ensure that Mr. Crosby was indeed alive during the hours and minutes leading up to him being found unresponsive in his cell. Given that three separate COs were involved in carrying out the Special Observation Checks and the documentation and video evidence demonstrates all three were often carrying out that responsibility in violation of policy in terms of adequate documentation, staggered checks and obtaining signs of life, DRVT suggests that the environment at the facility during this time period was one where DOC staff did not expect prompt quality assurance reviews and consequences for behavior not meeting requirements. There should be little doubt that the failure to professionally provide these checks had a significant impact on Mr. Crosby's death, but those failures are to be understood within the context of corrections oversight and quality assurance practices that created an environment where in the failures occurred.

3. Cause of Death in Relation to DOC and PHS Staff Errors and Policy Violations

On August 27, 2009 the Chief Medical Examiner performed an autopsy examination on Mr. Crosby and issued a Final Report of Autopsy on October 14, 2009. The Medical Examiner found the cause of Mr. Crosby's death to be "Acute mixed (Diazepam, Methadone, Oxycodone, Tramadol and Citalopram) intoxication" with contributory factors of "hypertensive and atherosclerotic cardiovascular disease, obesity (body mass index 34.0), and chronic substance abuse." The manner of death was listed as: "Accident (substance abuse; overdose of prescribed and non-prescribed medication)."

Of the drugs identified by the Medical Examiner as being in Mr. Crosby's system at the time of his death, only Citalopram was noted in the records as prescribed to Mr. Crosby by a physician. Given these autopsy findings that identify Mr. Crosby had unprescribed drugs in his system that resulted in his death, the failure of DOC and PHS staff to effectively identify and/or communicate, and professionally evaluate the possibility that Mr. Crosby was under the influence of substances at the time of his admission is striking. The many levels of redundancy and training that were intended by the DOC to assure that individuals with detoxification/withdrawal and other significant medical concerns are properly evaluated and treated failed utterly for Mr. Crosby. As this investigation demonstrates, both PHS and DOC staff failed to follow policies and procedures during the ten and a half hours that Mr. Crosby was incarcerated prior to his death. Implementation of many of those policies should have resulted in timely and professional medical care for Mr. Crosby that would have given him a significantly better potential to survive. Instead, Mr. Crosby was left in a cell without necessary medical attention until he died. As noted above, both the individual DOC and PHS staff involved and the staff that is responsible for oversight and quality assurance share responsibility for the negligent conduct that contributed significantly to Mr. Crosby's death.

V. CONFIDENTIAL: PHS MORTALITY REVIEW

On August 22, 2009 the PHS Site Medical Director completed a Mortality Review Form regarding Mr. Crosby's death. Pursuant to federal law and an agreement with PHS, DRVT obtained documents relating to the PHS review of Mr. Crosby's death as part of this investigation. Due to confidentiality requirements, DRVT does not provide details of the content of PHS's review or our reaction to PHS's review in this report.

VI. CONFIDENTIAL: VERMONT DEPARTMENT OF HEALTH ROOT CAUSE ANALYSIS FINAL REPORT

A. Root Cause Analysis

On or about December 31, 2009, the Department of Health (DOH) completed a Root Cause Analysis Final Report regarding Mr. Crosby's death and provided it to the DOC. Pursuant to federal law and an agreement with the DOC, DRVT reviewed the Root Cause Analysis and has provided our comments on that analysis to the DOC in a separate document. Due to confidentiality requirements, DRVT does not provide details of the content of the Root Cause Analysis or our comments about it in this report.

VII. CONFIDENTIAL: AGENCY OF HUMAN SERVICES INVESTIGATIONS UNIT REPORT

On April 6, 2010 the Agency of Human Services (AHS) Investigations Unit Chief sent a death investigation report regarding Mr. Crosby to the DOC Commissioner and Deputy Commissioner. Pursuant to federal law and an agreement with the DOC, DRVT reviewed the AHS report and has provided our comments on that report to the DOC in a separate document. Due to confidentiality requirements, DRVT does not provide details of the content of the AHS investigative report in this report.

