Ombudsman for Corrections Investigative Report 94-1

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INTRODUCTION

On January 21, 1994 an inmate was found dead lying on the floor of his segregation cell at Minnesota Correctional Facility - Stillwater (MCF-STW). The Medical Examiner Provisional Report indicated that the cause of death was: 1. Acute Suppurative Peritonitis due to; 2. Perforated Gastric Ulcer. The manner of death was natural. This was confirmed by the autopsy.

The Ombudsman's office was contacted to conduct an investigation into what might be suspicious circumstances surrounding this death. The Ombudsman was subsequently contacted by the family and others also requesting an investigation.

The Ombudsman requested the logs and other documents that were pertinent to the investigation from MCF-STW. We were denied access to some of the information until such time as MCF-STW staff had sufficiently completed their internal investigation.

The Warden met with the Ombudsman and turned over the remainder of the requested documents. Since then, the Department of Corrections cooperated fully with the Ombudsman in the subsequent investigation, making available all records and staff for interview purposes.

The scope of the investigation included interviews with inmates and staff from the living unit to which the inmate was assigned, interviews with inmates housed in segregation at the same time as the inmate, Correctional Counselors, Sergeants, Lieutenants, Watch Commanders, the Captain, Unit Directors, Health Service nurses and the medical doctor. We reviewed videotapes, pictures, policies of the institutions, records, logs, and documentation from the week the inmate spent in segregation.

This investigation began as a review of the circumstances prior to the inmate's death. In the course of the investigation many questions were raised about the inmate as a mentally ill person and how that was handled at MCF-STW. Special attention was given to this issue and will be addressed separately in this report.

The Ombudsman also interviewed psychological services staff from the Minnesota Correctional Facilities at Stillwater and Oak Park Heights (MCF-OPH) and an Assistant Washington County Attorney. The Ombudsman reviewed the records of interviews with the Internal Affairs unit of the Department of Corrections (DOC) and interviewed staff from that unit regarding their investigation. The Ombudsman reviewed the DOC Health Services policies and policies specific to MCF-STW and the Oak Park Heights Mental Health Unit (OPH-MHU).

SECTION I

The purpose of this section is to present the facts of this case and to examine relevant policies and procedures as they relate to the inmates at MCF-STW.

HISTORY

The inmate was a 46 year old male. He was committed to MCF-STW to a 96 month sentence in 1993.

Per policy, each inmate newly admitted to MCF-STW is given a medical examination and a psychological examination within the first three days which includes an evaluation and review of written case material, a personal interview and possible administration and interpretation of standardized psychological tests. These examinations are completed prior to an inmate being released into the general population.

The initial medical examination indicated that the inmate had problems with hypertension, stomach discomfort and constipation. A prescription for blood pressure medication was renewed and the inmate was given a prescription for Zantac for his stomach problems. Both prescriptions remained in effect for his entire stay at MCF-STW.

The inmate's initial psychological evaluation indicated that he had a documented history of mental illness prior to his incarceration at MCF-STW. He had a prior commitment to a state hospital. He had been diagnosed with Schizophrenia, Paranoid Type, Chronic Passive/Aggressive Personality Disorder. The records indicate that he had been treated with medication until it appeared his mental illness was in fairly good remission. He was discharged from that facility by the Psychiatric Security Review Board.

Based on his history a referral was made to the consulting psychiatrist at MCF-STW. The inmate was seen by the psychiatrist who determined he was not demonstrating any psychiatric disorder and he was referred back to the staff psychologist.

Sometime later, following an interview with the inmate, the Social-Worker Specialist thought that medication might be helpful to control grandiose and manic patterns and completed another referral to the consulting psychiatrist for further evaluation. He was seen by the psychiatrist who again concluded that he was not in need of medication at that time.

The inmate had resided at MCF-STW in a regular living unit. The Ombudsman interviews with staff confirmed that he was a neat and orderly individual. He was friendly and polite. He was well liked by inmates and staff. He had been employed as a cell hall janitor (swamper).

CHRONOLOGY OF EVENTS

DAY ONE - Staff noticed that the inmate's cell was dirty and smelly, he was paged to the cell where he was questioned. Staff reported that the inmate appeared to be disoriented and was "acting crazy". The security squad was called and when they arrived, because he was unfamiliar with them, he became more agitated and loud. It appeared to the staff that he was planning to jump from the tier.[1] The staff person most familiar with him asked if he was planning to commit suicide. He responded that he was. He was cuffed by the security squad. He asked if he could have his Bible and was given it. This appeared to have a calming influence on him. He was given additional time to calm down while waiting for the crowd of inmates that had gathered on the flag[2] to return to their cells. Following this incident, a disciplinary report was written for disobeying a direct order and disorderly conduct.

The inmate had no disciplinary infractions during his stay at MCF-STW prior to this report.

The inmate was escorted from his cell and placed in a segregation observation cell.[3]

The observation cell is located directly in front of the segregation security bubble which is manned 24 hours a day. The security bubble officer is able to have continual direct observation of these cells.

Per policy, an inmate may be placed on observation status by a psychologist, or by the Watch Commander in the absence of a psychologist. Only a psychologist can take an inmate off observation status.

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[1]The inmate lived on the second floor.

[2]The "flag" is the main floor of the cell block.

[3]Forced move #1 was videotaped.

> "Specific Cells at MCF/STW have been designated as Observation Cells. These cells are provided as a resource for inmates who have been identified as being under substantial stress. All special management inmates are personally observed by a Correctional Officer at least every 30 minutes on an irregular schedule. Inmates who are violent or mentally disordered or who demonstrate unusual or bizarre behavior receive more frequent observation; suicidal inmates are under continuous observation. These cells are located in areas that maximize the ability of segregation staff to observe the behavior of inmates housed therein, in order to prevent attempted suicides or other self injurious behavior.
>
> Observation Status (Psychological) - An inmate may be placed in the designated cell for observation or treatment purposes. Placement on Observation Status occurs during normal working hours and is an order from a Staff Psychologist or Social Worker Specialist. If a Staff Psychologist or Social Worker Specialist is not present, the Watch Lt., upon approval of the Officer of the Day, may order an inmate into Observation Status. The OIC of the relevant unit will be notified by the assigning staff person and the inmate will report to or be escorted to the appropriate Observation Cell. A staff Psychologist or Social Work Specialist will assess the inmate on the following working day and determine whether Observation Status should continue or be discontinued."[4]

The Watch Commander was contacted and ordered fifteen minute observation checks as a suicide precaution. A segregation intake interview was conducted by Correctional counselor staff, who reported that the inmate was disoriented and confused.

A Health Services nurse who was in the area checked on him. Medical logs indicate that he had been placed in a suicide thwarting gown and given a suicide thwarting

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[4]Minnesota Correctional Facility-Stillwater Policy Manual Section 0-8, page 1.

blanket and that the water was turned off.[5] There was a small scratch on the forearm and treatment was refused. There was an additional notation that his prescription had not been picked up. A psychological referral was made.

DAY TWO - A staff person familiar with the inmate attempted to serve discipline papers on him. This staff person stated that the inmate "just stared" at him "with no response".

Observation logs indicate that the inmate was:

> ". . . awake all night, standing at the bars, lying on the floor . . . accepted and took his medications . . . was naked, happy and carefree . . . made noises and talked nonsensically."

Segregation staff thought that his condition may have been drug induced. They handed him a cup in an effort to obtain a urinalysis. He took the cup, dipped it into the toilet bowl and drank from it. No urinalysis was ever received.

Later that morning, when segregation staff thought the noise level was becoming too disruptive, the Security squad was called to move him from the observation cell to a more "secure" quiet cell.[6] Fifteen minute observation checks continued to be logged by the segregation staff working the area.

Observation logs indicate that later that afternoon, the inmate was:

> ". . . lying under the bunk, standing, talking nonsensically to himself, talking about outer-space . . .was pounding on the bunk and cell door."

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[5]This was a precaution because of concern that his behavior may have been drug induced.

[6]Forced move #2 was videotaped.

Segregation staff observed a white pen lying on the bunk. They ordered him to give them the pen. He did not comply and reports said he rammed the pen up his nose.[7]

The Security Squad was called. The inmate was instructed to submit to cuffing. He did not comply. The Security Squad used a chemical agent to subdue him. After the chemical was sprayed into the cell, the squad moved in with the shield, cuffed him and escorted him to the shower to remove the chemical agent from his face and eyes. He was then moved to another cell and placed on the restraint board.[8] Nursing services was called to examine him and make sure that his circulation was not impaired.

The inmate remained on the restraint board approximately one and one half hours. He was released from the restraint board because he was no longer being disruptive and seemed able to identify the staff speaking with him.[9] He was placed into a quiet cell.[10]

The observation logs indicate that for the next several hours the inmate was:

> ". . . talking about God . . . standing at the door . . . talking to the door . . . talking to the toilet.

DAY THREE - The inmate remained in the quiet cell.

Observation logs indicate that nursing service was in the segregation unit early in the morning to dispense medication.

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[7]When asked by the Ombudsman, segregation staff stated that they did not know how the inmate came to have a pen in his possession.

