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OFFICE OF THE COMMONWEALTH'S ATTORNEY
CITY OF PORTSMOUTH

Report of Investigation

In-Custody Death of Jamycheal Mitchell

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REPORT OF INVESTIGATION – IN CUSTODY DEATH OF JAMYCHEAL MITCHELL

On April 22, 2015, Jamycheal Mitchell was arrested at the 7-11 located at 3201 George Washington Highway in the city of Portsmouth for alleged trespass and petit larceny. Mr. Mitchell was booked into the Portsmouth City Jail (hereinafter PCJ) that night and eventually transferred to the Hampton Roads Regional Jail (hereinafter HRRJ) on May 11, 2015. Mr. Mitchell was found deceased in his cell at HRRJ in the early morning hours of August 19, 2015. After his death, allegations arose that during his incarceration, Mr. Mitchell was allowed to live in substandard conditions, physically assaulted, and denied meals by HRRJ correctional officers. HRRJ's medical services provider during Mr. Mitchell's incarceration, NaphCare, Inc., was also alleged to have neglected Mr. Mitchell by providing substandard medical and mental health care.

On May 10, 2016, our office requested that the Virginia State Police (hereinafter "VSP") conduct a criminal investigation into the circumstances of Mr. Mitchell's death. On August 30, 2016, VSP delivered the initial results of their investigation to our office, which included, among other things, various investigative reports, Mr. Mitchell's medical records, various witness statements, and the medical examiner's report in this matter. On September 13, 2016, our office requested that VSP interview eleven additional correctional officers who were alleged to have exhibited potential criminal behavior toward Mr. Mitchell. The results of that supplemental investigation were delivered to our office on November 18, 2016.

After reviewing the results of the first supplemental investigation, our office further requested that VSP interview several other correctional officers, as well as that NaphCare make a list of employees available for interview. VSP produced a second supplemental report of investigation to our office on December 1, 2016.

Our office began an internal review of the initial investigative materials and two

supplemental reports submitted to us by VSP. On March 17, 2017, representatives from our office met with Mr. Mitchell's attorney and family members, who at that time examined Mr. Mitchell's signatures on certain NaphCare records and claimed that they were forgeries. On the same day, our office reached out to VSP to request that they re-open their investigation to formally interview several family members about Mr. Mitchell's signatures, to interview employees alleged to have obtained Mr. Mitchell's signature, and to consider consulting a handwriting analyst to evaluate the claim of forgery. We additionally submitted two anonymous letters to VSP that had been sent to our office with allegations regarding conduct by specific correctional officers toward Mr. Mitchell. We requested that VSP attempt to identify and interview the author of the letters, as well as to interview the correctional officers named therein. On June 6, 2017, VSP produced a third supplemental report of investigation to our office based on these inquiries. The third supplemental investigation ended VSP's investigative tasks on this case.[1]

Because NaphCare had previously declined to make its employees available for full interviews when approached by VSP, our office attempted on May 24, 2017 to empanel a special grand jury to investigate their treatment of Mr. Mitchell. Our motion to empanel a special grand jury was denied on May 26, 2017. However, NaphCare indicated it would cooperate by voluntarily producing 22 employees to our office for interviews. Between June 7, 2017 and January 10, 2019, our office attempted to interview the 22 requested NaphCare employees. NaphCare's attorneys produced 14 of the requested individuals for interviews.

Various correctional officers of different ranks encountered Mr. Mitchell at HRRJ. Similarly, numerous NaphCare employees with different job titles and duties observed Mr.

[1] After a February 5, 2019 request by our office's investigator, the Portsmouth Sheriff's Department produced additional records pertaining to Mr. Mitchell's incarceration on February 13, 2019. These records contained additional documents not previously obtained by VSP that were generated by PCJ and PCJ's medical services provider, Correct Care Solutions.

Mitchell and/or attempted to provide him with services. Several individuals incarcerated at HRRJ also made allegations about Mr. Mitchell's treatment during his incarceration. These individuals' identities have been redacted for their privacy.

To prepare this report, we consulted the Virginia Code, its annotations, relevant case law on the potential crimes that could be charged, and NaphCare's then-existing healthcare policies and procedures. This report is based upon a review conducted by our office of 2,000+ pages of records, 47 discs containing over 50 hours of audio and video, and numerous in-person interviews conducted by Portsmouth Commonwealth's Attorney's Office investigators. We are still missing a great deal of information, but in the interest of making what happened to Jamycheal available to the public and seeking change in his memory to ensure this never happens again, we are electing to issue this report, along with its recommendations, at this time.

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I. Chronology of Jamycheal Mitchell's Incarceration

This office has reviewed various records related to Mr. Mitchell's contacts with Portsmouth Police, Maryview Medical Center (hereinafter "Maryview"), PCJ, and HRRJ. The records consist of Portsmouth Police reports on Mr. Mitchell's temporary detention order and later misdemeanor arrest, Portsmouth General District Court records, medical records from Maryview, and intake and medical documents from PCJ and HRRJ. The medical service provider for PCJ during Mr. Mitchell's incarceration was Correct Care Solutions. As previously mentioned, the medical service provider for HRRJ was NaphCare, Inc.

This timeline of Mr. Mitchell's incarceration has been compiled gradually from the following records: Portsmouth Police reports, Portsmouth General District Court records, Portsmouth City Jail records, NaphCare medical records, and HRRJ records. The relevant PCJ records are identified individually within the following chronology due to Mr. Mitchell's limited (19-day) stay there. The relevant NaphCare records are Mr. Mitchell's chart notes, intake screening documents, the various forms generated to document his refusals of medication and treatment, and the mental health director's close observation logs. The relevant HRRJ records include Behavior/Suicide Watch Reports, Daily Confinement Records, and Feeding Rosters. These forms are all handwritten by correctional officers, and they purport to detail Mr. Mitchell's food, medication delivery, and showering history.

The Behavior/Suicide Watch reports contain sections of 15-minute intervals at which officers were to write down their observations of Mr. Mitchell, as well as a section where officers were to indicate whether Mr. Mitchell had not consumed breakfast, lunch, or dinner. The Behavior/Suicide Watch reports contain a section where officers were to indicate when medications were taken or not taken. Any observations about whether Mr. Mitchell actually

ingested food or medication are contained solely on the Behavior/Suicide Watch reports, and not on the Daily Confinement Records or Feeding Rosters.

The Daily Confinement Records contain blocks for breakfast, lunch, and dinner in which officers were to write the time that meals were provided to Mr. Mitchell. All of the Daily Confinement Records are signed off on by a supervising sergeant. Each daily confinement record indicates that Mr. Mitchell's "Weight In" (his weight when he was booked into HRRJ) was 190 pounds.

The Daily Confinement Records allege that Mr. Mitchell refused the opportunity to have recreation on multiple occasions between May 11, 2015 and August 19, 2015, and there is no indication that Mr. Mitchell ever had recreation time between May 11 and August 19. According to HRRJ records, recreation was offered to incarcerated persons daily, except when the jail was on lockdown for sanitation or other security reasons.

The Daily Confinement Records also allege that Mr. Mitchell never made a phone call between May 11 and August 19, and that he refused the opportunity to make a phone call on multiple occasions. A separate visitation list alleges that Mr. Mitchell two approved individuals on the list, but that he had no visitors between May 11 and August 19. The forms allege that Mr. Mitchell was afforded a medical visit every day between May 11 and August 19, except that he did not have a visit on the evening of August 3.

The Feeding Rosters contain check boxes that officers were to fill in when Mr. Mitchell was served a meal. HRRJ only produced feeding rosters from mid-July 2015 on. Neither the Daily Confinement Records nor the Feeding Rosters required officers to specify whether 1) the incarcerated person was observed ingesting food or medication, or 2) the incarcerated person was merely provided with food or medication.

April 7, 2015

Portsmouth Police were dispatched to the 900 block of Centre Avenue in Portsmouth, where they made contact with a mental health worker who informed them of unusual circumstances involving Mr. Mitchell. The worker stated that Mr. Mitchell needed to be taken to Maryview. Police located Mr. Mitchell, who told them he had not slept in four days and then became agitated and refused to tell police any further information. Mr. Mitchell's mother was contacted, and according to police records, she stated that Mr. Mitchell had not slept in four days, was stealing things, and had not taken his prescription medication (Haldol) in 7 months. According to the records, Mr. Mitchell's mother stated that Mr. Mitchell had lost weight in the past few days due to not eating. Mr. Mitchell then purportedly told police he didn't like taking his medication because it made him feel bad.

Mr. Mitchell was admitted to Maryview pursuant to a Temporary Detention Order.[2] The Maryview doctor's admission notes reflect that Mr. Mitchell had a history of schizoaffective disorder and had not been taking his medications for the last seven months. The doctor noted that Mr. Mitchell had been diagnosed with schizophrenia and bipolar disorder, and that his last of his multiple admissions to psychiatric units was in 2012. The doctor noted that Mr. Mitchell would likely need to be court-ordered to receive medications, as he was unable to understand and cooperate with the doctor.

[2] Va. Code § 37.2-809(B) provides the following procedure for obtaining a temporary detention order: "A magistrate shall issue, upon the sworn petition of any responsible person [or] treating physician . . . a temporary detention order if it appears from all evidence readily available, including any recommendation from a physician or clinical psychologist treating the person, that the person (i) has a mental illness and that there exists a substantial likelihood that, as a result of mental illness, the person will, in the near future, (a) cause serious physical harm to himself or others as evidenced by recent behavior causing, attempting, or threatening harm and other relevant information, if any, or (b) suffer serious harm due to his lack of capacity to protect himself from harm or to provide for his basic human needs; (ii) is in need of hospitalization or treatment; and (iii) is unwilling to volunteer or incapable of volunteering for hospitalization or treatment. The magistrate shall also consider, if available, (a) information provided by the person who initiated emergency custody and (b) the recommendations of any treating or examining physician licensed in Virginia either verbally or in writing prior to rendering a decision . . ."

April 10, 2015

A history and physical completed by a Maryview nurse noted that Mr. Mitchell presented "after several months of not taking medication, psychosis, insomnia, anorexia, and bizarre, dangerous behavior." The nurse listed Mr. Mitchell's weight at 72.576 kg, or 160 lbs.

April 16, 2015

Mr. Mitchell was discharged from Maryview.

April 20, 2015

A doctor from Maryview Medical Center (the same doctor who examined Mr. Mitchell on April 7, 2015) produced a discharge summary for Mr. Mitchell's stay. The doctor reported that upon Mr. Mitchell's discharge from Maryview, he was not psychotic and was capable of self-care and had the capacity to make his own decisions. The doctor noted that Mr. Mitchell had been court-ordered to take his medications, and that he had been given an antipsychotic medication (Haldol) in the form of a shot and a twice-daily oral administration. Mr. Mitchell was adamant that he was not going to take his medication after being discharged because of a fear of weight gain.

The doctor noted that Mr. Mitchell "was able to vocalize in a linear and logical fashion the pros and cons of not taking medications and an understanding that it is his right to make a bad decision if he wishes to do so." The doctor additionally stated that Mr. Mitchell "was understanding of treatment recommendations and medication management."

April 21, 2015

Mr. Mitchell was arrested for trespass at 7-11 on George Washington Highway.

April 22, 2015

Mr. Mitchell was arrested for trespass and petit larceny shortly after midnight at the 7-11 on George Washington Highway. The items allegedly stolen were snacks, included a 2-liter of

Mountain Dew ($2.29), a king size Snickers ($1.89), and a Zebra Cake ($0.75), for a pre-tax total of $4.93. According to police records, Mr. Mitchell had been banned from the 7-11 on April 21, 2015 by a Portsmouth police officer.

Mr. Mitchell was arraigned in Portsmouth General District Court later on the morning of April 22, 2015. A document contained in Mr. Mitchell's court file ("order for continued custody") reports that Mr. Mitchell received a $3,000 surety bond on the charges of Trespass and Petit Larceny. The order indicates that Mr. Mitchell's next court date was May 7, 2015. A subsequent document ("commitment order"), however, indicates that Mr. Mitchell was held without bail.

Mr. Mitchell signed a form waiving his right to be represented by a lawyer. The presiding judge made several notations on the waiver form, including "Def[endant] competent," "Def[endant] understood proceedings – did not want atty."

A Correct Care Solutions employee completed a document titled "Receiving Screening." The employee reported that Mr. Mitchell kept dozing off during the screening, repeatedly saying "I love Louisiana" and "I'm going to Maryview." The report indicates that Mr. Mitchell did not have a history of taking psychotropic medication, and that he was not currently on such medication. The report notes that Mr. Mitchell underwent psychiatric inpatient hospitalization at Maryview Hospital in April 2015. The report also indicates that Mr. Mitchell's mental state was alert and oriented, that his thought processes did not make sense, and that his affect, speech, and mood were appropriate. The form contains the following notation above the patient signature section: "I have answered all questions fully. I have been instructed on and received information on how to obtain/access medical services. I have been instructed and have received information on sexual assault awareness. I hereby give my consent for Correct Care Solutions to provide health care services." Below this section, the document contains a referral to the mental health department and

Mr. Mitchell's purported signature.

Mr. Mitchell's vital signs were also taken. He reportedly weighed 178 pounds, and his body mass index was calculated at 24.8.

A PCJ medical staff member produced a "Medical Awareness Report" for Mr. Mitchell. On the form, the box "Isolation cell **without** privileges" (emphasis in original) was checked under the heading "Housing Assignment." The end date for the conditions described in this report was designated as "Until Cleared by Mental Health." The form is signed by the PCJ Watch Commander on duty.

A Correct Care Solutions document titled "Inmate Medical Screening" was generated. Several of the documented responses claim that Mr. Mitchell indicated he had no mental health complaints, that he never had considered or attempted suicide, and that he did not presently feel harmful to himself.