VIII. SUMMARY AND CONCLUSIONS

DRVT's investigation into the August 26, 2009 death of CRCF prisoner Mr. Michael Crosby found that the following Directives, Policies, and Protocols were violated by DOC staff:

- DOC Administrative Directive 362 Suicide Prevention & Intervention in Facilities, Effective Date: 11/09/05;
- DOC Protocol 361.01.08 Management of Chemical Dependency and Withdrawal, Effective Date 8/20/97;

- DOC Protocol 361.01.01 Mental Health Receiving Screening, Effective Date: 8/20/97;
- CRCF Policy 362.00.01, Potential Suicides, Effective Date 4/27/2009;
- DOC Policy 351 Health Care Services, Section 4.6.1.3.1 Admissions Officer/Supervisor, Effective Date 2/10/86;
- CRCF Post Order Number 403.00.14, Title: Booking Post, Effective Date 5/12/09.

DRVT also found that the following Directives, Policies, and Protocols were violated by PHS staff:

- PHS Health Services Policy PH-01 Health Record Format and Contents, Procedure #5;
- DOC/PHS Contract # 10962 Section II. Health Care Services A. Intake Screening;
- DOC/PHS “Intakes/Transfers” Protocol per Email Correspondence dated 6/10/09;
- DOC/PHS “Detox” Protocol per Email Correspondence dated 7/01/09;
- PHS “Intake Process” Memorandum per Email Correspondence dated 8/20/09;
- CRCF Health Center “Intake/Night Shift” Protocol (undated);
- CRCF Health Center “Triaging Medical Intakes” Protocol (undated).

DRVT concludes that the most egregious of these violations involved the lack of any formal medical assessment of Mr. Crosby upon his admission to CRCF. This failure led to the lack of notification of an on-call physician and appropriate monitoring and repeated assessment. In addition to this main error, there were a variety of substantive policy violations, documentation errors and omissions, and overall communication problems between the DOC staff and PHS staff, from the initial arrest and placement of Mr. Crosby at CRCF until the final, ineffective Special Observation check that also likely contributed to his death. These multiple failures, error and omissions are indicative of a system that was not being sufficiently monitored and evaluated for compliance with expectations. DRVT hopes that, as time has gone by since Mr. Crosby’s death and a new medical and mental health provider has been engaged, the areas of concern highlighted by DRVT’s investigative report, and the other reviews mentioned herein, will be effectively monitored and appropriate conduct promptly enforced in response to Mr. Crosby’s death.

IX. RECOMMENDATIONS

DRVT provides the following recommendations to the Department of Corrections, policy makers and concerned citizens of Vermont:

1. DOC staff and contracted providers who violated directives, policies, and procedures should be appropriately disciplined, including termination and reporting to appropriate licensing boards;
2. DOC staff and contractors should receive improved training in recognizing and reporting signs, symptoms, and behaviors associated with intoxication and withdrawal of substance use and other potentially life threatening conditions upon admission to incarceration;
3. DOC Protocol 361.01.01 Mental Health Receiving Screening should be revised to require automatic referral to medical staff for immediate evaluation of any newly admitted prisoner who answers affirmatively to question # 12 “Do you have any drugs in your system that were not prescribed by a doctor?”
4. DOC Protocol 361.01.01 Mental Health Receiving Screening should be revised to require automatic referral to medical staff for immediate evaluation of any newly admitted prisoner who answers affirmatively to the question # 14 “Is the inmate showing signs of substance abuse or chemical withdrawal (e.g., slurring or speech, unstable gait, strong odor of alcohol, dazed look?”;
5. DOC and its contracted medical care providers should revise the Intake/Transfer Protocol regarding Nursing Rounds in Booking to include a substantive element of such rounds as a means of ensuring timely and appropriate medical intake and follow up;
6. DOC and its contracted medical providers should ensure that registered nurses rather than licensed practical nurses are on duty during all hours of the day, including nights and weekends, at each DOC facility in order to provider for adequate assessment and evaluation of prisoners’ medical needs and circumstances;
7. DOC should improve its quality assurance system to ensure that staff and contractors are in compliance with required Directives, Policies, Procedures, Protocols, and contract conditions. Independent monitoring has been shown to be an effective mechanism to identify compliance problems in the past and should be considered by DOC at this time.

For more information or to discuss this report further, please contact DRVT at 1-800-834-7890, or by email at info@disabilityrightsvt.org, or by U.S. mail at the address listed on the cover page.