[8]Forced move #3. This move was videotaped.

[9]Removal from the restraint board was videotaped.

[10]This cell had a stainless steel toilet. Staff were concerned that the inmate might injure himself on the porcelain toilet in another cell.

Other notes indicate that the inmate:

> ". . . refused medications and was barking like a dog."

The observation logs indicate that he ate breakfast that morning, was later given lunch, and was seen by the psychological services director.

The indicate that the inmate's behavior was:

> ". . . psychotic based on his posturing, staring past him, not communicating with him, and talking nonsensically. The inmate turned over the mattress on the bunk on which his food had been placed. . . he attempted to get him to voluntarily go to the Mental Health Unit at the Minnesota Correctional Facility at Oak Park Heights (OPH-MHU) at this time."

That afternoon, segregation staff thought that the inmate was in possession of plastic eating utensils from his lunch and ordered him to return the utensils to them. He was not responding coherently and segregation staff made the determination that the cell should be searched. The Lieutenant and the Security Squad entered the unit. He did not comply with the directive to be cuffed. A chemical agent was shot into the cell. Staff entered the cell, laid him on the floor, cuffed him and took him to the shower.[11] The cell was searched and no utensils were found. Staff indicated the cell smelled of fecal matter. The cell was cleaned while he was being showered to remove the chemical agent from his face and eyes. The cell had not, however, been cleaned to the satisfaction of the supervisor so he was again escorted to the shower area and again showered while the cell was recleaned. He was then returned to the quiet cell.

Health Services was called to check on the inmate. Medical notes indicate the only visible injuries were scratches. The nursing notes also indicate that he was:

> ". . . uncooperative and very aggressive, had no clothing, and was acting psychotic. He had not taken his blood pressure meds or Zantac."

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[11]Forced move #4 was videotaped.

Notes indicate the plan was to have Psychological Services move the inmate to the Mental Health Unit at Oak Park Heights (OPH-MHU) the following day.

Observation logs later that day indicate that for the remainder of the day the inmate was:

> ". . . masturbating, drinking toilet water, sitting on the bed, singing, dancing, lying on the floor, crawling on the floor, sitting on the bunk, licking from the toilet bowl, pacing and lying on the bunk."

DAY FOUR - The inmate remained in the quiet cell.

A report states that the inmate:

> ". . . did not respond to the presence of the psychologist nor to his request to have him sign to voluntarily go to the Mental Health Unit at Oak Park Heights . . . he stood with his hands over his head, reciting the alphabet, rotating in a circle with each letter . . ."

Other notes indicate that the inmate did not accept medications that day.

The inmate was asked repeatedly by segregation staff if he would like the water turned on so that he would have clean water. He was unresponsive.

The observation logs indicate the inmate was:

> ". . . yelling, splashing water out of his cell."

Around noon that day, a MCF-STW doctor, accompanied by a nurse entered segregation and stopped to see the inmate. The inmate reached through the slot in the door and grabbed the doctor's hand. The doctor recalled that the inmate was "wet and cool, not warm or feverish." The inmate did not complain to him of health problems and the doctor did not observe any discomfort.[12]

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[12]There was no formal request for the doctor to see the inmate; this occurred as the doctor was walking by his cell conducting rounds.

That afternoon, the psychologist re-entered segregation to talk with the inmate in an effort to get him to volunteer to go to OPH-MHU. His report indicates that the inmate was still unresponsive and he expressed concern that the inmate's condition was not improving.

The observation logs that afternoon indicate that the inmate was:

> ". . . jumping up and down and talking to himself . . . lying in his food . . . "

Other notes indicate that the inmate was:

> ". . . still refusing his medication . . . lying supine on bunk with the bunk brace between his teeth . . . growling, masturbating, digitally stimulating anus . . . placing four fingers in rectum and then in mouth . . . that this behavior had also occurred previously. A referral to psychological services was made."

That morning, segregation staff, still attempting to coax the inmate to eat something, gave him a banana. He tried to eat the banana peel.

That evening segregation staff called reporting their concerns. Segregation staff had asked repeatedly if the inmate wanted his water turned on or if he would like clothing; there was no response.

The observation logs indicated that he had been throwing food onto the floor with semen and then eating from the floor. Another log indicates an intention to contact the Health Services Unit Director in the morning.

DAY FIVE - The inmate remained in the quiet cell.

Observation logs report that the inmate was pounding on the bunk in the early morning hours.[13]

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[13]Interviews with staff indicated that inmates were complaining because of the inmate's pounding. Segregation staff told the Ombudsman that there was discussion whether it might become necessary to again place him on the restraint board. This action was decided against, thinking that he would soon "run out of gas".

Observation logs that day indicate throughout the morning the inmate was active:

> ". . . lying on the floor, lying under the bunk, pounding on the bunk, standing, pacing, pounding, talking at the bars . . . washing his hands in the toilet and smearing on the walls."

Health Services staff contacted their supervisor and when he became aware of the degree of decompensation, the information was immediately taken to the Associate Warden and other staff who were instructed to get further information from the psychologist. After they spoke, the psychologist immediately placed a call to OPH-MHU and reported back that OPH-MHU did not think that the inmate met the requirements for imminent danger. Administrative staff were told that a court order was another suggested option that could be pursued. They left the area believing this would be accomplished.[14]

Later that day, the psychologist went to check on the inmate and noted significant deterioration.

Observation logs that afternoon indicate that the inmate was:

> ". . . sliding on the floor in his food . . . masturbating . . . playing in the toilet, pouring milk over his body . . . urinated on himself . . . licking floor . . . jamming the toilet bowl with garbage . . . was offered food, water, shower, gown . . . crawling on floor . . . talking to himself . . . masturbating . . . lying on floor . . ."

DAY SIX - The inmate was in the quiet cell.

The observation logs reported that he was sleeping most of the night.

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[14]The Ombudsman learned during interviews with staff that they had become increasingly frustrated that the transfer to OPH-MHU had not yet been accomplished. Nursing staff, with similar frustrations, continued to document their concerns with the inmate's behavior in an effort to assist in expediting the move.

Early that morning, the nurse entered the unit to pass out medications. The inmate still had not taken any medication.

The observation logs that morning indicate that the inmate was:

> ". . . lying on the floor . . . lying on the floor pounding . . . sleeping . . ."

That morning, the psychology staff was called by segregation staff expressing concern that the inmate must be moved to the Mental Health Unit before the weekend. Segregation staff called Count Control to verify the intended transfer and was told who would do the transfer.

Later that morning, records indicate that the psychologist was in segregation, attempted to talk with the inmate and observed that he was lying on the floor near the door. His report stated that the inmate did not respond when he tried to talk with him.

The psychologist was in segregation again that afternoon. His report indicates that he called out to the inmate but there was no response. The Watch Commander and the Security Squad arrived in segregation to prepare him for transfer to OPH-MHU. Attempts were made to get him to cooperate with the move. The inmate did not respond to their requests.

A request was made for a flashlight.[15] The cell was opened and it was obvious that the inmate was dead. According to staff, the cell smelled vile. The staff slid him out of the cell to the floor in front of his cell. Staff attempted to find a pulse but were unable to bend his arm. Rigor mortis had set in, therefore no CPR was administered.[16]

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[15]Despite the fact that it was the middle of the afternoon, staff told the Ombudsman that they could not see in the cell. Lights were of no use because the plastic covering over the window and over the light were covered with body waste and were too dirty.

[16]The Ombudsman has been told that under the circumstances (sub-zero temperatures outside and lying on a concrete floor) it would take two to three hours for rigor mortis to occur.

INVESTIGATION

Issue: Identification of Mental Health Issues

There was concern over the events that occurred previous to the inmate's death. We talked with the staff and inmates in the living unit where he had resided for the preceding ten months. All indications were that his behavior appeared to be perfectly normal prior to this incident. He was happy and jovial much of the time. There was nothing in his demeanor that caused concern.

Staff were not alarmed when the inmate did not report to work. Inmates frequently quit their jobs without notice.

After the inmate's death, staff in the living unit conducted their own informal investigation and found that during the previous week, the inmate had been attempting to give away his belongings (such as his T.V.), attempting to solicit sex, was eating jalapeno peppers and drinking urine. During interviews, inmate's reported these same behaviors to the Ombudsman.

Other notes indicate that the inmate was deteriorating for three days prior to being moved to segregation. He was reported to have been walking naked in the flag area, speaking and acting in a bizarre manner, and flooding his cell.

Issue: Due Process

Inmates charged with disciplinary infractions are, per the Consent Decree of September, 1973, to be served a copy of the charges within 24 hours. Unless a continuance is requested, discipline hearings are scheduled within four days of the inmate being served.

The inmate's hearing was scheduled to occur within this time period.

MCF-STW policy states:

> "When an inmate is charged with a disciplinary Rule violation and there is an indication of mental illness or an emotional disturbance in the inmate, the prosecutor

> will consult with Psychological Services and the Associate Warden of Operations to decide whether or not to prosecute the case."[17]

This policy was not followed.

No communications were established with the Associate Warden of Operations nor with Psychological Services with regard to the inmates competency to appear as required by the above policy.