A Correct Care Solutions employee generated a document titled "Inmate Mental Health Evaluation." The document indicates that Mr. Mitchell reported to have received inpatient psychiatric treatment at Maryview in the past on an unknown date. The document further indicates that Mr. Mitchell reportedly refused to say whether he had been previously prescribed mental health medication. The document appears to indicate that Mr. Mitchell reported that he received Social Security Disability Insurance due to his diagnosis with bipolar disorder. According to the document, Mr. Mitchell reported that he had not attempted self-harm in the past.

The "Inmate Mental Health Screening" lists the provider's conclusion that they were not concerned about Mr. Mitchell's ability to cope while incarcerated. The provider indicated that Mr. Mitchell's attempts to address any current mental health issues were unknown, because "client refuses/can't engage in screening process." The provider further wrote in the "Clinician

Observations" section that "client refuses to participate in screening." The provider listed Mr. Mitchell's mental status as alert, distractible, and agitated, with an elevated and irritable mood, an inappropriate affect, and pressured speech with loose associations apparent in his thought process. The provider referred Mr. Mitchell for a psychiatric follow-up on April 28, 2015.

A Correct Care Solutions "Segregation Rounds Log" indicates that Mr. Mitchell was observed by staff at 9:00 p.m. with no significant health findings or comments.

April 23, 2015

A Correct Care Solutions "Segregation Rounds Log" indicates that Mr. Mitchell was observed by staff at 9:00 p.m. with no significant health findings or comments.

April 24, 2015

A sheriff's deputy with the Portsmouth Sheriff's Office generated an "Internal Incident Report Form" dated "04/24/15" at "0610" hours. The report lists the type of incident as "Inmate wants to commit suicide." It gives the following brief description of the incident: "Inmate Mitchell, Jamycheal 4P02 states he wanted to commit suicide."

The report reads as follows: "While I was issuing cleaning equipment to 4D-Block and Lt. [redacted] was making rounds, Inmate Mitchell, Jamycheal 4P02 stated to Lt. [redacted] and myself that he wants to kill himself. Lt. [redacted] contacted medical nurse [redacted] to notified (sic) him of the situation. Inmate Mitchell, Jamycheal 4P02 was escorted off the floor by Lt. [redacted], Deputies [redacted], [redacted], [redacted], [redacted], and [redacted], to 5P03 where he was placed on a 15 minute watch by medical nurse [redacted]. Watch Commander, Lt. [redacted] notified. Medical nurse [redacted] notified. Medical 4-part completed. PSD-14 completed."

A PCJ medical staff member produced a "Medical Awareness Report" for Mr. Mitchell.

On the form, the box "Isolation cell **without** privileges" (emphasis in original) was checked under the heading "Housing Assignment." Under the "Isolation cell **without** privileges" box, the following two sub-categories are checked: "Green suicide blanket only" and "15 minute (staggered) checks with documentation. Offer water each check." The end date for the conditions described in this report was designated as "Until Cleared by Mental Health." The form is signed by the PCJ Watch Commander on duty.

A Correct Care Solutions employee generated a "Suicide Potential Screening Form" for Mr. Mitchell. The form requires the provider to make 15 assessments about the incarcerated person. Four of the assessments are highlighted as demonstrating high risk for suicide if responded to affirmatively by the inmate. The form directs the provider to notify correctional officers and Mental Health personnel if the incarcerated person responds "yes" to 4 or more of the assessments, or to any one of the "high risk" assessments. The assessments are as follows, with the high risk items bolded, including Mr. Mitchell's reported answers:

1. Has had negative/distressing telephone or personal contact with family/friend since intake to facility. (NO)
2. Lacks close family/friends in community. (YES)
3. Worried about major problems other than legal situation (terminal illness). (NO)
4. Family member or significant other has attempted or committed suicide (spouse/parent/sibling/close friend/lover). (UNK)
5. Has psychiatric history (psychotropic medication or treatment). (YES)
6. **Holds position of respect in community (professional/public official) and/or alleged crime is shocking in nature. Expresses feelings of embarrassment/shame.** (NO)
7. **Expresses thoughts about killing self.** (NO)
8. **Has a suicide plan and/or suicide instrument in possession.** (NO)
9. Has previous suicide attempt. (UNK)
10. **Expresses feelings there is nothing to look forward to in the future (feelings of helplessness and hopelessness).** (NO)
11. Shows signs of depression (crying or emotional flatness). (NO)
12. Appears overly anxious, afraid, or angry. (YES)
13. Appears to feel unusually embarrassed or ashamed. (NO)
14. Is acting and/or talking in a strange manner (cannot focus attention/hearing or seeing things not there). (YES)

15. Is this individual's first arrest? (YES)[3]

The provider indicated that Mental Health was contacted and orders were received in response to the Suicide Potential Screening.

A separate document titled "Suicide Risk Assessment Checklist" was generated, but it is blank. It contains the handwritten notation "Inmate refused/couldn't not (sic) participate in screening."

A Correct Care Solutions employee generated a document titled "Self Harm Watch/MH Observation Initial Assessment." The provider noted that "it is reported that inmate was placed on suicide watch because of suggesting that he would harm himself." The form contains the following mental status evaluation:

> Sensorium: Distractible/Poor concentration
> Behavior: Agitated
> Mood: Elevated/Irritable
> Thought Process: Disorganized/Loose Associations
> Thought Content: Delusions
> Appearance: Other (WNL)
> Speech: Pressured/Poverty
> Affect: Inappropriate
> Memory: Recent Intact/Remote Intact
> Cognitive Estimate: None listed

The provider noted that Mr. Mitchell reportedly was not on any medication and was unable to verbalize a willingness to work on maintaining safety. The provider recommended that Mr. Mitchell be referred to psychiatry. The provider noted that "It s (sic) recommended that the client remain on suicide watch. His thought processes are disorganized with loose associations. He does not respond directly to questions regarding suicidal ideations but rambles from subject to subject; he talks about having plenty of bread, getting anything he wants from Maryview which is where

[3] Despite the claim that this was Mr. Mitchell's first arrest, PCJ records suggest that Mr. Mitchell had been arrested and booked into PCJ several times before.

he needs to be now and where Bill Gates and Steve Jobs are."

A Correct Care Solutions "Segregation Rounds Log" indicates that Mr. Mitchell was observed by staff at 9:10 p.m. with no significant health findings or comments.

April 25, 2015

A PCJ medical staff member produced a "Medical Awareness Report" for Mr. Mitchell. On the form, the box "Isolation cell **without** privileges" (emphasis in original) was checked under the heading "Housing Assignment." The end date for the conditions described in this report was designated as "Until Cleared by Medical." The form is signed by the PCJ Watch Commander on duty.

A Correct Care Solutions employee generated a document titled "TB Record." The document indicates that Mr. Mitchell reportedly refused a PPD skin test to detect the presence of tuberculosis. The document contains the notation "iso no priv."

A Correct Care Solutions "Healthcare Request" form was generated for Mr. Mitchell in regard to his "cracked feet." The form indicates "cannot sign" in the patient signature area, and reports that Mr. Mitchell was seen in response to this request.

A Correct Care Solutions "Segregation Rounds Log" indicates that Mr. Mitchell was observed by staff at 9:00 p.m. with no significant health findings or comments.

April 26, 2015

A Correct Care Solutions "Segregation Rounds Log" indicates that Mr. Mitchell was observed by staff at 10:00 p.m. with no significant health findings or comments. The form lists vital signs, including a weight of 178 lbs.

April 27, 2015

A Correct Care Solutions "Segregation Rounds Log" indicates that Mr. Mitchell was

observed by staff at 9:00 p.m. with no significant health findings or comments.

April 28, 2015

A Correct Care Solutions employee reported that Mr. Mitchell was prescribed several medications. The employee listed Mr. Mitchell's weight at 182 lbs.

A Correct Care Solutions "Medication Order" was entered. The order listed two medications that Mr. Mitchell was to receive for 60 days, and two that were to be administered once immediately. A copy of the handwritten medication order is included in the records. A separate Correct Care Solutions "Medication Order" was indicating that Mr. Mitchell was to receive one medication for two days.

A Correct Care Solutions document titled "Order Record History" indicates that an order was entered for Mr. Mitchell to receive an injection of two different medications. The same "Order Record History" reports the status of the two injections was "Not Given," but in a subsequent note, the two injections were reported as "administered at 04/28/2015 12:02."

A Correct Care Solutions employee generated a form titled "Behavioral Health Psychiatric Provider Initial Evaluation." The form contains the handwritten notation that "Pt seen today for visit Very Psychotic – delusional (illegible)." In a section titled "Current Psychotropic Medications," the provider notes that Mr. Mitchell apparently refused one of the medications. The provider's mental status exam of Mr. Mitchell contains twelve individual sections of boxes to check, all of which are empty. The document contains an illegible diagnosis and a reference to two medications Mr. Mitchell had been prescribed. It also contains an illegible follow up date.

A Correct Care Solutions form titled "Mental Health Weekly Segregation Rounds Form" was generated. The form indicates that Mr. Mitchell's affect was euphoric, that his mood was agitated, and that his cognition was marked by hallucinations and delusions. The form indicates

that Mr. Mitchell was compliant with his psychotropic medications, and that his cell was clean.

A Correct Care Solutions "Segregation Rounds Log" indicates that Mr. Mitchell was observed by staff at 9:00 p.m. with no significant health findings or comments.

April 29, 2015

Mr. Mitchell appeared in Portsmouth General District Court. A court document ("order for continued custody") indicates that Mr. Mitchell was held without bond, and that his next court hearing was May 29, 2015.

A sheriff's deputy with the Portsmouth Sheriff's Office generated an "Internal Incident Report Form" dated "04/29/15" at "1041" hours. The report lists the type of incident as "Inmate Refused to Remove Jumper." It gives the following brief description of the incident: "Inmate Mitchel (sic), Jamycheal Refused To Give Up His Jumper And Shower Shoes."

The report stated that Mr. Mitchell returned from court and was escorted to the 5th floor of the Portsmouth City Jail by three deputies. The reporting deputy wrote that "[o]nce Mr. Mitchell enter (sic) his cell he stated 'I am not getting naked again.'" The reporting deputy wrote that he then called for the Watch Commander to come up to the 5th floor of the jail. The deputy wrote that the watch commander apparently tried to talk with Mr. Mitchell, but that Mr. Mitchell still refused to give up his jail jumper and shoes.

The reporting deputy wrote that the watch commander along with three other sheriff's deputies "enter[ed] the cell and did a escorted (sic) to a take down on Inmate Mitchell. The Jumper and shower Shoes were removed at that time." The deputy reported that a nurse went to the 5th floor at 11:08 a.m. to check on Mr. Mitchell, and that the nurse 'cleared' Mr. Mitchell.

An "Incident Report" was also generated by an unknown PCJ staff member. This form contains a heading directing the writer to "[d]escribe [the] incident fully and indicate rule(s)

violated." The reporting officer related the same narrative as was contained in the "Internal Incident Report Form." However, at the end of the narrative, the reporting deputy wrote that "Inmate Mitchell, Jamycheal 5P03 is being charged with the following violations: Major Violation: 117: Reusing (sic) to obey the direct order of a security staff member. Minor Violation: 204: Disruptive behavior."

The "Incident Report" form prompts the writer to indicate whether they feel that the incident warrants disciplinary action. On this form, the "Yes" box is checked. The "Incident Report" form then prompts the writer to indicate the desired procedure by which to discipline the incarcerated person. The options for discipline include "Verbal reprimand only. (Have violator sign below)," "Verbal reprimand and the following disciplinary action: (Have violator sign below)," and "Request formal disciplinary hearing of the Adjustment Committee." The box is checked next to the latter two options.

In the space beneath the section marked "Verbal reprimand and the following disciplinary action," the following handwritten notation appears: "Loss of all earned good time[4] and cell restriction without privileges for each Major and 15 days for each minor charge for a total of 45 days." A sergeant's handwritten signature appears next to this handwritten disciplinary request.

Below the request for discipline, the "Incident Report" form contains two sections for the incarcerated person to read and sign. The two sections allow the incarcerated person to choose whether they do or do not accept the recommended discipline. Those two sections are not filled out, and they do not contain Mr. Mitchell's signature. Below the two sections for the incarcerated person to sign is a line for the "Chief Correctional Officer / Sheriff" to sign. That line bears the

[4] Under Virginia's statutory "good time" scheme, which is outlined in Va. Code § 53.1-201 and related sections, incarcerated persons serving misdemeanor sentences generally are only required to serve half of their sentence. The statutory scheme allows jail officials the discretion to determine whether inmates receive good time credits based upon their disciplinary record for alleged misconduct.

signature of a PCJ major.

A Correct Care Solutions document titled "Order Record History," which contains information related to the administration two medications for this date, contains the status "Refused" along with the text "dw" at 8:00 a.m.

A Correct Care Solutions "Segregation Rounds Log" indicates that Mr. Mitchell was observed by staff at 9:00 p.m. with no significant health findings or comments.

April 30, 2015

An unknown PCJ employee from the Classification Division generated a notification that was addressed to Mr. Mitchell. The notification stated that "YOU HAVE BEEN TENTATIVELY SCHEDLED TO APPEAR BEFORE THE ADJUSTMENT COMMITTEE REGARDING **PSD-10** (emphasis in original) WRITTEN BY: DEP. [redacted] ON 04-29-15. YOUR HEARING IS SCHEDULED FOR: 05-07-15." This notification is typewritten, but it contains a handwritten notification in one corner that reads "5-7-15 unable conduct hearing Inmate's mental status."