The psychologist has informed the Ombudsman that this policy is very rarely followed.

On the date of the scheduled hearing, the Lieutenant informed Due Process of the inmate's inability to show up for his hearing. The hearing was continued to a non-specified date.

Another MCF-STW policy states:

> "Pleas of not guilty for the reason of mental illness or emotional disturbances shall not be accepted."[18]

This policy indicates the importance for the prosecutor to have dialogue with the appropriate persons prior to prosecution of the case.

Issue: Forced Moves, The Use of Chemical Agents and Restraint Board

Forced Move #3 - On the first day, segregation staff observed the inmate with a pen and when asked for it, he rammed it up his nose. The security squad was called and instructed him to submit to cuffing. He was sprayed with a chemical agent by the security squad. The squad moved in with their masks and shield, cuffed him and escorted him for a shower. He was then moved to another cell where he was placed on the restraint board and where he remained in excess of 1-1/2 hours. (Inmates are placed naked, face down on a wooden body

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[17]Minnesota Correctional Facility-Stillwater Policy Manual Section D4, page 8, item #2.

[18]Minnesota Correctional Facility-Stillwater Policy Manual Section D4, page 5.

length board with restraint straps at the ankles, thighs, wrists, upper-arms, waist and chest. The board is lying on the floor).

The pen was not recovered. It was assumed by segregation staff that the pen must have been placed in the air vent.

According to the American Correctional Association (ACA) sample policy regarding Use of Force and Restraints:

> " . . . force should only be used when necessary and only to the degree necessary to subdue an individual inmate . . . The use of force is sometimes necessary in the correctional environment for justifiable self-defense, protection of others, protection of property, and prevention of escapes, but only as a last resort . . . Force should be employed only to the degree necessary to control the inmate, to a level that will be effective with a minimum of harm to both staff and the inmate."[19]

The ACA sample policy entitled Use of Chemical Agents states:

> "It is the policy of the Department of Corrections to use all less forceful means available to resolve situations involving confrontation or aggression by inmates; when those means are not effective, chemical agents may be employed to enable staff to subdue an individual inmate or to restore order among a disruptive group of inmates."[20]

MCF-STW policy states:

> "JUSTIFIABLE USE OF FORCE
>
> The use of necessary physical force may be required in order to maintain security,

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[19]American Correctional Association, sample policy number 3.1.8.

[20]American Correctional Association, sample policy number 3.1.9.

order, and a safe environment for inmates and staff.

1. Staff are permitted to use force in the following situations:

   a. Self-defense;
   b. Defending or aiding other staff, inmate or third party;
   c. Enforcing institution regulations/institution discipline;
   d. Preventing commission of a crime, including riot and escape;
   e. Preventing destruction of property."[21]

"No Riot Control Chemical Agents, including Aerosol Irritant Projectors, is to be used to quiet a prisoner, nor is any Riot Control Chemical Agents/Aerosol Irritant Projectors to be used against an unarmed inmate who is under adequate physical control regardless of how provocative or belligerent he may appear . . .

D. Under the supervision and direction of the Watch Lieutenant, the use of Aerosol Irritant Projectors is authorized to prevent destruction of property or to control an inmate who is physically out of control, providing a more humane method of subduing the man does not exist. The Warden shall review, after the fact, the appropriateness of those decisions.

E. The use of Aerosol Irritant Projectors is authorized for self-defense and/or defense of other staff or inmates. The Warden shall review, after the fact, the appropriateness of those decisions, as well."[22]

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[21]Minnesota Correctional Facility-Stillwater Policy Manual, Section C18, page 5 and 6.

[22]Minnesota Correctional Facility-Stillwater Policy Manual, Section F2, page 2.

> "The amount of force must be reasonable under the circumstances. It must be the minimum amount necessary to resolve the situation. The inmate, by his behavior, determines when, what kind and how much force is to be used. Only the amount of force necessary to secure order and control will be used in any situation calling for the use of force."[23]

In this policy, the use of Aerosol Irritant Projectors is authorized to prevent destruction of property or to control an inmate who is physically out of control; providing a more humane method of subduing the man does not exist.

The prevailing belief at MCF-STW is that the use of chemical agents is the most humane method for subduing an inmate. This belief is contrary to ACA sample policy Use of Force and Restraints.

MCF-STW does not have a specific policy for the use of psychiatric restraints (restraint board). There is no supporting documentation in this instance for the use of the restraint board other than the inmate was being loud and disruptive. The cell he was moved to was the only cell large enough to accommodate the "board" and is not a quiet cell.

The inmate had already been residing in a quiet cell and the Ombudsman finds no reason for the placement on the "board". The Ombudsman is concerned that the use of both chemical irritants and placement on the restraint board exceeded what was necessary force in this instance to secure order and control.

Forced move #4 - occurred on the second day because segregation staff thought the inmate was in possession of plastic eating utensils which usually accompany styrofoam trays. The styrofoam tray had been sent because the kitchen had run out of bags.

Segregation staff thought the inmate might again try to injure himself with the plastic utensils and felt a cell search was warranted.

The inmate did not comply with directives given him by the Lieutenant and the squad was called. He was ordered to place his hands through the flap to be

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[23]Minnesota Correctional Facility-Stillwater Policy ManualSection C18, page 5.

cuffed and did not comply. Two one second bursts of chemical agent were shot into the cell. The squad entered the cell. He was kneeling over the toilet. He was then cuffed and showered.

No one verified with the kitchen whether or not utensils had been included with his meal until after the forced move had taken place.

The Ombudsman has learned that no utensils were included with this tray when it was sent to segregation from the kitchen.

The Ombudsman requested copies of Special Incident Reports on the Use of Chemical Agents, or Physical Force Reports as a result of force being used on the inmate or reports on the appropriateness of the decisions for the usage, as policy F2 requires. We were told several times that there were no such reports.

Issue: Hygiene and Cell Cleanliness

Segregation staff told the Ombudsman that during that week there were feces and urine on the floor and that the cell smelled.

The MCF-STW Segregation Manual states:

> ". . . inmates are expected to maintain their personal hygiene at an acceptable level. Dirty, unkept or unsanitary conditions will not be tolerated . . . Failure to comply will result in a direct order or disciplinary action."[24]

The Ombudsman questions who is to be held responsible for the personal hygiene and cell cleanliness for those persons incapable of caring for themselves?

No provision exists to provide a humane environment for a mentally decompensating individual housed within a quiet cell at MCF-STW.

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[24]Minnesota Correctional Facility - Stillwater Segregation Manual.

Issue: Quiet Cells

The inmate spent five days in what is termed the quiet cell. There are four such cells in MCF-STW segregation unit. Each is a totally enclosed 10 foot by 6 foot cell with a small observation window, and a flap that is able to be secured or let down to allow for passage of food or cuffing of hands. There is only a metal bunk (usually a mattress) suspended on metal chains from the wall, a sink and a toilet.

The MCF-STW Segregation Unit Operating Manual states:

> "When an inmate in the Segregation Unit is exhibiting destructive behavior, is threatening and/or inciting other inmates to destructive acts or exhibiting any behavior which has the potential of affecting the security of the unit, he may be moved to the quiet cell . . . moves to the Quiet Cell shall be made by the Security Squad, with segregation staff serving as back up, and should be videotaped . . . An inmate shall be released from a quiet cell when the behavior which caused his placement has ceased and when it is reasonably apparent that behavior will not shortly recur . . . No inmate shall be detained in a quiet cell beyond 24 hours unless the Unit Lt/Watch Lt. on duty has reviewed the situation and found that such continuation is necessary and appropriate. If the Lieutenant determines that circumstances warrant continued placement . . . will remain in a Quiet Cell for up to ten days . . . If the inmate shows improved positive behavior while in the Quiet Cell, he may be released from the status."

<u>Mentally ill inmates do not have the capacity to "show improved positive behavior while in the Quiet cell" as is required for release according to the above policy.</u>

There were no cameras in the quiet cells.

The only lighting for the cell is controlled by the segregation staff from outside the cell. There is a florescent light located at the top of the bars outside the cell with an opaque plastic covering at the cell bars.

Despite being on "observation status", with a standing order for fifteen minute checks throughout the inmate's stay in the quiet cells, observation became increasingly more difficult. As he decompensated and smeared body waste and food throughout the cell, the window that was intended to provide easy visibility became "marred". The Ombudsman was told during interviews with staff that "the only way to observe him was to drop the flap, put your face to the flap and look inside the cell."

This was an especially cold week. The National Weather Service recorded a temperature of -26°F with a windchill factor of -53°. Given their proximity to an outer wall, observation cells and quiet cells in segregation are especially cold at MCF-STW.

Segregation staff told the Ombudsman that this inmate was "so out of it he didn't know whether it was cold or not". "Most inmates would have asked for a blanket."

Issue: Chain of Command and Communications

MCF-STW Policy L, page 2 states:

> "Morning Reports
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> Line supervisory staff on all shifts should indicate to their Watch Lieutenant the results of their daily inspections so this can be reported to the Warden and A/W of Operations' staff via an entry on the daily morning report by the Watch Lieutenant.
>
> When serious or chronic situations are observed during these inspections, these staff should direct a written report (memorandum or incident report) to their supervisor with a copy to the A/W of Operations and/or the Warden.
>
> Unit Meetings
>
> Assessments of the institution, both positive and negative, as a result of inspections of the institution should be brought to the unit staff meetings for discussion. If unable to attend, a written report should be submitted.

> Discussion and/or consensus of positive or negative observations on the quality of institution living for the inmate - be it security, programming, health or safety - should be conducted at these meetings and transmitted quickly up the organization chain of command."[25]

At MCF-STW briefings take place as one shift replaces another. Reports on the inmate's behavior were conveyed at segregation staff briefings. The segregation Lieutenant was aware of the concerns of segregation correctional counselors.

Morning meetings are held by the Associate Warden of Operations each working day following the Warden's morning meeting. When asked why the Lieutenant had not brought these concerns to the Associate Warden's morning meeting our office was told that would not have been a proper forum to bring such concerns since the meeting was not a time for information sharing, but rather information receiving.

The segregation Lieutenant did not report his staff's concerns over the inmate's behavior to the Unit Director and indicated he felt the situation was being handled by Psychology.

When the Ombudsman interviewed staff that attended the Warden's and the Associate Warden's (AW) morning meetings, they indicated no recollection of reports regarding the inmates decompensation, nor recollection of any discussion taking place regarding the inmate.

The Ombudsman was unable to find "Use of Chemical Reports", "Incident Reports", or "Forced Move Reports"; any one of which would have brought his deteriorating condition to the attention of the Associate Warden of Operations and/or the Warden.

Segregation staff had from 2 1/2 years to 23 years experience in Corrections. In interviews, the Ombudsman found the staff extremely knowledgeable and were familiar with the chain of command. During these interviews, staff reported that the frustration level created by inaction regarding the movement of the inmate caused some of them to be ready to jeopardize their careers by jumping the chain of

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[25]Minnesota Correctional Facility-Stillwater Section L2 page 2.

command had the situation been allowed to continue much longer.

Health Service nurses, concerned about the inmate's condition, kept explicit notes documenting each stage of decompensation. Nurses made frequent visits to his cell to check on him. Nursing staff checked with correctional counselors regarding his condition. Health services made frequent calls to Psychological Services trying to assist in getting him moved to a more appropriate setting and were told that it was being taken care of but that it had not been clearly documented that he was in imminent danger. Health services staff attempted to assist by further documenting those behaviors they considered to be dangerous.

When this documentation still failed to meet the criteria required for movement to the OPH-MHU, on the fourth day, a call was placed to a supervisor to apprise him of nursing staff concerns. Those concerns were immediately taken up the chain of command.

SECTION II

The purpose of this section is to examine the issues relevant to the inmate as a mentally ill inmate incarcerated in a facility of the Minnesota Department of Corrections.

SUMMARY

DAY ONE, occurred on a holiday week-end. The inmate was transferred from his living unit to an observation cell in the segregation unit for bizarre behavior and for informing the unit staff that he was suicidal. He was placed on observation status by the Watch Commander with 15 minute observations to be done by the correctional staff. Shortly after being placed in an observation cell, he was moved to a shrouded quiet cell for his disruptive behavior. He remained in that cell and was not seen by Psychological Services until the third day, 45 hours after being placed on observation status.

On DAY THREE, after seeing the inmate, the psychologist noted that the inmate appeared to be psychotic based on his posturing, staring, not communicating and nonsense talk. He continued him on observation status. The psychologist contacted staff at the OPH-MHU in an effort to transfer him as an involuntary patient. The psychologist described his bizarre behavior and stated that he was concerned that the inmate was not responsible to make a decision about whether or not he needed to be hospitalized. The psychologist believed that there would be no treatment available for him in the segregation unit. After discussing his condition, staff at the OPH-MHU told the psychologist that they did not think the inmate met the criteria for imminent danger to himself or others and suggested the psychologist go to the court for a civil commitment.

On DAY FOUR, the psychologist saw the inmate twice. He was concerned that his condition was deteriorating. He then contacted another staff at OPH-MHU, regarding transferring him to the OPH-MHU. In responding to the questions if this was an "emergency", the psychologist stated that he did not think the inmate was going to die right away, but thought he needed to be in the OPH-MHU because of his bizarre and decompensating behavior. The staff person at OPH-MHU refused to accept him on a 72 hour hold because he did not believe the inmate's

condition met the criteria for the hold. He suggested that the psychologist go to the court for a civil commitment.

On DAY FIVE, at the request of his supervisor who had concerns that the inmate was in segregation, the psychologist again contacted OPH-MHU. He told them that the inmate was getting worse, that he "was refusing medication, growling, masturbating, and digitally stimulating his anus. He was also placing fingers containing feces in his mouth."[26] The staff person at OPH-MHU again stated he still did not think that the inmate met the criteria for an emergency hold. He told MCF-STW psychologist that "he wasn't going to risk being criticized by the courts because he had gotten burned before on the review of a 72 hour hold."[27] The psychologist was told to contact the Washington County Attorney for a 72 hour hold from the court.

Later that day the psychologist contacted an Assistant Washington County Attorney and advised her of his concern about the inmate and that he wanted to have the inmate transferred on a 72 hour hold to the OPH-MHU. She advised him that this would be a problem based on the fact that he had already attempted to have him placed in the OPH-MHU, and they were refusing the referral.

The records indicate that, the OPH-MHU (reluctantly) agreed to the transfer when the psychologist stated he believed the inmate was dangerous to himself based on two counts:

> "1. The risk of head injury from sliding on the cell floor or falling from his bunk; and,
>
> 2. The risk of stroke based on medical opinion that inmate had high blood pressure and was not taking medications."[28]

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[26]Behavior described in nursing notes.

[27]Ombudsman interview with the psychologist.

[28]Examiners Statement in Support of Emergency Hospitalization.

DAY SIX, in the afternoon, when the Correctional Officers went to transfer him to the OPH-MHU, they had a difficult time entering the cell because he was lying on the floor in such a way that the cell door was blocked. When the cell door was forced open, the records indicate that was dead; lying on the floor in vomit and urine. Rigor mortis was present.

WHAT IS A SERIOUS MENTAL HEALTH NEED AND WHAT CRITERIA DO THE COURTS USE TO DECIDE?

BACKGROUND

In order to understand the treatment for the mentally ill in other settings, the Ombudsman has consulted with staff psychiatrists at the St. Peter Security Hospital and a staff psychiatrist at the Ramsey Medical Center. The Ombudsman has consulted with the MN Mental Health Ombudsman to learn about the rights of the mentally ill. In order to understand the standards for treatment in the community at large, the Ombudsman spoke with a licensed psychologist with the Hennepin County pre-petition screeners office, and various Clinical Social Workers at the St. Paul Ramsey Hospital Emergency Room. The Ombudsman studied the Civil Commitment Act, Minn. Stat. Chapter 253.B, reviewed legal cases relating to the care of mentally ill inmates and read numerous articles and journals relating to issues of the mentally ill in prisons.

The Ombudsman considered the following; standards established by law, the standards for good mental health practices, and some of the policies of the DOC as they relate to the care of the mentally ill in this investigation.

In 1993, The National Coalition for the Mentally Ill in the Criminal Justice System published a monograph as part of a larger effort to improve the provision of mental health services to prison inmates. The monograph summarizes where we begin:

> "Security aside, having custody of a person creates rights on behalf of the kept and obligations imposed on the keeper. Two of the clearest of those obligations are:
>
> 1. To keep and hold safely, to provide a non-life threatening environment, and

2. To provide medical and mental health care to prevent needless suffering, avoidable deterioration, even death."[29]

"A captive is just that: unable to obtain life saving or life preserving care; unable to obtain relief from physical or mental suffering. That obligation falls to the captor and regardless of the reason, the place or the duration of custody, and regardless of the cause of a medical or psychiatric condition, appropriate care for serious disorder is constitutionally mandated."[30]

CASELAW

In Rights of Prisoners, Michael Mushlim states:

"There can be no doubt that the requirement that inmates receive needed medical care includes the requirement that they receive needed mental health care. Innumerable class actions have held that psychiatric care is as much an element of a minimally adequate medical care system as any other form of care . . . Delays in providing needed psychiatric care violate the Constitution."[31]

In *Gaudrealt v. Municipality of Salem,*[32] the court determined:

"A medical need is serious if it is one that has been diagnosed by a physician as mandating treatment, or one that is so obvious that even a lay person would easily

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[29]Henry J. Steadman and Joseph J. Cocozza, ed. "Mental Illness In America's Prisons", Monograph (National Coalition for the Mentally Ill in the Criminal Justice System, Seattle, Washington, 1993), page 29.

[30]Ibid pages 28-29.

[31]Mushlin, Michael, Rights of Prisoners, Second Edition, Shephard's McGraw Hill, Inc. Colorado Springs, CO, 1993, pg 157-158.

[32]*Gaudrealt V. Municipality of Salem, Mass.* 923f.2D 203, 208, (1st Cir. 1988).

> recognize the necessity for a doctor's attention. . . The seriousness of an inmate's needs may also be determined by reference to the effect of the delay of the treatment."