A Correct Care Solutions employee generated a form titled "Refusal of Treatment." The form indicates that Mr. Mitchell allegedly refused his medication at 8:45 a.m. It contains a section for the employee to indicate the reason for refusal, and whether the potential consequences were explained to the incarcerated person. The "reason for refusal" section contains a handwritten notation "D/W." A box is checked indicating that the employee apparently explained to Mr. Mitchell that his medical conditions could worsen as a consequence of the refusal of the medication.

Below the section regarding potential consequences of refusal, the form contains the following statement: "I acknowledge that I have been fully informed of and understand the above refused treatment and the risks involved in refusing. I hereby release and agree to hold harmless

CCS and correctional personnel from all responsibility and any ill effects which may result from this refusal. I have read this form and certify that I understand its contents." The form is signed by two witnesses, with the notation "LPN/(illegible)" appearing next to one of the signatures. The handwritten notation "RTS" appears on the "Inmate Signature" line.

A Correct Care Solutions employee generated a document titled "Self Harm Watch/MH Observation Follow-Up Note." The form contains the following mental status evaluation:

Sensorium: Distractible/Poor concentration
Behavior: Agitated
Mood: Elevated/Irritable
Thought Process: Disorganized
Thought Content: Undetermined
Appearance: Other (Safety Blanket)
Speech: Pressured/Poverty
Affect: Inappropriate
Memory: Impaired
Cognitive Estimate: Undetermined

The provider noted that Mr. Mitchell reportedly did not report a current suicidal ideation. The provider reported that Mr. Mitchell continued to be psychotic, that his thoughts were very disorganized, and that the provider attempted "supportive contact" as an intervention. The provider recommended that Mr. Mitchell be continued on watch status with daily follow-up.

A Correct Care Solutions document titled "Order Record History," which contains information related to the administration one medication for this date, contains the status "Refused" along with the text "DW" at 8:00 a.m.

A Correct Care Solutions "Segregation Rounds Log" indicates that Mr. Mitchell was observed by staff at 9:00 p.m. with no significant health findings or comments.

May 1, 2015

A Correct Care Solutions employee generated a form titled "Refusal of Treatment" that is identical to the form generated on April 30, 2015. The form indicates that Mr. Mitchell allegedly

refused his medication at 8:00 a.m. The "reason for refusal" section contains a handwritten notation reading "AM Meds." A box is checked indicating that the employee apparently explained to Mr. Mitchell that his medical conditions could worsen as a consequence of the refusal of the medication. The form is signed by two witnesses, and the handwritten notation "Rts" appears on the "Inmate Signature" line.

A Correct Care Solutions document titled "Order Record History" lists, under the sub-heading "Medication Orders," that Mr. Mitchell was reportedly given[5] two medications at 9:00 p.m. According to the document, Mr. Mitchell reportedly refused the same two medications at 8:00 a.m. The "Notes" section of the same "Order Record History" contains the status "Refused" along with the text "dw" at 8:00 a.m.

A Correct Care Solutions "Segregation Rounds Log" indicates that Mr. Mitchell was observed by staff at 9:00 p.m. with no significant health findings or comments.

May 2, 2015

A Correct Care Solutions document titled "Order Record History" lists, under the sub-heading "Medication Orders," that Mr. Mitchell was reportedly given two medications at 8:00 a.m. and 9:00 p.m.

A Correct Care Solutions "Segregation Rounds Log" indicates that Mr. Mitchell was observed by staff at 9:00 p.m. with no significant health findings or comments.

May 3, 2015

A Correct Care Solutions employee generated a form titled "Refusal of Treatment" that is identical to the form generated on April 30, 2015. The form indicates that Mr. Mitchell allegedly refused his medication at 8:00 a.m. The "reason for refusal" section contains a handwritten

[5] The records do not specify whether Mr. Mitchell was observed ingesting and swallowing the medication.

notation reading "AM Meds." A box is checked indicating that the employee apparently explained to Mr. Mitchell that his medical conditions could worsen as a consequence of the refusal of the medication. The form is signed by two witnesses, and the handwritten notation "Rts" appears on the "Inmate Signature" line.

A Correct Care Solutions document titled "Order Record History" lists, under the sub-heading "Medication Orders," that Mr. Mitchell was reportedly given two medications at 9:00 p.m. According to the document, Mr. Mitchell reportedly refused the same two medications at 8:00 a.m. The "Notes" section of the same "Order Record History" contains the status "Refused" along with the text "dw" at 8:00 a.m.

A Correct Care Solutions "Segregation Rounds Log" indicates that Mr. Mitchell was observed by staff at 10:00 p.m. with no significant health findings or comments. The form lists vital signs, including an illegible weight.

May 4, 2015

A Correct Care Solutions employee generated a document titled "Medical History and Physical Assessment with Mental Health." The document indicates that Mr. Mitchell reportedly claimed to suffer from asthma, and that he refused an assessment of his vision. An employee wrote that Mr. Mitchell "has been on suicide precautions since 4/25/15. Able to answer some questions, but had inappropriate (sic) and/or did not respond to other questions." The document indicates that Mr. Mitchell reportedly refused to respond to questions about whether he had ever attempted or recently considered attempting suicide. The document indicates that Mr. Mitchell was prescribed two psychotropic medications by a Correct Care Solutions employee beginning on April 28, 2015. Mr. Mitchell reportedly refused to answer a question about the last time he had been psychiatrically hospitalized.

The document described Mr. Mitchell as being disoriented and appearing disheveled, having an inappropriate affect, demonstrating an elated mood with loud speech, and that he was unable to sit still or demonstrate a thought process that made sense. The document concluded that Mr. Mitchell had mental health problems requiring routine follow-up, and that he required a mental health referral as soon as possible due to suicide precaution procedures.

A Correct Care Solutions employee took Mr. Mitchell's blood pressure, pulse, respiratory rate, weight, and body mass index. Mr. Mitchell's weight was reported at 186 lbs., and his body mass index was reported at 25.9.

A Correct Care Solutions document titled "Order Record History" lists, under the sub-heading "Medication Orders," that Mr. Mitchell was reportedly given two medications at 9:00 p.m. According to the document, Mr. Mitchell reportedly refused the same two medications at 8:00 a.m. The "Notes" section of the same "Order Record History" contains the status "Refused" along with the text "dw" at 8:00 a.m.

A Correct Care Solutions "Segregation Rounds Log" indicates that Mr. Mitchell was observed by staff at 9:00 p.m. with no significant health findings or comments.

May 5, 2015

As part of the documentation of Mr. Mitchell's transfer from PCJ to HRRJ, a Correct Care Solutions employee took Mr. Mitchell's blood pressure, pulse, respiratory rate, temperature, weight, and body mass index. Mr. Mitchell's weight was reported at 182 lbs., and his body mass index was reported at 25.4.

A sheriff's deputy with the Portsmouth Sheriff's Office generated an "Internal Incident Report Form" dated "05-05-15" at "0025" hours. The report lists the type of incident as "Inmate refused to return jumper and shoes." It gives the following brief description of the incident:

"Inmate Mitchell, Jamycheal (5P03) refused to return his jumper, socks and shoes back to Deputies."

According to the report, Mr. Mitchell was placed back in his cell by two deputies after returning from showering in the basement. Deputies instructed Mr. Mitchell to return his jumper, socks, and shoes, but Mr. Mitchell apparently refused. The watch commanders on Mr. Mitchell's floor were notified, and Mr. Mitchell still allegedly refused to give up his jumper, shoes, and socks. The reporting deputy wrote that the door to Mr. Mitchell's cell was opened, and that the two watch commanders entered along with two other sheriff's deputies. The report further stated that Mr. Mitchell was taken to the floor by one deputy as the watch commanders followed behind. The report stated that Mr. Mitchell's jumper, socks, and shoes were removed and put in Mr. Mitchell's storage bag. According to the report, a nurse was notified of the incident. The nurse assessed Mr. Mitchell shortly after the deputies removed Mr. Mitchell's items, and the nurse reported that no physical harm had been caused to Mr. Mitchell.

An "Incident Report" was also generated by an unknown PCJ staff member. The form contains a heading directing the writer to "[d]escribe [the] incident fully and indicate rule(s) violated." The reporting officer related the same narrative as was contained in the "Internal Incident Report Form." However, at the end of the narrative, the reporting officer wrote that "Inmate Mitchell, Jamycheal 5P03 is being charged with the following major violation. 117: Refusing to obey the direct order of a security staff member."

The "Incident Report" form prompts the writer to indicate whether they feel that the incident warrants disciplinary action. The "Yes" box is checked in response to this question. The "Incident Report" form then prompts the writer to indicate the desired procedure by which to discipline the incarcerated person. The options for discipline include "Verbal reprimand only.

(Have violator sign below)," "Verbal reprimand and the following disciplinary action: (Have violator sign below)," and "Request formal disciplinary hearing of the Adjustment Committee." The box is checked next to the latter two options.

In the space beneath the section marked "Verbal reprimand and the following disciplinary action," the following handwritten notation appears: "Loss of all earned good time and cell restriction without privileges for 30 days." A sergeant's handwritten signature appears next to this handwritten disciplinary request.

Below the request for discipline, the "Incident Report" form contains two sections for the incarcerated person to read and sign. The two sections allow the incarcerated person to choose whether they do or do not accept the recommended discipline. Those two sections are not filled out, and they do not contain Mr. Mitchell's signature. Below the two sections for the incarcerated person to sign is a line for the "Chief Correctional Officer / Sheriff" to sign. That line bears an illegible signature.

An unknown PCJ employee from the Classification Division generated a notification that was addressed to Mr. Mitchell. The notification stated that "YOU HAVE BEEN TENTATIVELY SCHEDLED TO APPEAR BEFORE THE ADJUSTMENT COMMITTEE REGARDING **PSD-10** (emphasis in original) WRITTEN BY: DEP. [redacted] ON 05-05-15. YOUR HEARING IS SCHEDULED FOR: 05-07-15."

A Correct Care Solutions document titled "Order Record History" lists, under the sub-heading "Medication Orders," that Mr. Mitchell was reportedly given two medications at 8:00 a.m. and 9:00 p.m. Mr. Mitchell was reportedly given a third medication for the first time at PCJ at 9:00 p.m.

A typewritten Correct Care Solutions "Medication Order" was entered. The order listed

one medication that Mr. Mitchell was to receive for 90 days. A copy of the handwritten medication order is included in the records.

A Correct Care Solutions employee generated a form titled "Behavioral Health Psychiatric Provider Follow Up Note." The form contains the handwritten notation that "Pt seen today Psychotic/Delusional (illegible) Partial Compliance." The provider's mental status exam of Mr. Mitchell noted the following. Each individual response is a box checked out of a list of several options.

Appearance: Bizarre
Speech: Pressured/Poverty
Mood: Irritable
Affect: Labile/Hostile
Thought Form: Tangential/Loose Association/Flight of Ideas
Thought Content: Delusional
Orientation: Person/Place
Intelligence: Below Average
Memory: Intact
Insight: Poor
Judgment: Poor
Behavior: Agitated

The provider made an illegible note in the 'Aims" section of the document. The provider wrote that Mr. Mitchell's response to treatment was "Non Compliant." The document contains an illegible diagnosis and a reference to two medications Mr. Mitchell had been prescribed. It also contains an illegible follow up date.

A Correct Care Solutions "Segregation Rounds Log" indicates that Mr. Mitchell was observed by staff at 9:00 p.m. with no significant health findings or comments.

May 6, 2015

A Correct Care Solutions document titled "Order Record History" lists, under the sub-heading "Medication Orders," that Mr. Mitchell was reportedly given three medications at 8:00 a.m. and 9:00 p.m.

A Correct Care Solutions employee generated a document titled "Self Harm Watch/MH Observation Follow-Up Note." The form contains the following mental status evaluation:

Sensorium: Alert/Oriented x3
Behavior: Calm
Mood: Other (WNL)
Thought Processes: Goal-Directed
Thought Content: Hallucinations/Delusions
Appearance: Self-neglect
Speech: Pressured/Poverty
Affect: Blunted
Memory: Recent Intact/Remote Intact
Cognitive Estimate: Average

The provider noted that Mr. Mitchell reportedly refused to answer questions about possible suicidal ideation. The provider reported that "Inmate continues to present as acutely psychotic – Deputies report that he goes for hours just yelling." The provider noted that Mr. Mitchell was not compliant with his medications and indicated that "supportive contact" was used as an intervention. The provider recommended that Mr. Mitchell be continued on watch status with daily follow-up, and recommended a referral to psychiatry.

A Correct Care Solutions "Segregation Rounds Log" indicates that Mr. Mitchell was observed by staff at 9:00 p.m. with no significant health findings or comments.

May 7, 2015

A form titled "Adjustment Resolution Form" was generated by an unknown PCJ employee. The form lists the major and minor disciplinary offenses that Mr. Mitchell had been charged with in reference to the April 29, 2015 allegation that he refused to give up his jumper and shower shoes. The form contains a section in which the decision of the Adjustment Committee is to be notated; however, no typewritten or handwritten notation of the decision of the Adjustment Committee appears on the form.

The form contains a space for the incarcerated person to sign and indicate whether they

agree or disagree with the Adjustment Committee's decision. There are no signatures in either space. A space containing a list of committee members contains one handwritten notation that reads "B -------." The form additionally contains two spaces for Sheriff Bill Watson to sign and indicate whether he concurred with the Adjustment Committee's decision; those spaces are blank.

A second "Adjustment Resolution Form" was generated by an unknown PCJ employee in reference to the May 5, 2015 allegation that Mr. Mitchell refused to give up his jumper, shoes, and socks. The form lists the major disciplinary offense that Mr. Mitchell had been charged with in relation to that allegation. The form contains a section in which the decision of the Adjustment Committee is to be notated; however, no typewritten or handwritten notation of the decision of the Adjustment Committee appears on the form.