McGukin v. Smith,[33] a more recent federal court decision, states:

> "A serious medical need exists if the failure to treat a prisoner's condition could result in further significant injury or the unnecessary and wanton infliction of pain . . . The existence of any injury that a doctor or patient would find important and worthy of comment or treatment, the presence of a medical condition that significantly affects the individual's daily activities, or the existence of chronic and substantial pain are examples of indications that a prisoner has a serious need for medical treatment."

A few other generalities can be distilled from the case law:

> "1. The diagnostic test is one of medical or psychiatric necessity.
> 2. Minor aches, pains or distress will not establish such necessity.
> 3. A desire to achieve rehabilitation from alcohol or drug abuse, to lose weight to simply look or feel better will not suffice.
> 4. A diagnosis based on professional judgment and resting on some acceptable diagnostic tool, e.g. DSM-III(R), is presumptively valid.
> 5. By the same token, a decision by a mental health professional that mental illness is not present also is presumptively valid.

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[33]*McGukin v. Smith*. 974 F.2d 1059-60 (9th Cir. 1992).

6. While "mere depression" or behavioral and emotional problems alone do not qualify as serious mental illness, acute depression, paranoid schizophrenia, "nervous collapse" and suicidal tendencies do qualify."[34]

PSYCHIATRIC STANDARDS

The American Psychiatric Association (APA) task force on Psychiatric Services in Jails and Prisons states:

> "Severely mentally ill inmates should not be housed in correctional facilities unless the following conditions are met: . . . b. written procedures for adequate observation . . . d. medical mental health staff available to provide adequate treatment and supervision and . . . e. patients are transferred to an appropriate mental health facility according to a written policy approved by the appropriate mental health authority and the correctional facility administration when these conditions cannot be met.[35]
>
> Emergency treatment includes transfer to special medical/psychiatric housing units, transfer to inpatient psychiatric units, use of psychotropic medications, and special observation."[36]

MINNESOTA CIVIL COMMITMENT ACT

The Civil Commitment Act, Minn. Stat. Chapter 253B Subd. 13 defines:

> **Mentally ill person** means any person who has an organic disorder of the brain or a substantial psychiatric disorder of thought, mood, perception, orientation, or memory which grossly impairs judgment, behavior, capacity to recognize reality or to reason or

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[34]F. Cohen, Article "Legal Issues and the Mentally Disordered Prisoner" published in "Mental Illness in America's Prisons, page 32.

[35]Ibid page 29.

[36]Ibid page 29.

understand which:
(a) is manifested by instances of grossly disturbed behavior . . . or faulty perceptions; and
(b) poses a substantial likelihood of physical harm to self or others as demonstrated by:
(i) failure to obtain necessary food, clothing shelter, or medical care as a result of the impairment, or
(ii) a recent attempt or threat to physically harm self or others. This impairment excludes (a) epilepsy, (b) mental retardation, (c) brief periods of intoxication caused by alcohol or drugs, or (d) dependence upon or addiction to any alcohol or drugs.

253B.05 **Emergency Admission** Subd. 1 **Emergency Hold**

(a) any person may be admitted or held for emergency care and treatment in a treatment facility with the consent of the head of the treatment facility upon a written statement by an examiner that: (1) the examiner has examined the person not more than 15 days prior to admission, (2) the examiner is of the opinion, for stated reasons, that the person is mentally ill, mentally retarded or chemically dependent and is in imminent danger of causing injury to self or others if not immediately restrained, and (3) an order of the court cannot be obtained in time to prevent the anticipated injury.

AMERICAN CORRECTIONAL ASSOCIATION STANDARDS

FC2-4074 Written policy and procedure specify the provision of mental health services for inmates in need of such services to include, but not be limited to, services provided by qualified mental health professionals who meet educational and licensure/certification criteria specified by the respective professional discipline, i.e. psychiatric nursing, psychiatry, psychology and social work (2-4283).[37]

[37]American Correctional Association Standards.

> **C2-4146** Inmates who are severely disturbed or mentally retarded are referred for placement in either appropriate non-correctional facilities or in specially designated units for handling this type of individual. (2-4296).

DISCUSSION: It is inappropriate to place severely disturbed and mentally retarded individuals in a prison setting. They are vulnerable to abuse by other inmates and require an inordinate amount of personal attention. An individual is considered severely disturbed when he/she is a danger to him/herself or is incapable of attending to basic physiological needs.[38]

DEPARTMENT OF CORRECTIONS POLICIES

The MN DOC has made provisions to meet these obligations. The Mission Statement of the Health Care Unit of the DOC states:

> "The Department of Corrections is responsible for providing inmates with a full range of health services at a level of quality comparable to that which is available in the community."[39]

The Health Services Policy manual states that health services are delivered by means of a multi-faceted approach:

> " . . . 3) inpatient-outpatient care at the major contracting facility, St. Paul-Ramsey medical Center; . . . (5) an inpatient mental health service for the acute mentally ill and suicidal adult male population, as well as ambulatory mental health assessment and treatment services for all inmates at state correctional facilities."[40]

Minn. Statute 241.69 establishes the Correctional Psychiatric Unit for the care and treatment of those inmates who become mentally ill. The OPH-MHU opened in

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[38] American Correctional Association Standards.

[39] Introduction; Department of Corrections Health Unit Policy Manual.

[40] Ibid.

1982 as a response to the treatment and care of the mentally ill and as an alternative to the Security Hospital at St. Peter for the hospitalization of DOC inmates.

Each DOC institution has specific policies that address the procedures related to the services, evaluations and transfer of mentally ill inmates.[41]

CONSULTATIONS

A summary of the inmate's observed behaviors over the six days the inmate was held in the segregation unit was reviewed by three psychiatrists, a community psychologist and the Mental Health Ombudsman.[42]

The Ombudsman asked each consultant the following questions:

> 1) How would this situation have been handled in your setting?
> 2) In your opinion, did this inmate meet the criteria for a 72 hour hold under MN Chapter 253.B, and at what point?
> 3) In addition, the psychiatrists were asked what intervention you would have considered and when?

Their responses to these questions were:

Staff Psychiatrist, St. Peter Security Hospital:

> "The person would have been secluded (comparable to an involuntary transfer in that setting) on the first day based on his history of becoming acutely psychotic and manic. Any psychiatric unit would have

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[41]Department of Corrections Health Unit Policy 6:040 and 6:050.

Minnesota Corrections Facility-Stillwater Policy Manual Section P-21, page 3 of 4.

Minnesota Corrections Facility-Oak Park Heights Policy Manual Section P.33, page 2 of 3.

Oak Park Heights Mental Health Unit Policy Manual Section 401.

[42]See Appendix A

> picked up on the serious nature of the psychosis." He also stated that he would have started neuroleptic medications on an emergency basis on the second day. (He stated that the psychosis could have induced the ulcer.)[43]

Staff Psychiatrist, St. Peter Security Hospital:

> "The person would have been secluded on the first day based on the prior history and the acute onset of the psychosis." He stated that he would have started emergency medications on the second day. (He went on to state that it is dangerous not to treat; that you can be penalized for not providing care. He noted that you have to rule out that this is a delirium which is always considered to be a medical emergency. He stated that the peritonitis might have caused the bizarre behavior.)[44]

Psychiatrist, Ramsey Medical Center, stated that:

> "Based on the cumulative psychotic behavior the person would have been admitted to a hospital had he been in the community and seen in an emergency room on the second day." He stated that by the fifth day he would have started emergency medications."[45]

Psychologist, Hennepin County Pre-Petition Screening Unit, stated that:

> "By the third day he would have considered involuntary placement appropriate in apsychiatric unit based on the decompensating behavior."[46]

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[43]Phone interview.

[44]Phone interview.

[45]Interview.

[46]Phone interview.

The Mental Health Ombudsman had the summary reviewed by their Medical Review Subcommittee (MRS). The MRS indicated that:

> "On the first day there were significant signs for a 72 hour hold, but certainly by day 2 or 3. This is based on a number of factors such as:
>
> 1. Dramatic change in behavior
> 2. History of Major Mental Illness
> 3. Staff was unable to assess a cause for change
> 4. Unit unable to provide a therapeutic environment
> 5. Unit unable to protect the inmate from himself
> 6. The symptoms were escalating
>
> The general criteria for the hold would have been "danger to self or others but that can be subjective"."[47]

In another letter, the Mental Health Ombudsman stated:[48]

> "Based on the information provided, it is the opinion of this office that:
>
> 2. The individual provided reason to believe that s/he was a danger to self by indicating that s/he was suicidal.
>
> 3. That from the information provided, it is not possible to determine whether or not the course of his/her physical condition could have been altered had any intervention occurred earlier.
>
> 4. That this individual may not have been competent, at that time, of making an informed decision about his/her desire to seek or refuse treatment from the mental health unit on a voluntary basis.

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[47]Letter to the Ombudsman for Corrections.

[48]Letter to the Ombudsman for Corrections.

5. That serious questions remain unanswered as to the ethics and humanness of allowing any human being to suffer to this degree without intervention."

Each of the individuals consulted in this case concurred with the MCF-STW psychologists evaluation and thought that the request to transfer to the OPH-MHU for the purposes of evaluation and treatment was appropriate, assuming that thorough evaluation and treatment was not available in segregation.

INVESTIGATION

Issue: Treatment received in segregation

In the course of this investigation, the Ombudsman has been told that at MCF-STW, mentally ill persons, like this inmate are often taken to segregation as a result of some kind of disciplinary infraction resulting from their mental illness. In segregation, they are sometimes placed on observation status and referrals are made to psychological services.

We were told by both staff and the Warden that it's not unusual for inmates to demonstrate behavior like this inmate's while in segregation. The psychologist told the Ombudsman, however, that he had "never seen anyone as mentally ill as this inmate was."

Because the inmate was unable to sign himself into the OPH-MHU and because they refused to accept him on an emergency basis, he remained on observation status with 15 minute checks the entire time he was in segregation.

The psychologist stated the treatment plan was to move him to the OPH-MHU; he stated that he believed there was nothing they could do for him in segregation. No physicians were called in to evaluate him. He was not taken to the hospital. <u>There was no treatment.</u>

Issue: Emergency Care

If this inmate, in his acute psychotic state, could not get into the OPH-MHU because he was unable to sign himself in, the Ombudsman must question who, then, is supposed to go the OPH-MHU? <u>The Ombudsman is concerned that adequate assessments and interventions are not available for this most vulnerable, mentally ill population.</u>

The Health Unit Policy 1:060 identifies the criteria for various medical care categories. <u>Category I. Emergency Care</u> doesn't describe any psychiatric emergency situation.

Each of the psychiatrists the Ombudsman consulted with suggested that the inmate's situation was an emergency situation and under their care, medications would have been forced for emergency treatment purposes.

There are conflicting DOC policies as to the ability to force medications in an emergency situation; the DOC Health Services Policy 1:380 states:

> ". . . the introduction of any medication into the body of an inmate/patient without his/her expressed consent or against his/her will is prohibited . . . If the illness is acute, life threatening, and there is no time to approach the court, the inmate should be forcibly taken to the nearest medical center - St. Paul Ramsey Medical Center if feasible."

None of the individuals the Ombudsman interviewed could remember a time when an inmate had been taken to St. Paul Ramsey for psychiatric evaluation or hospitalization. (An exception might be an inmate who is seen by the Social Worker at St. Paul Ramsey if they have come there for medical attention following a suicide attempt; these inmates are then referred from St. Paul Ramsey to the OPH-MHU.)

At MCF-OPH, the INMATES' MEDICAL RIGHTS AND RESPONSIBILITIES states:

> ". . . every inmate has the right to and/or responsibility for . . . (14) be free from mental and physical abuse and free from chemical and physical restraints, except in emergencies, or as authorized in writing by his physician for a specified and limited period of time and when necessary to protect the inmate from injury to himself or others;"

The Minnesota Correctional Facility - St. Cloud (MCF-SCL) has a policy regarding Administering Involuntary Psychotropic Drugs - Chapter: 7.3, Section 2 states:

> ". . . 2. A consultant psychiatrist or institution physician has been fully apprised of the inmate's condition and orders involuntary medication. Such a physician's order must be renewed every eight hours. Standing orders for involuntary medication are not permitted."

However, staff at MCF-SCL, stated that the Health Services Policy 1:380 takes precedence and didn't believe they could implement their policy. He went on to state that he has been working with Health Services to change that policy, but to date, this has not occurred.

When we asked about policies regarding forced medications in the OPH-MHU, we were told they would use the protocol established by the Department of Human Services. They could not remember the last time they ever forced medications without the courts consent.[49]

Because inmates are neither taken to the hospital for psychiatric emergencies nor does it appear that the OPH-MHU is practicing emergency care, the current policies and practices are inadequate for timely and appropriate interventions in a psychiatric emergency.

Issue: Civil Commitment

The inmate was unable to agree to go to the OPH-MHU; the psychologist indicated that he wasn't refusing, he just wasn't agreeing. This was critical because the inmate was then viewed as an involuntary person. The Ombudsman was told that the preference is to have the inmates come voluntarily.

The law is clear that when a person is unable to make decisions for themselves based on their mental status, then the burden of those decisions is with the person examining them.[50]

The psychologist thought the inmate needed to be transferred to OPH-MHU on an emergency basis, and he had been requesting this since his first observations of the inmate.

When the Ombudsman asked the psychologist why he didn't pursue a civil commitment as recommended by the staff at the OPH-MHU, he stated that he thought the inmate needed to be transferred "now" and that a civil commitment would take too long. He thought that he, as the examiner, should have the ability to do that with the emergency hold.

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[49]*Jarvis v. Levine*, 418 N.W. 2d 139 (Minnesota 1988).

[50]Civil Commitment Act, Minn. Stat. Chapter 253B.

The Ombudsman asked an Assistant Washington County Attorney the procedure for commitment; she explained the options for:

1) Review of a 72 hour hold
2) Apprehend and hold orders
3) Civil commitments

She stated that to her knowledge, she had never seen an apprehend and hold request from the DOC. She also explained that this kind of request is usually used when there is no examiner available to evaluate the person. The court would be obligated to meet the same criteria for a hold as the examiner would, and would have to have a facility to transfer the person to. She went on to explain that because the DOC has their own "examiners" it wouldn't be necessary for them to come to the court for emergency holds. She stated that they process the requests for continued hold reviews and civil commitments. She stated that a civil commitment usually takes several weeks to process.[51]

Because staff at OPH-MHU implied that 72 hour holds were obtained from the court, and specifically urged the psychologist to obtain one in order to transfer , we requested verification of those cases where this had occurred. A memo given to the Ombudsman regarding "MI Commitments without Emergency Holds: 1983 - present", indicates that there have never been any inmates from MCF-STW or MCF-OPH admitted to the OPH-MHU with an Order for Apprehension, Confinement, and Notice of Hearing.[52]

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[51]Phone interview.

[52]This memo does indicate that there have been four inmates admitted from MCF-SCL with an Order for Apprehension, Confinement, and Notice of Hearing. The Ombudsman notes that not all of the psychologists at MCF-SCL are qualified examiners which might explain this difference.

Although staff at OPH-MHU did not disagree that the inmate probably belonged in the OPH-MHU, there was disagreement as to the need to do an involuntary transfer. While the psychologist believed he needed more help than could be provided in segregation, when pressed by OPH-MHU for the threshold for imminent danger, he could not justify this to satisfy them.

The staff at OPH-MHU have told the Ombudsman that to define imminent danger they use a standard that involves overt acts. Examples of overt acts were described as:

> ". . . the inmate has a noose hanging right there or he's got a sharp object and is threatening to cut himself."[53]

This interpretation of the intent of the MN Commitment Law (253B) is a very narrow one. The Ombudsman does not support this interpretation, nor do the professionals the Ombudsman consulted with:

> One St. Peter psychiatrist stated that "a reasonable standard for care was not met, that you should not allow anyone to be treated like that."[54] Another St. Peter psychiatrist stated that this "was atrocious and bordered on malpractice." The third psychiatrist had problems with not being able to transfer the inmate and not having treatment available in segregation. He stated, "just being able to observe someone in an isolated cell is not enough."[55]

The MCF-STW psychologist was told by OPH-MHU staff that they were not willing to be criticized by the courts for putting inmates in the OPH-MHU too soon. A DOC Internal Affairs investigator and the Ombudsman were told by that there had been problems with the courts regarding transfer of inmates on holds. When the Ombudsman requested information about this, we received a memo stating:

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[53]Ombudsman interview and phone message with OPH-MHU staff.

[54]Phone interview.

[55]Interview.

> "I only vaguely remember the situation referred to by Internal Affairs. There was no written court order or directive. I do not remember the patient's name, but the judge told the county attorney who told me that it appeared to him that we were too quick to put an Emergency Hold on that patient and we should have gotten to court instead. This was not a recent event, but most of the judges are the same ones we have dealt with for years. County attorneys change more frequently."[56]

This information is not sufficient to substantiate the claim that the DOC has been criticized by the courts and should not consider bringing inmates to the OPH-MHU on an emergency basis.

If the standard used in this inmate's situation to diagnose and treat mental illness persists, it is unlikely that severely mentally ill inmates will receive necessary care. The Ombudsman is concerned that the DOC will then leave itself vulnerable to litigation claiming failure to provide appropriate and adequate treatment.

Langley[57] provides an exhaustive list of the type of specific claims that indicate constitutionally inadequate mental health care:

> " . . . 5. failure to properly diagnose mental conditions . . . 9. Seemingly cavalier refusals to consider bizarre behavior as mental illness even when a proper diagnosis existed."

In *Estelle v. Gamble*,[58] the courts established that grossly incompetent or inadequate medical care can constitute deliberate indifference, as well as refusal to provide essential care. The courts generally recognize that deliberate indifference by prison personnel of an inmate's serious medical needs violates the inmate's Eight Amendment right to be free from cruel and unusual punishment.

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[56]Memo to the Ombudsman.

[57]*Langley v. Coughlin*, 715 F. Supp at 540-41.