The form contains a space for the incarcerated person to sign and indicate whether they agree or disagree with the Adjustment Committee's decision. There are no signatures in either space. A space containing a list of committee members contains one handwritten notation that reads "B S-------." The form additionally contains two spaces for Sheriff Bill Watson to sign and indicate whether he concurred with the Adjustment Committee's decision; those spaces are blank.

A Correct Care Solutions document titled "Order Record History" lists, under the sub-heading "Medication Orders," that Mr. Mitchell was reportedly given three medications at 8:00 a.m. and 9:00 p.m.

A Correct Care Solutions "Segregation Rounds Log" indicates that Mr. Mitchell was observed by staff at 9:00 p.m. with no significant health findings or comments.

May 8, 2015

A Correct Care Solutions employee generated a form titled "Refusal of Treatment" that is identical to the form generated on April 30, 2015. The form indicates that Mr. Mitchell allegedly

refused his medication at 8:00 a.m. The "reason for refusal" section contains a handwritten notation reading "AM Meds." A box is checked indicating that the employee apparently explained to Mr. Mitchell that his medical conditions could worsen as a consequence of the refusal of the medication. The form is signed by two witnesses, and the handwritten notation "Rts" appears on the "Inmate Signature" line.

A Correct Care Solutions employee also generated a document titled "Medical Information Transfer Form." The document indicates that Mr. Mitchell was being transferred to HRRJ. The document noted that Mr. Mitchell had been identified as requiring current medical treatment or having other special needs; namely, that he required psychotropic medication maintenance. The document indicated three psychotropic medications that Mr. Mitchell had been prescribed. The document further indicated that Mr. Mitchell required "high risk" medical treatment, referencing the alleged suicide risk. Mr. Mitchell's weight was reported at 182 lbs. in this document.

A Correct Care Solutions document titled "Order Record History" lists, under the sub-heading "Medication Orders," that Mr. Mitchell was reportedly given three medications at 9:00 p.m. According to the document, Mr. Mitchell reportedly refused the same three medications at 8:00 a.m. The "Notes" section of the same "Order Record History" contains the status "Refused" along with the text "dw" at 8:00 a.m.

A Correct Care Solutions employee generated a document titled "Self Harm Watch/MH Observation Follow-Up Note." The form contains the following mental status evaluation:

> Sensorium: Alert/Oriented x3
> Behavior: Agitated
> Mood: Elevated/Irritable
> Thought Processes: Disorganized
> Thought Content: Hallucinations/Delusions
> Appearance: Other (NA)
> Speech: Pressured/Poverty
> Affect: Constricted

Memory: Impaired
Cognitive Estimate: None listed

The provider noted that Mr. Mitchell reportedly refused to answer questions about possible suicidal ideation. The provider reported that Mr. Mitchell continued to be psychotic, that he verbalized no concerns, and that the provider attempted "supportive contact" as an intervention. The provider recommended that Mr. Mitchell be continued on watch status with daily follow-up.

A Correct Care Solutions form titled "Mental Health Weekly Segregation Rounds Form" was generated. The form indicates that Mr. Mitchell's affect was "Other: Manic," that his mood was agitated, and that his cognition was marked by hallucinations and delusions. The form indicates that Mr. Mitchell was non-compliant with his psychotropic medications, and that his cell was clean.

A Correct Care Solutions "Segregation Rounds Log" indicates that Mr. Mitchell was observed by staff at 9:00 p.m. with no significant health findings or comments.

May 9, 2015

A sheriff's deputy with the Portsmouth Sheriff's Office generated an "Internal Incident Report Form" dated "05/09/15" at "0628" hours. The report lists the type of incident as "Inmate refused to relinquish his tray and cup." It gives the following brief description of the incident: "Inmate spat on Deputy trying to recover his tray and cup, items had to be extracted from cell."

The report stated that a deputy asked Mr. Mitchell to return his tray and cup while he was making rounds to pick up breakfast trays. The reporting deputy wrote that Mr. Mitchell spat on his chest and refused to comply. The deputy wrote that he again asked Mr. Mitchell to return the tray and cup, and Mr. Mitchell reportedly called the deputy a "demon" because the deputy would not give Mr. Mitchell another tray. The reporting deputy wrote that notified the Watch Commander, who responded with four other sheriff's deputies. Mr. Mitchell reportedly still refused to give up

his tray and cup, so the watch commander and two other deputies entered Mr. Mitchell's cell, "gained control" of him, and removed the tray and cup from the cell. The reporting deputy wrote that medical staff were notified, and a nurse responded and apparently cleared Mr. Mitchell medically. The report contains a handwritten notation from the watch commander indicating that Mr. Mitchell allegedly spat on the deputy's uniform, but that the spit did not make contact with the deputy's skin.

A Correct Care Solutions employee generated a form titled "Refusal of Treatment" that is identical to the form generated on April 30, 2015. The form indicates that Mr. Mitchell allegedly refused his medication at 9:38 p.m. The "reason for refusal" section contains a handwritten notation reading "none given." A box titled "Other _____" is checked in the section that prompts the employee to indicate whether the potential consequences of refusal were explained to the incarcerated person. The line next to "Other" is blank. The form is signed by two witnesses, and the handwritten notation "Refused to sign" appears on the "Inmate Signature" line.

A Correct Care Solutions document titled "Order Record History" lists, under the sub-heading "Medication Orders," that Mr. Mitchell was reportedly given three medications at 8:00 a.m. According to the document, Mr. Mitchell reportedly refused the same three medications at 9:00 p.m. The "Notes" section of the same "Order Record History" contains the status "Refused" along with the text "i (sic) dont (sic) want it" at 9:00 p.m.

A Correct Care Solutions "Segregation Rounds Log" indicates that Mr. Mitchell was observed by staff at 9:00 p.m. with no significant health findings or comments.

May 10, 2015

A Correct Care Solutions document titled "Order Record History" lists, under the sub-heading "Medication Orders," that Mr. Mitchell reportedly refused his three medications at 8:00

a.m. and 9:00 p.m. The "Notes" section of the same "Order Record History" contains the status "Refused" along with the text "dnw" at 8:00 a.m. and "i (sic) dont (sic) want it" at 9:00 p.m.

A Correct Care Solutions "Segregation Rounds Log" indicates that Mr. Mitchell was observed by staff at 10:00 p.m. with no significant health findings or comments. The form lists vital signs, including a weight of 182 lbs.

May 11, 2015

A Correct Care Solutions document titled "Order Record History" reports, under the sub-heading "Medication Orders," that Mr. Mitchell was given three medications at 8:00 a.m.

Mr. Mitchell was later booked into HRRJ. His weight was listed at 178 lbs. on his "Receiving Screening." Mr. Mitchell was apparently presented with several "Comprehensive Nurse Exam" forms by a NaphCare employee. A section in one of the forms labeled "Consent" contains the name "Jamycheal Mitchell" in cursive, underneath the following bold text:

> I have answered all questions on the Comprehensive Nurse Exam forms truthfully to the best of my knowledge and ability. I have been told and shown how to obtain medical and mental health services. I hereby give consent for professional services to be provided to me by and through NaphCare, Inc.

The name "Jamycheal Mitchell" appears in cursive underneath the text "General Informed Consent." This signature appears to be a carbon copy of the signature appearing beneath the "Consent" section. The "General Informed Consent" section contains the following language:

> I hereby give my consent to NaphCare, Inc., its employees and agents to perform any diagnostic laboratory procedures, examinations, x-rays, oral or injected medications or other procedures recommended by the physician. I also agree to engage in consultation with a licensed professional using the telemedicine format. I know this process involves real-time audio and video technology and data may be recorded as part of the diagnostic and therapeutic process. I am aware the practice of medicine is not an exact science and I acknowledge no guarantees have been made regarding the result of treatments, consultations or examinations performed by NaphCare, Inc. I understand that I may withdraw this consent to any specific treatment by refusing the treatment or test. I sign this willingly in full understanding of the above.

The "Comprehensive Nurse Examination" forms also note that NaphCare staff attempted to perform a PPD (tuberculosis) test on Mr. Mitchell, which he allegedly refused. Mr. Mitchell was placed in segregation due to his apparent refusal of the tuberculosis test.

In the "General Mental Health Assessments" section of the forms, NaphCare staff reported that Mr. Mitchell refused to answer questions when asked to describe any abnormal thoughts he was having. In the "Additional Chronic Care History" section, NaphCare staff reported that at some point while collecting information, Mr. Mitchell refused to answer any more questions. According to their records, NaphCare staff referred Mr. Mitchell to a mental health nurse and recommended that Mr. Mitchell be placed on close observation.

Mr. Mitchell was also seen by a NaphCare-employed social worker. The social worker noted that Mr. Mitchell had been referred for a mental health evaluation by the intake nurse. The social worker reported that Mr. Mitchell was currently on psych meds, that he was transferred from PCJ on suicide watch, that he had disorganized and rambling thoughts, including frequent outbursts of laughter, and that he made many references to Louisiana. Mr. Mitchell reported no suicidal ideation to the social worker at the time, stating that "I love myself." The social worker reported Mr. Mitchell's medical history as asthmatic and "diabetic a little bit," according to Mr. Mitchell.

The social worker also completed a form detailing Mr. Mitchell's initial placement on "close observation." According to the form, close observation involved "physical checks at staggered intervals not to exceed every 15 minutes." The social worker reported that Mr. Mitchell's initial mental health evaluation was complete, and described Mr. Mitchell's demeanor as alert, oriented, and cooperative to an extent. The social worker stated that Mr. Mitchell had to be reeducated often. The social worker described Mr. Mitchell as having rambling speech and low

risk for self-harm. The social worker recommended that Mr. Mitchell be placed on close observation after having been transferred from PCJ on suicide watch.

According to the Behavior/Suicide Watch reports, a correctional officer wrote that Mr. Mitchell was observed eating dinner at 5:40 p.m. No meals are circled as having not been consumed. The section of the log labeled "Medications (Indicate the Time) Accepted and Taken _____ Not Taken _____" is blank. Various entries describe Mr. Mitchell as "talking to self," and "yelling at door."

In the Daily Confinement Record, a correctional officer wrote "NA" in the boxes for breakfast, lunch, and dinner.

Mr. Mitchell was presented with a form titled "Hampton Roads Regional Jail Medical Information." The form described medical services the jail provided at no cost, and the co-payments required for other medical services. The form contains the following language, below which appears Mr. Mitchell's purported handwritten name, his purported signature, and the signatures of two witnesses: "This information was explained to me upon admission to the Hampton Roads Regional Jail. I understand how to obtain medical services and any co-payment involved with such services."

Mr. Mitchell was presented with a form titled "Hampton Roads Regional Jail Work Program Assessment Form." Mr. Mitchell was not cleared for a work program due to his refusal of a tuberculosis test. Mr. Mitchell's purported handwritten name and signature appear at the bottom of the form. His signature purportedly appears on a form titled "Hampton Roads Regional Jail Programs Need/Assessment Form."

A "Special Needs Form" generated by medical personnel indicates that Mr. Mitchell was placed on lockdown for refusing the tuberculosis test, with the lockdown lasting until the test was

completed. A HRRJ "Incident Report" was also generated detailing Mr. Mitchell's refusal of the tuberculosis test. A nurse's note additionally indicates that Mr. Mitchell was to remain on the same mental health medication as he had at PCJ for 90 days.

May 12, 2015

Mr. Mitchell was seen by the HRRJ Mental Health Director, a NaphCare employee. The director logged a "Suicide Watch Progress Note" in which she stated that they observed Mr. Mitchell talking at his cell door, that he was cooperative, that his affect was flat, and that he was "oriented x3." Mr. Mitchell also stated that he was depressed, asked if he could get out, and then "return[ed] to rambling." The director recommended that Mr. Mitchell be continued on close observation with a 24-hour follow-up interval.

According to the Behavior/Suicide Watch reports, Mr. Mitchell was observed taking his medication at 4:36 a.m. He was observed eating a meal at 11:41 a.m. The section of the log labeled "Medications (Indicate the Time) Accepted and Taken _____ Not Taken _____" is blank. No meals are circled as having not been consumed. Various entries describe Mr. Mitchell as "banging on the door screaming" and "yelling through door." Mr. Mitchell was reported to have been asleep for approximately 3.7 hours.

In the Daily Confinement Record, a correctional officer reported that Mr. Mitchell received breakfast at 5:01 a.m., lunch at 11:41 a.m., and dinner at 4:51 p.m. Mr. Mitchell reportedly received his medication at 4:30 a.m. and 6:00 p.m. An officer reported that Mr. Mitchell showered at 7:40 a.m. The log sheet bears the signature of a supervising corrections sergeant.

NaphCare staff generated a form documenting Mr. Mitchell's alleged refusal of bloodwork. The form used is a NaphCare form titled "Release of Responsibility – Specific Procedure." The form contains the following language:

> I have hereby clearly expressed or indicated a decision to refuse to accept the following medical treatment/recommendations: (blank space)
>
> The above treatment/recommendations and the risks and benefits involved have been satisfactorily explained to me. In addition, I have had the opportunity to ask questions about the proposed recommendation and have had these answered to my satisfaction.
>
> I have decided **NOT** (emphasis in original) to accept/permit the treatment/recommendations listed above and understand that my failure to follow the advised medical treatment may seriously affect my health.
>
> By signing below, I assume responsibility for all of the risks and consequences of my refusal and hereby release and agree to hold harmless NaphCare, Inc. and its employees and agents from all responsibility and ill effect which may occur as a result of my refusal to accept/permit the proposed recommendation(s).

The form purports to contain Mr. Mitchell's signature, and it is additionally signed by one witness.

A HRRJ Incident Report for "making sexual proposals or forcible advances toward another" was generated by correctional officers when Mr. Mitchell allegedly stated to a correctional officer, "Can you suck my dick." HRRJ staff referred Mr. Mitchell to medical staff for a psychological review based upon this incident.