[58]*Estelle V. Gamble*, 429 U.S. 97 (1976).

The Protection and Advocacy for Mentally Ill Individuals Act of 1986 defines:

> "(4)The term neglect means a negligent act or omission by any individual responsible for providing services in a facility rendering care or treatment which caused or may have caused injury or death to a mentally ill individual or which placed a mentally ill individual at risk of injury or death, and includes an act or omission such as the failure to establish or carry out an appropriate individual program plan or treatment plan for a mentally ill individual, the failure to provide adequate nutrition, clothing or health care to a mentally ill individual, or the failure to provide a safe environment for a mentally ill individual . . ."[59]

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[59]United States General Accounting Office, GGD-91-35, Mentally Ill Inmates, April, 1991.

SECTION III

The purpose of this section is to draw conclusions based on the facts and findings, identify changes which have occurred and make additional recommendations for further change.

CONCLUSIONS

- The DOC must protect the liberty interests of individuals. The DOC must also protect the constitutional rights of the inmates. The mental health professionals must exercise good judgment to balance the rights of the inmates and the department's obligations to provide treatment for the inmates.

- Because the Department of Corrections did not provide any treatment for this inmate in a timely manner, the Ombudsman's opinion is that they were negligent in this incident.

- For 6 days, the inmate lived naked, in a cold cell and in filthy conditions. He ate the paint off his walls, ate his own feces and drank out of the toilet. He was observed to be decompensating for this entire period. He could not sign himself into the mental health unit nor was he perceived as being in imminent danger to himself and, therefore, he did not meet the DOC's criteria for a 72 hour hold.

- The inmate's death was a tragic and unfortunate one. Whether or not it could have been avoided had he been moved to the OPH-MHU is something the Ombudsman cannot conclude with certainty. The Ombudsman does believe, however, that had the inmate been transferred and evaluated by a physician as the law requires, perhaps the perforated ulcer would have been avoided or at least been detected. Had he been given medications for his psychosis he might have cleared enough to communicate that he was in physical distress. Given the fact that none of these things happened, we are certain of the outcome.

- The Department of Corrections has not adhered to their standards for providing a standard of care comparable to that in the community.

- The Department of Corrections does not have adequate policies, procedures and practices for the diagnosis and emergency treatment of the severely mentally ill inmates.

- Severely mentally ill inmates do not belong in segregation when there are no treatment services available to them.

- The inmate should have been admitted to the Oak Park Heights - Mental Health Unit as a serious mentally ill inmate when the first request was made. The recommendations to go to court for an Apprehend and Hold Order (72 hour hold) were inappropriate.

- Correctional officers are not adequately trained to deal with mentally ill inmates.

- The Minnesota Correctional Facility - Stillwater policy regarding charging mentally ill inmates with disciplinary offenses was not followed.

- There is no policy regarding forced moves in segregation.

- The use of the restraint board exceeded what was necessary to obtain order and control.

- No provision exits to provide for hygiene and a clean environment when a mentally decompensating inmate housed within a quiet cell at Minnesota Correctional Facility - Stillwater is unable to provide such an environment for himself.

- The quiet cell did not allow for adequate observation.

- The chain of command regarding communications was not followed.

CONTRAST IN EXISTING POLICY WITH POLICY REVISIONS

The Ombudsman recognizes that a number of positive improvements have occurred at MCF-STW following this death. Some of these changes have helped to improve the conditions in the segregation unit. Policies have been developed which address some of the concerns identified by the Ombudsman in this report. Some practices have changed and more inmates are being transferred on emergency holds to the mental health unit.

- Quiet cells have been renovated. They have been painted white for easier observation of inmates. The bunks have been replaced with concrete slabs so inmates cannot hide under them. Cameras have been installed in two of the four quiet cells. The solid metal cell fronts have been replaced with clear plastic. The lighting fixtures have been changed.

- The segregation policy has been changed to require "live counts" rather than "flesh counts". The previous policy required only that the officer conducting the count make sure they saw flesh - the current policy requires them to see "movement".

- When an inmate has been placed on observation status on a weekend or holiday, policy now requires that a nurse from Health Services see that inmate personally on each watch. The nurse may request psychological services staff to report to the institution for further evaluation or treatment planning.

- Distribution of the "Observation Status" form has been expanded to include Administration.

- Entries in the observation log and/or quiet cell log must be more specific and include a description of behavior.

- When an inmate is placed on observation status the Watch Commander now will record the action on the Warden's daily report.

- The Unit Director will be included in the reviews for continuation of observation or Quiet Cell status and be provided copies of treatment plan.

- Language regarding the possibility of staying in the quiet cell for 10 days for a single violation has been deleted from the segregation manual.

The Ombudsman is making the following recommendations to address the remainder of the issues identified in this report.

RECOMMENDATIONS

1. That the Department of Corrections review current practices regarding emergency psychiatric placements and implement any changes needed to ensure that their practices are consistent with good mental health practices, community standards and constitutional requirements for treatment.

2. That the Department of Corrections review existing policies and practices that relate to the treatment of the mentally ill inmates and implement any changes needed to ensure that policies and practices are consistent with good mental health standards, community standards and constitutional requirements for treatment.

3. That the Department of Corrections review the practices regarding the charging and prosecution of mentally ill inmates and make any changes needed to ensure that they are in compliance with existing policies.

4. That the Minnesota Corrections Facility - Stillwater develop a non-punitive policy regarding the use of the restraint board. In the development of this policy specific attention be given to the use of the restraint board for mentally ill inmates.

5. That the Minnesota Corrections Facility - Stillwater develop a policy regarding the use of force methods for segregation. In the formulation of this policy they consider the American Correctional Association accelerated steps for use of force.

6. That the Minnesota Corrections Facility - Stillwater examine the current practice and frequency of use of chemical agents as a preferred method of subduing inmates.

7. That the Minnesota Corrections Facility - Stillwater consider additional methods to improve direct communications from line staff to administration such as the establishment of a "suggestion box."

The following information was distributed to the various mental health professionals that the Ombudsman consulted with during the investigation.

APPENDIX A

The standard for care for the DOC is to provide a full range of health services at a level of quality comparable to that which is available in the community. The DOC has a 22 bed inpatient mental health service for the acute mentally ill and suicidal adult male population, as well as in-house ambulatory mental health assessment and treatment services for all inmate at the state correctional facilities. Admissions to the mental health unit are either voluntary or by emergency referral or civil commitment pursuant to Minnesota Statute 253B. Please see the attached document describing the Mission, Organization and Philosophy for health care services for the MN DOC.

The following information is available for assessment of this inmate:

Inmate has a diagnosis of schizophrenia, paranoid type, chronic as well as passive/aggressive personality disorder. (1982)

Inmate was committed to a state mental hospital from 1982-1991. Inmate was treated with medication until 1989, at which time his mental illness was "in fairly good remission." Inmate had not demonstrated active psychosis since 1988.

Other diagnosis include Bi-polar disorder, manic in remission and narcissistic personality disorder.

Inmate was noted to be hallucinating in a local jail in 1992, but refused medications.

Inmate was committed to the DOC in February 1993. He functioned quite well from that time until this incident. Inmate was described by staff as being very friendly, courteous, and neat in appearance. Inmate kept his living quarters neat and clean. Inmate has no record of disciplinary infractions.

Day 1

During routine security rounds, officers note inmates cell in complete disarray; several containers of urine and feces are in the cell, there is burned paper and a broken stool with parts of the stool bent around electrical conduit. Both officers are quite familiar with inmate and state situation was completely out of character.

Inmate was called to his cell; he was observed by officers to be "acting strange"; making nonsensical gestures toward other inmates, was disoriented, and was shouting statements such as "there's a whole lotta trouble going on" and "I've found something," while pointing at the toilet. When asked by officers if he was feeling suicidal, he indicated he was. Inmate was moved to segregation and placed on 15 minute observation status.

Throughout remainder of evening, officers observed inmate to be naked, standing at bars, squatting at bars, laying down (under bunk, on top of bunk).

Day 2

Observation logs indicate that inmate did not sleep during the night. At 1100 hours, inmate was observed to be more agitated, loud and disruptive.

When asked to comply with UA sample to rule out drugs as the cause of inmate's bizarre behavior, inmate dipped the UA container in the commode and drank from it. Inmate was babbling incoherently.

Inmate was moved to a quiet cell where he was observed to be walking around talking, standing and talking, talking to himself, talking about outer space people. Inmate observed to be pounding on bars and cell door. At 1943 hours staff observed inmate to be in possession of a pen and that he was sticking it in his nostrils. Staff ordered him to cooperate with them, he refused several orders to allow them to handcuff him and at one point he attempted to hold his mattress up against the cell door. After several more orders, the officer ordered the use of a chemical agent; a one second burst of "Freeze Plus P" was sprayed into the cell at which

time officers entered with a shield and after a brief struggle were able to handcuff the inmate. Inmate was taken to the shower and then placed on a 4 point restraint board due to his continued aggressive behavior. He remained on the board for approximately two hours. Inmate was moved back to the quiet cell and throughout the rest of that evening and into the early a.m., inmate was observed to be talking about God, standing, talking to the toilet, pacing.

Day 3

Inmate was seen by the psychologist at 1420 hours who attempted to get inmate to sign voluntarily to go to the mental health unit. At this time the psychologist observed the inmate given food and then he placed the food on his mattress and then turned the mattress over. He continued to talk nonsense. The psychologist report indicates that " the inmate appears to be psychotic based on his posturing, staring, not communicating and nonsense talk."

At 1445 hours staff suspected inmate to be in possession of some plastic eating utensils. Officers ordered inmate to be handcuffed and allow his cell to be searched. Inmate refused and was described by staff to be taking "menacing stances." Officers then ordered the use of a chemical agent, discharging a one second burst of "Freeze Plus P" into the cell. Inmate then laid on the floor, staff entered and handcuffed inmate. He was not resistant. Staff took him to the shower and then searched his cell and thoroughly cleaned and scrubbed the cell.

In the afternoon, and into the evening the observation logs indicate the inmate was masturbating, standing, singing, drinking toilet water, dancing, crawling, pacing and licking toilet bowl.

Day 4

Inmate is seen again by the psychologist whose records indicate the inmate was standing in his cell, raising his arms and reciting the alphabet. The records indicate the psychologist repeatedly told the inmate he wanted to help him and have him go to the treatment unit where he could get some help. The inmate made no attempt to recognize the psychologist nor did he comment or respond in any way to these statements.

Other notes indicate inmate observed to be laying supine on bunk with bunk brace between teeth, growling,masturbating, and digitally stimulating anus. Staff state behavior continues to be inappropriate.

Inmate does not acknowledge wanting water turned on. Inmate throws food on floor and semen and eats from the floor. Inmate only drinking from the toilet.

Throughout this day, observation logs indicate inmate was standing, drinking from the toilet, playing in the toilet, talking to self, jumping, laying on his food, howling, masturbating, putting fingers in rectum then sucking fingers, slapping the walls, scraping the walls, yelling, kneeling with his face in the toilet screaming, laying, sitting in the corner. This type of behavior continues throughout the night.

Day 5

Inmate continues to be observed to hiding under the bed, sliding on the floor and food, masturbating, urinating on himself, playing in the toilet, peeling and eating dried paint on the walls, crawling on the floor in food and urine, talking to himself and masturbating.

The psychologist saw the inmate again in the afternoon. Records indicate he was observed to be sliding around on the floor on his back, naked. Occasionally he came to the bars, but only for a few seconds. Again he was told by the psychologist that he wanted to help him and transfer him. He responded by putting his hand into the toilet in the urine and feces. He did not speak or respond. He was breathing hard and fast.

At 2215 hours inmate was observed to be laying on the floor. No movement or activity was observed during the rest of the evening or early a.m.

Day 6

At 0745 hours the inmate was observed to be laying on the floor. At 0830 hours he was observed to be pounding. Other observations this day indicate the inmate was sleeping or laying.

Other records indicate that a 72 hour hold was signed in the morning to transfer the inmate to the mental health unit. The following reasons were cited for this hold:

1. The risk of head injury from sliding on cell floor or falling from bunk.

2. The risk of high stroke based on unit opinion that inmate had high blood pressure and was not taking his medication.

At approximately 1540 hours staff were going to shower and prepare the inmate for the transfer. They were unable to open the cell as the inmate had been laying on the cell floor in front of the door for many hours blocking the entrance to the cell. When they were able to force the door open, they discovered that the inmate was dead. No resuscitation efforts were made because they were unable to find a pulse, inmate was cold to the touch as was stiff.

The Medical Examiner documented the cause of death as follows:

1. Acute Suppurative Peritonitis due to:

2. Perforated Gastric Ulcer.

Manner of death: Natural

Minnesota Department of Corrections

Office of the Commissioner

November 15, 1994

Patricia Seleen
Ombudsman for Corrections
1885 University Avenue, Suite 395
St. Paul, Minnesota 55104

Dear Ms. Seleen:

This letter is the Minnesota Department of Corrections' response to "Critical Report 94-1, Investigation [redacted]" The purpose of our response is threefold. First, although the department continuously seeks system improvements, we strongly support the conclusions of the thorough investigations conducted by independent agencies and our department. Second, we want to ensure that you are aware of the changes that have been and will be made as a result of our investigation into [redacted] death. Finally, we have some general concerns about this report and the way in which it was developed. As we have discussed with you, because this matter is the subject of litigation, it is the opinion of the attorney general's office that it is not in the best legal interest of the state to refute specific allegations and opinions contained in the report.

As you know, an internal investigation was conducted immediately after [redacted]s death. Our investigation revealed that [redacted]'s death was caused by an infection which resulted from a perforated gastric ulcer and not from any wrongdoing by facility staff. This conclusion is supported by the report issued by the Ramsey County Medical Examiner's Office and by investigations conducted by the Washington County Sheriff's Office and the Washington County Attorney's Office, all of which determined that [redacted] died of natural causes and not as a result of wrongdoing by staff.

After our investigation, the administration at the [redacted] facility determined that there were a number of changes they believed should be made. Since that time, th[redacted]r facility has made physical plant changes in the segregation unit which improve observation and monitoring capabilities in the observation cells. The management at the [redacted] facility has taken corrective personnel actions with certain employees who were involved in the incident, and reviewed and revised the [redacted] facility policies on inmate discipline and the use of the restraint board. The warden and his staff at [redacted] are to be commended for their prompt and thorough handling of this incident and the actions they have taken in response to it.

At a broader level, the institutions division is in the process of reviewing, among others, its policies on restraining inmates. In addition, the appropriate agencies have agreed to assist us in a review of programming for mentally ill inmates. This interagency group, which includes staff from our department, the department of human services, and the attorney general's office, will review our policies and make recommendations to Deputy Commissioner Bruton about improvements in this area. We are confident that all of these steps will significantly improve our ability to respond to

mental health emergencies such as the one that occurred with [redacted], and the routine programming needs of inmates who suffer from mental illness.

Historically, our department has cultivated and maintained a very positive working relationship with the office of the ombudsman for corrections. We have consistently taken seriously any observations and recommendations the ombudsman's office has made. Our agency is concerned that the process of this investigation and the development of this report prior to any discussion of your findings and recommendations with our department are unprecedented. The report title itself clearly sets a tone that the report's purpose is to be critical. We have long relied on the ombudsman's office to make constructive recommendations which help maintain our nationally recognized reputation as an outstanding corrections department. We hope this investigation and report do not signal a change in the level of credibility, trust and professional communication between the department of corrections and the ombudsman's office.

We are also concerned that the report includes what appear to be legal conclusions. The conclusions are apparently based on the information gathered in the investigation and an interpretation of the legal standards which are used by courts to determine liability in situations dealing with the handling of mentally ill inmates. There is, however, no comprehensive analysis of the facts in light of the standards which a court would do before issuing any legal conclusions. There are simply legal conclusions with which we strongly disagree and which we believe are beyond the scope of the ombudsman's authority.

Finally, although the title of the report indicates it is about the death of [redacted] which is one incident that involved one facility and one program at a second facility, the conclusions and recommendations suggest a need for systemic changes to the policies and practices in the entire department. As indicated earlier, the [redacted] facility has responded to the incident by taking corrective actions, and institution division policies regarding transfers to the mental health unit are being reviewed. The findings from an investigation of a single incident do not provide adequate basis for the broad and sweeping conclusions and recommendations made in this report.

Our department has always been, and will continue to be, committed to the ongoing evaluation of our programs and practices. Be assured that we will seriously consider the recommendations from your report.

Sincerely,

Frank W. Wood
Commissioner

FWW:jw

On September 14, 1995 the Commissioner of Corrections released the following report:

MENTAL HEALTH SERVICES
FOR ADULT INMATES
IN MINNESOTA CORRECTIONAL FACILITIES

In a letter to the Ombudsman dated August 23, 1995, Deputy Commissioner Bruton indicated that this report is the Department of Corrections reponse to the Ombudsman's investigative reports.

A copy of this report is available upon request.

STATE OF MINNESOTA
OMBUDSMAN for CORRECTIONS
1885 UNIVERSITY AVENUE, SUITE 395
SAINT PAUL, MINNESOTA 55104
(612) 643-3656

September 27, 1995

Commissioner Wood
Department of Corrections
1450 Energy Park Drive, Suite 200
St. Paul, MN 55104

Dear Commissioner Wood:

I have had a chance to review the ***MENTAL HEALTH SERVICES FOR ADULT INMATES IN MINNESOTA CORRECTIONAL FACILTIES*** Report. It is my understanding that this report is your response to my investigative reports 94-1 and 94-2 issued to you on August 9, 1994.

Thank you for your attention to the many issues I raised in my reports. I am satisfied that you and your staff have taken the concerns seriously and are addressing the problems related to inmates with mental illness in the correctional facilities. I look forward to information on the implementation of the recommendations made in this report.

After receiving your final response to my draft investigative reports I finalized the reports. I have enclosed the final reports.

Sincerely,

Patricia Seleen

Patricia Seleen
Ombudsman for Corrections

Enclosures

cc: Chief of Staff, Morrie Anderson
Deputy Commissioner Bruton

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