May 13, 2015

NaphCare staff generated two "Release of Responsibility – Specific Procedure" forms detailing two alleged attempts to provide Mr. Mitchell with medications. The forms were signed as having been witnessed by two employees. The "patient signature" line is blank on both forms.

The mental health director again saw Mr. Mitchell due to his "close observation" status. The director noted that Mr. Mitchell was cooperative, had a flat affect, and was less rambling, but not making sense. The director noted that Mr. Mitchell was "oriented x3" and recommended that Mr. Mitchell be continued on close observation with a 24-hour follow-up interval.

According to the Behavior/Suicide Watch reports, Mr. Mitchell was observed eating a meal

between 5:00 a.m. and 5:10 a.m., as well as between 5:00 p.m. and 5:15 p.m. No meals are circled as having not been consumed. The section of the log labeled "Medications (Indicate the Time) Accepted and Taken _____ Not Taken _____" is blank. Various entries describe Mr. Mitchell as "standing at door laughing," "on bunk yelling," and "screaming at mirror." Mr. Mitchell was reported to have been asleep for approximately 5.7 hours.

In the Daily Confinement Record, a correctional officer reported that Mr. Mitchell received breakfast at 4:40 a.m., lunch at 11:15 a.m., and dinner at 5:10 p.m. An officer additionally reported that Mr. Mitchell refused his medication at 4:50 a.m.

May 14, 2015

The mental health director saw Mr. Mitchell due to his "close observation" status. The director reported that she observed Mr. Mitchell talking at his cell door and described him as "minimal," having a flat affect, and "oriented x3." The director recommended that Mr. Mitchell be continued on close observation with a 24-hour follow-up interval. A nurse additionally created a medication note recommending that Mr. Mitchell's medications be administered in a crushed form. Mr. Mitchell was given crushed and floated medication. He drank the water off the top of the medication, but did not ingest the medication itself. Mr. Mitchell stuck his finger into the bottom of the cup, snorted, and said "that's good coke."

According to the Behavior/Suicide Watch reports, a correctional officer claimed they observed Mr. Mitchell eating a meal at 5:24 p.m. No meals are circled as having not been consumed. Mr. Mitchell was reported to have refused his medication at 4:55 p.m. The section of the log labeled "Medications (Indicate the Time) Accepted and Taken _____ Not Taken _____" is blank. Various entries describe Mr. Mitchell as "banging on door/screaming" and "standing at door/spitting." Mr. Mitchell was reported to have been asleep for approximately 11 hours.

In the Daily Confinement Record, a correctional officer reported that Mr. Mitchell received breakfast at 5:15 a.m., lunch at 11:20 a.m., and dinner at 5:07 p.m. An officer additionally reported that Mr. Mitchell received his medication at 4:45 a.m. An officer reported that Mr. Mitchell showered at 7:38 a.m.

May 15, 2015

NaphCare medical staff generated a "Release of Responsibility – Specific Procedure" form detailing an alleged attempt to provide Mr. Mitchell with medications. The form was signed as having been witnessed by two employees. The "patient signature" line is blank.

The mental health director reported that she saw Mr. Mitchell due to his "close observation" status. The director reported that she observed Mr. Mitchell laughing inappropriately, hollering out his cell door, having an exhilarated affect, and being "oriented x1." The director recommended that Mr. Mitchell be continued on close observation with a 24-hour follow-up interval. According to the Behavior/Suicide Watch reports, a correctional officer claimed that Mr. Mitchell was observed eating a meal at 5:24 p.m. No meals are circled as having not been consumed. Mr. Mitchell was reported to have refused his medication at 4:34 a.m. The section of the log labeled "Medications (Indicate the Time) Accepted and Taken _____ Not Taken _____" is blank. Mr. Mitchell was reported to be eating a meal at 10:35 a.m. and 5:04 p.m. Various entries describe Mr. Mitchell as "standing at the sink playing in water" and "yelling." Mr. Mitchell was reported to have been asleep for approximately 8.9 hours.

In the Daily Confinement Record, a correctional officer reported that Mr. Mitchell received breakfast at 5:15 a.m., lunch at 10:35 a.m., and dinner at 4:55 p.m. One officer additionally reported that Mr. Mitchell initially refused his medication; however, another officer reported that Mr. Mitchell was given his medication at 7:30 a.m. The same officer who initially reported Mr.

Mitchell's medication refusal later wrote that Mr. Mitchell was given medication at 4:27 p.m.

May 16, 2015

According to the Behavior/Suicide Watch reports, Mr. Mitchell was observed eating a meal at 5:32 a.m., 11:06 a.m., and 4:30 p.m. No meals are circled as having not been consumed. Mr. Mitchell was reportedly observed in the shower by a correctional officer between 7:55 a.m. and 8:06 a.m. The section of the log labeled "Medications (Indicate the Time) Accepted and Taken _____ Not Taken _____" is blank. Various entries describe Mr. Mitchell as "running from bunk to door," "laying on floor screaming," "yelling out loud at door," and "talking to himself." Mr. Mitchell was reported to have been asleep for approximately 3.9 hours.

In the Daily Confinement Record, a correctional officer reported that Mr. Mitchell received breakfast at 5:15 a.m., lunch at 11:03 a.m., and dinner at 4:25 p.m. An officer reported that Mr. Mitchell refused his medication. Mr. Mitchell was also reported to be in the shower at 7:44 a.m.

May 17, 2015

A NaphCare nurse made a psychiatric progress note for Mr. Mitchell. The nurse reported that Mr. Mitchell said he was at the jail "from an alien and I don't hear voices." The nurse described Mr. Mitchell as psychotic and significantly disorganized. The nurse continued Mr. Mitchell on the same medications he had been on at PCJ.

A NaphCare nurse additionally claimed to have observed Mr. Mitchell during "pill pass." The nurse reported that Mr. Mitchell's medication was crushed and floated. Mr. Mitchell allegedly drank the majority of the water in the cup, but handed the cup back with some of the crushed medication still in the cup. The nurse claimed that Mr. Mitchell then began to yell profanities.

According to the Behavior/Suicide Watch reports, Mr. Mitchell was observed eating a meal at 12:00 p.m. and 4:18 p.m. No meals are circled as having not been consumed. Mr. Mitchell was

described as "taking [his] medication" at 4:40 a.m. The section of the log labeled "Medications (Indicate the Time) Accepted and Taken _____ Not Taken _____" is blank. Various entries describe Mr. Mitchell as "screaming at door," "standing in cell laughing naked," and "kissing the cell walls." At 11:08 p.m., a correctional officer reported that Mr. Mitchell was "laughing being escorted out." Mr. Mitchell was reported to have been asleep for approximately 4 hours.

In the Daily Confinement Record, a correctional officer reported that Mr. Mitchell received breakfast at 5:35 a.m., lunch at 12:08 p.m., and dinner at 4:17 p.m. An officer additionally reported that Mr. Mitchell was given his medication at 5:00 a.m.

May 18, 2015

The mental health director saw Mr. Mitchell due to his "close observation" status. The director reported that she observed Mr. Mitchell rambling and lying on a mat. The director reported that Mr. Mitchell had a flat affect, was "oriented x3," and recommended that he be continued on close observation with a 24-hour follow-up interval.

According to the Behavior/Suicide Watch reports, Mr. Mitchell was observed eating a meal at 5:18 a.m., 10:47 a.m., and 5:22 p.m. No meals are circled as having not been consumed. An officer noted that Mr. Mitchell "received [his] medication" at 10:00 a.m. The section of the log labeled "Medications (Indicate the Time) Accepted and Taken _____ Not Taken _____" is blank. Mr. Mitchell was described as talking to himself and laughing for approximately 90 minutes straight during the day. Mr. Mitchell was reported to have been asleep for approximately 15 hours.

In the Daily Confinement Record, a correctional officer reported that Mr. Mitchell received breakfast at 5:07 a.m., lunch at 10:37 a.m., and dinner at 4:57 p.m. An officer additionally reported that Mr. Mitchell was given his medication at 9:57 a.m. and 10:30 p.m. An officer reported that Mr. Mitchell refused a shower at 7:15 a.m.

May 19, 2015

The mental health director saw Mr. Mitchell due to his "close observation" status. The director reported that she observed Mr. Mitchell talking at his cell door and described him as "cooperative." The director reported that Mr. Mitchell had a flat affect, was "oriented x3," and recommended that he be continued on close observation with a 24-hour follow-up interval.

According to the Behavior/Suicide Watch reports, Mr. Mitchell was observed eating a meal at 5:20 a.m., 11:16 a.m., and 4:42 p.m. No meals are circled as having not been consumed. The section of the log labeled "Medications (Indicate the Time) Accepted and Taken _____ Not Taken _____" is blank. Mr. Mitchell was described as laying down or standing at his cell door for most of the day. He was reported to have been asleep for approximately 18.25 hours.

In the Daily Confinement Record, a correctional officer reported that Mr. Mitchell received breakfast at 5:20 a.m., lunch at 11:23 a.m., and dinner at 4:42 p.m. An officer additionally reported that Mr. Mitchell was given his medication at 11:15 a.m. and 11:30 p.m. An officer reported that Mr. Mitchell refused a shower at 7:30 a.m. The records indicate that Mr. Mitchell was placed on disciplinary segregation that was to last from May 19, 2015 until May 29, 2015.

May 20, 2015

The mental health director saw Mr. Mitchell due to his "close observation" status. The director reported that Mr. Mitchell's behavior was inappropriate; that he stated that he was "fine" and shooed the director away, blowing her kisses as she approached his cell door. The director reported that Mr. Mitchell had an inappropriate affect, was "oriented x1," and recommended that he be continued on close observation with a 24-hour follow-up interval.

According to the Behavior/Suicide Watch reports, Mr. Mitchell was observed eating a meal at 5:05 a.m., 11:16 a.m., and 4:42 p.m. No meals are circled as having not been consumed. The

section of the log labeled "Medications (Indicate the Time) Accepted and Taken _____ Not Taken _____" is blank. Various entries describe Mr. Mitchell as "spinning in circles laughing," "standing at sink laughing," "standing on bunk laughing," "pacing in cell," and "talking to self." Mr. Mitchell was reported to have been taking a shower from 8:48 a.m. until 10:42 a.m. Mr. Mitchell reportedly had visitation at 2:10 p.m. He was reported to have been asleep for approximately 6.25 hours.

In the Daily Confinement Record, a correctional officer reported that Mr. Mitchell received breakfast at 5:05 a.m., lunch at 11:20 a.m., and dinner at 5:25 p.m. An officer additionally reported that Mr. Mitchell was given his medication at 11:25 a.m. and 9:45 p.m. An officer reported that Mr. Mitchell took a shower at 10:00 a.m.

Correctional officers generated a HRRJ Incident Report for destroying jail property when Mr. Mitchell allegedly ripped his mattress apart. Mr. Mitchell was placed on a 7-day property (mattress) restriction to begin on May 20 and end on May 27.[6]

May 21, 2015

NaphCare medical staff generated a "Release of Responsibility – Specific Procedure" form detailing an attempt to take Mr. Mitchell for a visit to a jail doctor. The form was signed as having been witnessed by two employees. The "patient signature" line does not contain Mr. Mitchell's signature, but contains the notation "refuses to sign."

The mental health director also saw Mr. Mitchell due to his "close observation" status. The director reported that she observed Mr. Mitchell talking at his cell door, that Mr. Mitchell stated "I want to go home," "I want the shot, please," and that Mr. Mitchell was cooperative. The director reported that Mr. Mitchell had a flat affect, was "oriented x1," and recommended that he be

[6] During this time, Mr. Mitchell apparently was not allowed to have a mattress.

continued on close observation with a 24-hour follow-up interval.

According to the Behavior/Suicide Watch reports, Mr. Mitchell was observed eating a meal at 5:11 a.m., 11:41 a.m., and 5:01 p.m. No meals are circled as having not been consumed. The section of the log labeled "Medications (Indicate the Time) Accepted and Taken _____ Not Taken _____" is blank. Various entries describe Mr. Mitchell as "laying down at door," "screaming and kicking cell door," and "I'm hungry (yelling)" shortly before he reportedly received a breakfast tray. Mr. Mitchell apparently alternated between screaming, kicking the cell door, and repeating "I'm hungry" for approximately an hour before breakfast arrived. He was reported to have been awake for 24 hours without sleeping.

In the Daily Confinement Record, a correctional officer reported that Mr. Mitchell received breakfast at 5:00 a.m., lunch at 11:24 a.m., and dinner at 5:01 p.m. An officer additionally reported that Mr. Mitchell was given his medication at 11:25 a.m. and 9:21 p.m.

A court-ordered psychological evaluation was completed on Mr. Mitchell. The evaluation was performed by a doctor specializing in forensic psychology. The evaluation was designed to determine Mr. Mitchell's competency to stand trial and sanity at the time of his alleged trespasses and petit larceny. The evaluator noted that he was only submitting a report on Mr. Mitchell's competency to stand trial to the court; he noted that Mr. Mitchell "was not mentally capable of participating in a sanity evaluation." The evaluation provides in relevant part:

> [Mr. Mitchell] was both manic *and* psychotic (emphasis in original) at this 5/20/15 interview. Mr. Mitchell's thought processes were so confused that only snippets of his sentences could be understood, the rest were mumbled statements that made no rational sense. His themes involved voodoo, music, how he was rich, and sex – ideas that were psychotic and grandiose. His speech was rapid. Mr. Mitchell was hyperactive, literally twirling around the visitation cell, then rapping, and several times he dropped his pants to show off his semi erect penis. He spit on the floor. Mr. Mitchell was too mentally and behaviorally disorganized to discuss his case or his background.

> After [the evaluator] gave up and left [the] (sic) interview room and went to another booth to evaluate a different defendant, for whatever reason it took the officers fully 30 minutes to remove Mr. Mitchell from his visitation booth. For the entire half hour, Mr. Mitchell could be heard relentlessly banking (sic) on the walls, singing, and yelling incomprehensibly. Only a manic patient could keep up such a high level of energy so long.
>
> Based upon the data available at this time, it is the opinion of [the evaluator] that [Mr. Mitchell] LACKED the capacity to assist counsel in preparing a defense; he probably could not be rational about court but that was difficult to assess at present.
>
> This court is urged to commit Mr. Mitchell to the Department of Behavioral Health for inpatient treatment to restore his competency under VA 19.2-169.2.

The same day, the Portsmouth General District Court produced an "order for treatment of incompetent defendant." The order memorialized the District Court's finding that Mr. Mitchell was "incompetent to stand trial" and could be treated to restore his competency "on an outpatient basis in jail or through a local mental health facility." The court ordered staff at Eastern State Hospital to attempt to restore Mr. Mitchell to competency.

May 22, 2015

The NaphCare mental health director made a progress note for Mr. Mitchell in which she described him as standing at his cell door, having a flat affect, and being "oriented x3."

According to the Behavior/Suicide Watch reports, Mr. Mitchell was observed eating a meal at 4:55 a.m. and 4:53 p.m. No meals are circled as having not been consumed. The section of the log labeled "Medications (Indicate the Time) Accepted and Taken _____ Not Taken _____" is blank. Various entries describe Mr. Mitchell as "pacing in cell" and "standing on bunk." He was reported to have been asleep for approximately 12.5 hours.

In the Daily Confinement Record, a correctional officer mislabeled today's entry as "5-21-15." That officer reported that Mr. Mitchell received breakfast on 5-22-15 at 4:41 a.m., lunch at 10:59 a.m., and dinner at 4:46 p.m. An officer additionally reported that Mr. Mitchell was given

his medication at 10:15 p.m. An officer reported that Mr. Mitchell refused a shower at 3:25 p.m.

May 23, 2015

A NaphCare nurse allegedly attempted to see Mr. Mitchell due to Mr. Mitchell's "close observation" status. The nurse reported that Mr. Mitchell was naked in his cell, that he was not observed, and that the nurse was "unable to assess." The nurse recommended that Mr. Mitchell be continued on close observation with a 24-hour follow-up interval.

According to the Behavior/Suicide Watch reports, Mr. Mitchell was observed eating a meal at 5:05 a.m., 11:01 a.m., and 5:03 p.m. No meals are circled as having not been consumed. The section of the log labeled "Medications (Indicate the Time) Accepted and Taken _____ Not Taken _____" bears the notation "2100" in the "Not Taken" section. Various entries describe Mr. Mitchell as "yelling inside cell" and "jumping on bunk." He was reported to have been asleep for approximately 5.75 hours.

In the Daily Confinement Record, a correctional officer reported that Mr. Mitchell received breakfast at 4:55 a.m., lunch at 11:01 a.m., and dinner at 4:42 p.m. An officer additionally reported that Mr. Mitchell was given his medication at 9:00 p.m.

May 24, 2015

According to the Behavior/Suicide Watch reports, Mr. Mitchell was observed eating a meal at 5:05 a.m. and 11:29 a.m. No meals are circled as having not been consumed. The section of the log labeled "Medications (Indicate the Time) Accepted and Taken _____ Not Taken _____" is blank. Various entries describe Mr. Mitchell as "playing in toilet" and "arms out tray slot." He was reported to have been asleep for approximately 4.75 hours.

In the Daily Confinement Record, a correctional officer reported that Mr. Mitchell received breakfast at 5:05 a.m., lunch at 11:21 a.m., and dinner at 4:22 p.m. An officer additionally reported

that Mr. Mitchell was given his medication at either 11:12 a.m. or 1:12 p.m. (handwriting illegible). This record indicates "NA" in the "Shower" block.

May 25, 2015

A NaphCare nurse saw Mr. Mitchell due to Mr. Mitchell's "close observation" status. The nurse reported that Mr. Mitchell was in the shower and that the nurse was "unable to assess." The nurse recommended that Mr. Mitchell be continued on close observation with a 24-hour follow-up interval.

According to the Behavior/Suicide Watch reports, Mr. Mitchell was reported to have refused a meal at 11:40 a.m. An officer noted that he received a dinner tray at 4:50 p.m. However, lunch and dinner are circled as having not been consumed. The section of the log labeled "Medications (Indicate the Time) Accepted and Taken _____ Not Taken _____" is blank. Various entries describe Mr. Mitchell as "walking in circles" and "talking to self." He was reportedly in the shower from 8:04 a.m. until 10:21 a.m. He was reported to have been awake for 24 hours without sleeping. Around 8:32 p.m., Mr. Mitchell was reportedly escorted from his cell for a medical visit.

In the Daily Confinement Record, a correctional officer reported that Mr. Mitchell received breakfast at 5:23 a.m., that he refused lunch at an unspecified time, and that he refused dinner at 4:49 p.m. An officer additionally reported that Mr. Mitchell was given his medication at 12:10 p.m. Another possible medication administration time is written illegibly below the 12:10 p.m. notation.

May 26, 2015

The mental health director saw Mr. Mitchell due to his "close observation" status. The director reported that she observed Mr. Mitchell standing at his cell door, and that Mr. Mitchell

stated he was "good." The director reported that Mr. Mitchell had a flat affect, was "oriented x1," and recommended that he be continued on close observation with a 24-hour follow-up interval.

According to the Behavior/Suicide Watch reports, Mr. Mitchell was reported to be eating breakfast at 4:50 a.m., and he ate lunch at 11:42 a.m. An officer noted that he refused dinner at 5:19 p.m. Dinner is circled as having not been consumed. The section of the log labeled "Medications (Indicate the Time) Accepted and Taken _____ Not Taken _____" is blank. Various entries describe Mr. Mitchell as having "placed [his] uniform in [the] toilet" and that he was "crying on [his] bunk." He was reported to have been awake for the entire day.

In the Daily Confinement Record, a correctional officer reported that Mr. Mitchell received breakfast at 4:50 a.m., that he received lunch at 11:29 a.m., and that he received dinner at 5:15 p.m. An officer additionally reported that Mr. Mitchell was given his medication at 9:19 a.m. and 9:13 p.m.

May 27, 2015

The mental health director saw Mr. Mitchell due to his "close observation" status. The director reported that she observed Mr. Mitchell standing at his cell door and rambling, and that Mr. Mitchell stated he was "good." The director reported that Mr. Mitchell had a flat affect, was "oriented x2," and recommended that he be continued on close observation with a 24-hour follow-up interval. Part of the director's additional notes reflects a referral of Mr. Mitchell to a psychiatrist for evaluation.

According to the Behavior/Suicide Watch reports, Mr. Mitchell was reported to be eating breakfast at 4:53 a.m., and he reportedly ate lunch at 11:43 a.m. and received dinner at 5:38 p.m. No meals are circled as having not been consumed. The section of the log labeled "Medications (Indicate the Time) Accepted and Taken _____ Not Taken _____" is blank. Various entries

describe Mr. Mitchell as "playing in toilet" and "banging on cell door." He was reported to have been awake for 24 hours without sleeping.

In the Daily Confinement Record, a correctional officer reported that Mr. Mitchell received breakfast at 4:40 a.m., that he received lunch at 11:34 a.m., and that he received dinner at 5:25 p.m. An officer additionally reported that Mr. Mitchell was given his medication at 11:50 a.m. and 10:15 p.m. An officer reported that Mr. Mitchell was given a shower at 8:25 a.m.

NaphCare Medical staff generated a "Segregation Evaluation Refusal Sheet" form detailing an apparent attempt to evaluate Mr. Mitchell. The form states that "I hereby refuse to accept the *complete 15 day segregation evaluation* by the medical department. I hereby release and agree to hold harmless Naphcare Inc. and Hampton Roads Regional Jail form all responsibility and ill effect, [sic] which may result from this action." The form was signed as having been witnessed by two employees. The "inmate signature" line does not contain Mr. Mitchell's signature, but contains the notation "refused."[7]

May 28, 2015

The mental health director saw Mr. Mitchell due to his "close observation" status. The director reported that she observed Mr. Mitchell standing naked in his cell, rambling about his food, and stated that he was cooperative. The director reported that Mr. Mitchell had a flat affect, was "oriented x3," and recommended that he be continued on close observation with a 24-hour follow-up interval.

According to the Behavior/Suicide Watch reports, Mr. Mitchell was reported to have

[7] "Segregation" rounds, also referred to as "restricted rounds," were attempts by NaphCare staff to provide inmates who were in the segregation wing of HRRJ with medical and/or mental health evaluations. This apparently differed from NaphCare's practice for general population inmates, who did not get regular rounds like these and were required to put in "sick call" requests at a kiosk in order to see a nurse or doctor. Mr. Mitchell was alleged to have refused these targeted rounds on eight separate days. He allegedly accepted treatment or evaluation during these special rounds on two different days.

received breakfast at 5:08 a.m. He reportedly ate lunch at 11:20 a.m. and ate dinner at 4:45 p.m. No meals are circled as having not been consumed. The section of the log labeled "Medications (Indicate the Time) Accepted and Taken _____ Not Taken _____" is blank. Various entries describe Mr. Mitchell as "refusing to stick arms in slot" and "talking to [the mental health director]." He was reported to have been asleep for approximately 5.75 hours.

In the Daily Confinement Record, a correctional officer reported that Mr. Mitchell received breakfast at 4:55 a.m., that he received lunch at 11:10 a.m., and that he received dinner at 4:34 p.m. An officer additionally reported that Mr. Mitchell was given his medication at 12:55 p.m. and 10:09 p.m. An officer reported that Mr. Mitchell was given a shower at 8:25 a.m.

A NaphCare nurse reported that she saw Mr. Mitchell and documented his refusal of an asthma treatment in the form of a "Chronic Care Refusal" note.

May 29, 2015

The mental health director apparently attempted to see Mr. Mitchell due to his "close observation" status, but Mr. Mitchell was in court. The director recommended that Mr. Mitchell be continued on close observation with a 24-hour follow-up interval.

Mr. Mitchell appeared in Portsmouth General District Court. An "order for continued custody" indicates that Mr. Mitchell was held without bail while "waiting on a bed at Eastern State Hospital."

According to the Behavior/Suicide Watch reports, Mr. Mitchell was reported to have received breakfast at 5:34 a.m. He was "out to court" at approximately 6:30 a.m., and he apparently returned to HRRJ shortly before 1:00 p.m. The logs indicate that no 15-minute checks were performed on Mr. Mitchell between 11:49 p.m. and 12:29 p.m. Mr. Mitchell. reportedly ate dinner at 5:22 p.m. No meals are circled as having not been consumed. The section of the log labeled

"Medications (Indicate the Time) Accepted and Taken _____ Not Taken _____" is blank. He was reported to have been asleep for approximately 30 minutes.

In the Daily Confinement Record, a correctional officer reported that Mr. Mitchell received breakfast at 5:15 a.m., that he received lunch at 11:10 a.m. (with the notation "court" next to this time), and that he received dinner at 5:19 p.m. An officer reported that Mr. Mitchell was given his medication at 11:50 a.m. and 9:45 p.m, and that he refused a shower.

May 30, 2015

A nurse saw Mr. Mitchell due to Mr. Mitchell's "close observation" status. The nurse reported that she observed Mr. Mitchell talking at his cell door and reporting that he was alright. The nurse reported that Mr. Mitchell had a flat affect. The nurse recommended that Mr. Mitchell be continued on close observation with a 24-hour follow-up interval.

According to the Behavior/Suicide Watch reports, Mr. Mitchell was reported to be eating breakfast at 5:05 a.m. He reportedly ate lunch at 11:30 a.m., and was seen eating dinner at 5:01 p.m. No meals are circled as having not been consumed. The section of the log labeled "Medications (Indicate the Time) Accepted and Taken _____ Not Taken _____" is blank. Various entries in the log range from "screaming loud" to several hours' worth of Mr. Mitchell standing at his cell door. He was reported to have been awake for 24 hours without sleeping.

In the Daily Confinement Record, a correctional officer reported that Mr. Mitchell received breakfast at 5:05 a.m., that he received lunch at 11:29 a.m., and that he received dinner at 5:03 p.m. An officer reported that Mr. Mitchell was given his medication at 1:50 p.m. and 9:35 p.m.

A NaphCare nurse additionally noted on Mr. Mitchell's chart that he allegedly refused his medications at 8:00 a.m.

May 31, 2015

A NaphCare nurse saw Mr. Mitchell due to Mr. Mitchell's "close observation" status. The extent of the nurse's observations is her alleged quotation of Mr. Mitchell stating that he was "OK." The nurse recommended that Mr. Mitchell be continued on close observation with a 24-hour follow-up interval.

According to the Behavior/Suicide Watch reports, Mr. Mitchell was reported to be eating breakfast at 5:05 a.m. He reportedly ate lunch at 11:38 a.m., and was seen eating dinner at 5:09 p.m. No meals are circled as having not been consumed. Mr. Mitchell was reported to be in the shower from 2:30 p.m. until 3:20 p.m. An officer wrote that Mr. Mitchell refused his medication at 9:40 p.m. However, the section of the log labeled "Medications (Indicate the Time) Accepted and Taken _____ Not Taken _____" is blank. Various entries in the log range from "dancing at door" to several hours' worth of Mr. Mitchell standing at his cell door. He was reported to have been awake for 24 hours without sleeping.

In the Daily Confinement Record, a correctional officer reported that Mr. Mitchell received breakfast at 5:05 a.m., that he received lunch at 11:38 a.m., and that he received dinner at 5:14 p.m. An officer reported that Mr. Mitchell was given his medication at 10:03 a.m. and 9:35 p.m.

June 1, 2015

The mental health director saw Mr. Mitchell due to his "close observation" status. The director reported that she observed Mr. Mitchell sitting on the toilet, and that Mr. Mitchell was cooperative and stated he was OK. The director reported that Mr. Mitchell had a flat affect, was "oriented x1," and recommended that he be continued on close observation with a 24-hour follow-up interval.

According to the Behavior/Suicide Watch reports, Mr. Mitchell was reported to be eating

breakfast at 5:00 a.m. He reportedly ate dinner at 5:23 p.m. No meals are circled as having not been consumed. The section of the log labeled "Medications (Indicate the Time) Accepted and Taken ____ Not Taken _____" is blank. The log indicates that Mr. Mitchell was either standing at his cell door, sitting on the toilet, or sitting down somewhere in his cell for the balance of the day. He was reported to have been awake for 24 hours without sleeping.

In the Daily Confinement Record, a correctional officer reported that Mr. Mitchell received breakfast at 5:00 a.m., that he received lunch at 11:45 a.m., and that he received dinner at 5:07 p.m. An officer additionally reported that Mr. Mitchell was given his medication at 12:30 p.m. and 10:35 p.m. Mr. Mitchell reportedly refused a shower.

June 2, 2015

The mental health director saw Mr. Mitchell due to his "close observation" status. The director reported that she observed Mr. Mitchell talking at his cell door, and that Mr. Mitchell was overactive and stated he was OK. The director reported that Mr. Mitchell had a flat affect, was "oriented x3," and recommended that he be released from close observation.

According to the Behavior/Suicide Watch reports, Mr. Mitchell was reported to have received breakfast at 5:14 a.m. He reportedly ate lunch at 11:57 a.m. No meals are circled as having not been consumed. The section of the log labeled "Medications (Indicate the Time) Accepted and Taken _____ Not Taken ____" is blank. The log indicates that Mr. Mitchell was either standing at his cell door, sitting on the toilet, or sitting or laying down somewhere in his cell for the balance of the day. He was reported to have slept for approximately 5.75 hours.

In the Daily Confinement Record, a correctional officer reported that Mr. Mitchell received breakfast at 5:05 a.m., that he received lunch at 11:49 a.m., and that he received dinner at 5:22 p.m. An officer reported that Mr. Mitchell was given his medication at 11:17 a.m. and 9:00 p.m.

June 3, 2015

Mr. Mitchell was apparently evaluated by the mental health director and removed from close observation.[8] In the Daily Confinement Record, a correctional officer reported that Mr. Mitchell received breakfast at 5:20 a.m., that he received lunch at 11:09 a.m., and that he received dinner at 5:25 p.m. An officer additionally reported that Mr. Mitchell was given his medication at 12:20 p.m. and 9:30 p.m. Mr. Mitchell reportedly refused a shower. The record contains the notation "on 06-03-15 inmate released by Mental Health from close observation."

June 4, 2015

In the Daily Confinement Record, a correctional officer reported that Mr. Mitchell received breakfast at 5:00 a.m., that he received lunch at 11:20 a.m., and that he received dinner at 5:44 p.m. An officer reported that Mr. Mitchell was given his medication at 10:18 a.m. and 9:45 p.m.

June 5, 2015

In the Daily Confinement Record, a correctional officer reported that Mr. Mitchell received breakfast at 4:45 a.m., that he received lunch at 11:05 a.m., and that he received dinner at 5:33 p.m. An officer reported that Mr. Mitchell was given his medication at 10:47 a.m. and 11:09 p.m. Mr. Mitchell reportedly refused a shower at 7:30 a.m.

June 6, 2015

In the Daily Confinement Record, a correctional officer reported that Mr. Mitchell received breakfast at 4:51 a.m., that he received lunch at 10:51 a.m., and that he received dinner at 4:34 p.m. An officer reported that Mr. Mitchell was given his medication at 1:00 p.m. and 9:30 p.m.

June 7, 2015

NaphCare medical staff generated a "Segregation Evaluation Refusal Sheet" form detailing

[8] There is no explanation of the reason(s) Mr. Mitchell was removed from close observation in the records provided to our office by NaphCare.

an apparent attempt to evaluate Mr. Mitchell. The form was signed as having been witnessed by two employees. The "inmate signature" line does not contain a signature, but contains the notation "refused."

In the Daily Confinement Record, a correctional officer reported that Mr. Mitchell received breakfast at 4:38 a.m., that he received lunch at 10:39 a.m., and that he received dinner at 4:35 p.m. An officer reported that Mr. Mitchell was given his medication at 12:50 p.m. and 9:30 p.m.

June 8, 2015

In the Daily Confinement Record, a correctional officer reported that Mr. Mitchell received breakfast at 5:05 a.m., that he received lunch at 10:25 a.m., and that he received dinner at 4:40 p.m. An officer additionally reported that Mr. Mitchell was given his medication at 11:20 a.m. and 9:12 p.m. Mr. Mitchell reportedly refused a shower at 7:30 a.m.

June 9, 2015

A NaphCare nurse reported that Mr. Mitchell did not receive his medications at 8:00 a.m. because he was allegedly very agitated and spat at the nurse and a correctional officer. In the Daily Confinement Record, a correctional officer reported that Mr. Mitchell received breakfast at 5:50 a.m., that he received lunch at 11:20 a.m., and that he received dinner at 4:45 p.m. An officer additionally reported that Mr. Mitchell was given his medication at 10:10 a.m. and 8:30 p.m. Mr. Mitchell reportedly refused a shower at 7:30 a.m.

June 10, 2015

In the Daily Confinement Record, a correctional officer reported that Mr. Mitchell received breakfast at 5:40 a.m., that he received lunch at 11:25 a.m., and that he received dinner at 5:12 p.m. An officer additionally reported that Mr. Mitchell was given his medication at 12:26 p.m. and 10:00 p.m. Mr. Mitchell reportedly refused a shower at 7:30 a.m.

June 11, 2015

A NaphCare nurse created a "psychiatric progress note" after meeting with Mr. Mitchell. The nurse reported that Mr. Mitchell stated "I like space," and proceeded to come close to the nurse and ask the nurse to touch his eyes and give him a kiss. The nurse reported that a review of Mr. Mitchell's record showed Mr. Mitchell took his medications intermittently at best. The nurse reported that Mr. Mitchell did not know what year or month it was, and that Mr. Mitchell said the nurse was the president. Mr. Mitchell left the evaluation after the nurse refused to give Mr. Mitchell a bottle of Mountain Dew the nurse had brought into the evaluation.[9] The nurse wrote that Mr. Mitchell appeared to remain psychotic and was not taking his medications. The nurse continued Mr. Mitchell's medications as ordered and reported that Mr. Mitchell had not displayed any unsafe behaviors.

In the Daily Confinement Record, a correctional officer reported that Mr. Mitchell received breakfast at 4:53 a.m., that he received lunch at 10:57 a.m., and that he received dinner at 5:00 p.m. An officer reported that Mr. Mitchell was given his medication at 9:42 a.m. and 9:24 p.m.

June 12, 2015

In the Daily Confinement Record, a correctional officer reported that Mr. Mitchell received breakfast at 5:19 a.m., that he received lunch at 11:00 a.m., and that he received dinner at 4:25 p.m. An officer additionally reported that Mr. Mitchell was given his medication at 9:15 a.m. and 9:40 p.m. Mr. Mitchell reportedly refused a shower at 7:35 a.m.

June 13, 2015

In the Daily Confinement Record, a correctional officer reported that Mr. Mitchell received

[9] Mr. Mitchell was initially incarcerated for his alleged theft of a 2-liter bottle of Mountain Dew. The records produced to us by NaphCare contain no indication that the nurse attempted to re-initiate with Mr. Mitchell after Mr. Mitchell was apparently triggered by the nurse denying him the Mountain Dew.

breakfast at 5:15 a.m., that he received lunch at 10:30 a.m., and that he received dinner at 4:15 p.m. An officer additionally reported that Mr. Mitchell was given his medication at 9:34 a.m.

June 14, 2015

In the Daily Confinement Record, a correctional officer reported that Mr. Mitchell received breakfast at 4:55 a.m., that he received lunch at 10:55 a.m., and that he received dinner at 4:05 p.m. An officer additionally reported that Mr. Mitchell was given his medication at 9:19 a.m. and 10:05 p.m. The log indicates that "Inmate Mitchell was taken out of his cell, given a clean uniform, and had his cell cleaned up on 6-14-15 at around 1700. His mattress was full of urine and had to be thrown away."[10]

June 15, 2015

In the Daily Confinement Record, a correctional officer reported that Mr. Mitchell received breakfast at 5:22 a.m., that he received lunch at 11:30 a.m., and that he received dinner at 5:10 p.m. An officer additionally reported that Mr. Mitchell was given his medication at 11:15 a.m. and 10:06 p.m. Mr. Mitchell reportedly refused a shower.

June 16, 2015

In the Daily Confinement Record, a correctional officer reported that Mr. Mitchell received breakfast at 5:22 a.m., that he received lunch at 11:45 a.m., and that he received dinner at 5:47 p.m. An officer reported that Mr. Mitchell was given his medication at 11:35 a.m. and 9:35 p.m.

June 17, 2015

In the Daily Confinement Record, a correctional officer reported that Mr. Mitchell received breakfast at 5:31 a.m., that he received lunch at 11:05 a.m., and that he received dinner at 4:54 p.m. An officer additionally reported that Mr. Mitchell was given his medication at 11:27 a.m. and

[10] There is no indication whether Mr. Mitchell was given a shower after being removed from his apparently urine-filled cell.

8:09 p.m. Mr. Mitchell reportedly refused a shower at 7:20 a.m.

June 18, 2015

NaphCare medical staff generated a "Release of Responsibility – Specific Procedure" form detailing Mr. Mitchell's alleged refusal of "restricted rounds." The form was signed as having been witnessed by two employees. The "patient signature" line does not contain a signature, but contains the notation "refused."

In the Daily Confinement Record, a correctional officer reported that Mr. Mitchell received breakfast at 5:08 a.m., that he received lunch at 10:39 a.m., and that he received dinner at 4:30 p.m. An officer reported that Mr. Mitchell was given his medication at 1:49 p.m. and 9:30 p.m.

June 19, 2015

In the Daily Confinement Record, a correctional officer reported that Mr. Mitchell received breakfast at 5:09 a.m., that he received lunch at 11:06 a.m., and that he received dinner at 4:32 p.m. An officer additionally reported that Mr. Mitchell was given his medication at 11:45 a.m. and 9:32 p.m. Mr. Mitchell reportedly refused a shower.

June 20, 2015

In the Daily Confinement Record, a correctional officer reported that Mr. Mitchell received breakfast at 5:17 a.m., that he received lunch at 10:33 a.m., and that he received dinner at 4:34 p.m. An officer reported that Mr. Mitchell was given his medication at 12:18 p.m. and 9:49 p.m.

June 21, 2015

In the Daily Confinement Record, a correctional officer reported that Mr. Mitchell received breakfast at 5:08 a.m., that he received lunch at 10:55 a.m., and that he received dinner at 4:15 p.m. An officer additionally reported that Mr. Mitchell was given his medication at 12:10 p.m.

June 22, 2015

In the Daily Confinement Record, a correctional officer reported that Mr. Mitchell received breakfast at 5:07 a.m., that he received lunch at 11:23 a.m., and that he received dinner at 5:16 p.m. An officer additionally reported that Mr. Mitchell was given his medication at 10:35 a.m. and 10:00 p.m. Mr. Mitchell reportedly refused a shower at 7:15 a.m.

June 23, 2015

In the Daily Confinement Record, a correctional officer reported that Mr. Mitchell received breakfast at 4:50 a.m., that he received lunch at 11:05 a.m., and that he received dinner at 5:00 p.m. An officer additionally reported that Mr. Mitchell was given his medication at 9:45 a.m. and 10:15 p.m. The log contains an entry noting that "on 06-23-15 inmate Mitchell was taken out of his cell and his cell was cleaned up."

June 24, 2015

In the Daily Confinement Record, a correctional officer reported that Mr. Mitchell received breakfast at 5:05 a.m., that he received lunch at 12:10 p.m., and that he received dinner at 5:03 p.m. An officer reported that Mr. Mitchell was given his medication at 10:10 a.m. and 9:46 p.m.

June 25, 2015

In the Daily Confinement Record, a correctional officer reported that Mr. Mitchell received breakfast at 5:24 a.m., that he received lunch at 11:08 a.m., and that he received dinner at 5:15 p.m. An officer reported that Mr. Mitchell was given his medication at 11:50 a.m. and 9:47 p.m.

June 26, 2015

In the Daily Confinement Record, a correctional officer reported that Mr. Mitchell received breakfast at 5:07 a.m., that he received lunch at 10:58 a.m., and that he received dinner at 5:29 p.m. An officer additionally reported that Mr. Mitchell was given his medication at 11:50 a.m. and

10:00 p.m. Mr. Mitchell reportedly refused a shower at 7:20 a.m.

June 27, 2015

In the Daily Confinement Record, a correctional officer reported that Mr. Mitchell received breakfast at 4:33 a.m., that he received lunch at 11:12 a.m., and that he received dinner at 4:48 p.m. An officer reported that Mr. Mitchell was given his medication at 11:44 a.m. and 11:20 p.m.

June 28, 2015

In the Daily Confinement Record, a correctional officer reported that Mr. Mitchell received breakfast at 4:45 a.m., that he received lunch at 10:30 a.m., and that he received dinner at 4:40 p.m. An officer additionally reported that Mr. Mitchell was given his medication at 10:15 a.m. and 8:31 p.m. A log entry reads that "on 06-28-15 inmate Mitchell was taken out of his cell and his cell was cleaned up from urine & feces."

June 29, 2015

In the Daily Confinement Record, a correctional officer reported that Mr. Mitchell received breakfast at 5:05 a.m., that he received lunch at 11:10 a.m., and that he received dinner at 5:04 p.m. An officer additionally reported that Mr. Mitchell was given his medication at 11:15 a.m. and 10:00 p.m. Mr. Mitchell reportedly refused a shower.

June 30, 2015

NaphCare medical staff generated a "Segregation Evaluation Refusal Sheet" form detailing an apparent attempt to evaluate Mr. Mitchell. The form was signed as having been witnessed by two employees. The "inmate signature" line does not contain Mr. Mitchell's signature, but contains the notation "refused."

In the Daily Confinement Record, a correctional officer reported that Mr. Mitchell received breakfast at 5:13 a.m., that he received lunch at 12:19 a.m., and that he received dinner at 4:52

p.m. An officer additionally reported that Mr. Mitchell was given his medication at 11:45 a.m. and 9:49 p.m. Mr. Mitchell reportedly refused a shower.

July 1, 2015

In the Daily Confinement Record, a correctional officer reported that Mr. Mitchell received breakfast at 5:15 a.m., that he received lunch at 10:39 a.m., and that he received dinner at 5:00 p.m. An officer reported that Mr. Mitchell was given his medication at 11:05 a.m. and 9:51 p.m.

July 2, 2015

In the Daily Confinement Record, a correctional officer reported that Mr. Mitchell received breakfast at 4:55 a.m., that he received lunch at 11:07 a.m., and that he received dinner at 4:57 p.m. An officer additionally reported that Mr. Mitchell was given his medication at 12:23 p.m. and 9:30 p.m. Mr. Mitchell reportedly refused a shower at 2:30 p.m.

July 3, 2015

In the Daily Confinement Record, a correctional officer reported that Mr. Mitchell received breakfast at 4:43 a.m., that he received lunch at 10:48 a.m., and that he received dinner at 4:25 p.m. An officer reported that Mr. Mitchell was given his medication at 11:00 a.m. and 9:30 p.m.

July 4, 2015

In the Daily Confinement Record, a correctional officer reported that Mr. Mitchell received breakfast at 5:00 a.m., that he received lunch at 11:16 a.m., and that he received dinner at 4:13 p.m. An officer reported that Mr. Mitchell was given his medication at 12:00 p.m. and 9:30 p.m.

July 5, 2015

In the Daily Confinement Record, a correctional officer reported that Mr. Mitchell received breakfast at 5:00 a.m., that he received lunch at 11:13 a.m., and that he received dinner at 3:43 p.m. An officer reported that Mr. Mitchell was given his medication at 12:21 p.m. and 8:30 p.m.

July 6, 2015

In the Daily Confinement Record, a correctional officer reported that Mr. Mitchell received breakfast at 5:00 a.m., that he received lunch at 10:20 a.m., and that he received dinner at 4:20 p.m. An officer additionally reported that Mr. Mitchell was given his medication at 11:00 a.m. and 9:28 p.m. Mr. Mitchell reportedly refused a shower at 7:45 a.m.

July 7, 2015

In the Daily Confinement Record, a correctional officer reported that Mr. Mitchell received breakfast at 5:30 a.m., that he received lunch at 10:12 a.m., and that he received dinner at 5:21 p.m. An officer reported that Mr. Mitchell was given his medication at 7:40 a.m. and 10:18 p.m.

July 8, 2015

In the Daily Confinement Record, a correctional officer reported that Mr. Mitchell received breakfast at 4:30 a.m., that he received lunch at 10:45 a.m., and that he received dinner at 4:30 p.m. An officer additionally reported that Mr. Mitchell was given his medication at 10:49 a.m. and 9:00 p.m. Mr. Mitchell reportedly refused a shower at 12:15 p.m.

July 9, 2015

In the Daily Confinement Record, a correctional officer reported that Mr. Mitchell received breakfast at 4:54 a.m., that he received lunch at 11:05 a.m., and that he received dinner at 5:22 p.m. An officer reported that Mr. Mitchell was given his medication at 2:01 p.m. and 9:56 p.m.

July 10, 2015

In the Daily Confinement Record, a correctional officer reported that Mr. Mitchell received breakfast at 5:29 a.m., that he received lunch at 11:14 a.m., and that he received dinner at 4:23 p.m. An officer additionally reported that Mr. Mitchell was given his medication at 10:30 a.m. and 10:30 p.m. Mr. Mitchell reportedly refused a shower at 8:00 a.m.

July 11, 2015

In the Daily Confinement Record, a correctional officer reported that Mr. Mitchell received breakfast at 4:06 a.m., that he received lunch at 10:34 a.m., and that he received dinner at 4:28 p.m. An officer additionally reported that Mr. Mitchell was given his medication at 9:13 p.m.

July 12, 2015

In the Daily Confinement Record, a correctional officer reported that Mr. Mitchell received breakfast at 4:30 a.m., that he received lunch at 10:23 a.m., and that he received dinner at 4:22 p.m. An officer reported that Mr. Mitchell was given his medication at 11:09 a.m. and 9:00 p.m.

July 13, 2015

In the Daily Confinement Record, a correctional officer reported that Mr. Mitchell received breakfast at 4:29 a.m., that he received lunch at 10:28 a.m., and that he received dinner at 4:30 p.m. An officer additionally reported that Mr. Mitchell was given his medication at 12:42 p.m. and 9:50 p.m. The log bears an entry stating "13 July 2015; Jail on lockdown 7-13-15 – 7-17-15"

July 14, 2015

A log of events occurring in Mr. Mitchell's pod indicates that Mr. Mitchell allegedly went to an unspecified medical visit in the jail at 3:43 p.m. The log does not indicate when Mr. Mitchell returned to his pod. In the Daily Confinement Record, a correctional officer reported that Mr. Mitchell received breakfast at 5:30 a.m., that he received lunch at 10:11 a.m., and that he received dinner at 5:38 p.m. An officer additionally reported that Mr. Mitchell was given his medication at 10:10 a.m. and 9:06 p.m. Mr. Mitchell reportedly refused a shower.

July 15, 2015

Medical staff generated a "Release of Responsibility – Specific Procedure" form detailing Mr. Mitchell's alleged refusal of "restricted rounds." The form was signed as having been

witnessed by two employees. The "patient signature" line does not contain a signature, but contains the notation "refused."

A NaphCare nurse's note in Mr. Mitchell's chart indicates that he allegedly refused his morning medications. A second nurse's note indicates that Mr. Mitchell allegedly refused lab work after the nurse attempted to educate him on the importance of complying with medical providers.

In the Daily Confinement Record, a correctional officer reported that Mr. Mitchell received breakfast at 5:56 a.m., that he received lunch at 11:29 a.m., and that he received dinner at 4:37 p.m. An officer additionally reported that Mr. Mitchell was given his medication at an illegible time in the morning, as well as at 11:00 p.m. The Feeding Roster indicates that Mr. Mitchell was served three meals.

July 16, 2015

NaphCare medical staff generated a "Release of Responsibility – Specific Procedure" form detailing an alleged attempt to perform blood work and labs on Mr. Mitchell. The form regarding blood work was signed as having been witnessed by two employees. The "patient signature" line of the blood work refusal form does not contain a signature, but contains the notation "refuse to sign." The form regarding labs was signed as having been witnessed by one employee, a nurse. The "patient signature" line of the labs refusal form does not contain a signature, but contains the notation "refused."

In the Daily Confinement Record, a correctional officer reported that Mr. Mitchell received breakfast at 4:35 a.m., that he received lunch at 10:57 a.m., and that he received dinner at 5:08 p.m. An officer additionally reported that Mr. Mitchell was given his medication at 1:00 p.m. and 10:13 p.m. The Feeding Roster indicates that Mr. Mitchell was served three meals.

July 17, 2015

NaphCare medical staff generated a "Release of Responsibility – Specific Procedure" form detailing an attempt to perform blood work on Mr. Mitchell. The form was signed as having been witnessed by one employee. The "patient signature" line does not contain a signature, but contains the notation "refuse to sign."

In the Daily Confinement Record, a correctional officer reported that Mr. Mitchell received breakfast at 5:00 a.m., that he received lunch at 10:59 a.m., and that he received dinner at 4:07 p.m. An officer additionally reported that Mr. Mitchell was given his medication at 11:52 a.m. and 10:01 p.m. Mr. Mitchell reportedly refused a shower at 3:32 p.m.

July 18, 2015

In the Daily Confinement Record, a correctional officer reported that Mr. Mitchell received breakfast at 5:43 a.m., that he received lunch at 10:25 a.m., and that he received dinner at 4:30 p.m. An officer reported that Mr. Mitchell was given his medication at 12:00 p.m. and 9:50 p.m.

July 19, 2015

In the Daily Confinement Record, a correctional officer reported that Mr. Mitchell received breakfast at 5:16 a.m., that he received lunch at 10:15 a.m., and that he received dinner at 4:19 p.m. An officer reported that Mr. Mitchell was given his medication at 12:11 p.m. and 9:43 p.m.

July 20, 2015

NaphCare medical staff generated a "Release of Responsibility – Specific Procedure" form detailing Mr. Mitchell's alleged refusal of "restricted rounds." The form was signed as having been witnessed by two employees. The "patient signature" line does not contain Mr. Mitchell's signature, but contains the notation "refused."

In the Daily Confinement Record, a correctional officer reported that Mr. Mitchell received

breakfast at 5:39 a.m., that he received lunch at 11:05 a.m., and that he received dinner at 4:58 p.m. An officer additionally reported that Mr. Mitchell was given his medication at 11:20 a.m. Mr. Mitchell reportedly refused a shower at 7:12 a.m. The Feeding Roster indicates that Mr. Mitchell was served three meals.

July 21, 2015

In the Daily Confinement Record, a correctional officer reported that Mr. Mitchell received breakfast at 4:35 a.m., that he received lunch at 10:26 a.m., and that he received dinner at 4:35 p.m. An officer additionally reported that Mr. Mitchell was given his medication at 12:13 p.m. and 9:02 p.m. The Feeding Roster indicates that Mr. Mitchell was served three meals.

July 22, 2015

In the Daily Confinement Record, a correctional officer reported that Mr. Mitchell received breakfast at 5:19 a.m., that he received lunch at 11:17 a.m., and that he received dinner at 4:35 p.m. An officer reported that Mr. Mitchell was given his medication at 10:41 a.m. and 10:00 p.m.

July 23, 2015

In the Daily Confinement Record, a correctional officer reported that Mr. Mitchell received breakfast at 5:21 a.m., that he received lunch at 10:05 a.m., and that he received dinner at 4:41 p.m. An officer additionally reported that Mr. Mitchell was given his medication at 12:30 p.m. The Feeding Roster indicates that Mr. Mitchell was served three meals.

July 24, 2015

In the Daily Confinement Record, a correctional officer reported that Mr. Mitchell received breakfast at 5:30 a.m., that he received lunch at 10:40 a.m., and that he received dinner at 4:20 p.m. An officer additionally reported that Mr. Mitchell was given his medication at 10:30 a.m. and 10:00 p.m. Mr. Mitchell reportedly refused a shower at 7:35 a.m. The Feeding Roster indicates

that Mr. Mitchell was served three meals.

July 25, 2015

In the Daily Confinement Record, a correctional officer reported that Mr. Mitchell received breakfast at 5:15 a.m., that he received lunch at 10:50 a.m., and that he received dinner at 4:05 p.m. An officer additionally reported that Mr. Mitchell was given his medication at 11:23 a.m. The Feeding Roster indicates that Mr. Mitchell was served three meals.

July 26, 2015

A NaphCare nurse created a "psychiatric progress note" after meeting with Mr. Mitchell. The nurse reported that Mr. Mitchell entered the evaluation room, cussed at the nurse, and refused to sit down. The nurse wrote that Mr. Mitchell did not participate in the evaluation. The nurse wrote that Mr. Mitchell was "[n]ot taking meds so will discontinue." The nurse reported that Mr. Mitchell had not displayed any unsafe behaviors. Mr. Mitchell's chart indicates that his medications were discontinued. The nurse who performed the evaluation and discontinued Mr. Mitchell's medications was the same nurse who evaluated Mr. Mitchell on June 11, 2015.

In the Daily Confinement Record, a correctional officer reported that Mr. Mitchell received breakfast at 4:20 a.m., that he received lunch at 10:37 a.m., and that he received dinner at 4:50 p.m. An officer additionally reported that Mr. Mitchell was given his medication at 12:01 p.m. and 5:30 p.m. The Feeding Roster indicates that Mr. Mitchell was served three meals.

July 27, 2015

In the Daily Confinement Record, a correctional officer reported that Mr. Mitchell received breakfast at 5:15 a.m., that he received lunch at 10:40 a.m., and that he received dinner at 4:40 p.m. An officer additionally reported that Mr. Mitchell was given his medication at 11:45 a.m. and 9:00 p.m. Mr. Mitchell reportedly refused a shower at 8:09 a.m.

July 28, 2015

In the Daily Confinement Record, a correctional officer reported that Mr. Mitchell received breakfast at 5:50 a.m., that he received lunch at 10:36 a.m., and that he received dinner at 4:48 p.m. An officer additionally reported that Mr. Mitchell was given his medication at 11:24 a.m. and one other time that is illegible.

July 29, 2015

An unspecified treatment was allegedly administered to Mr. Mitchell during segregation rounds. In the Daily Confinement Record, a correctional officer reported that Mr. Mitchell received breakfast at 6:00 a.m., that he received lunch at 10:16 a.m., and that he received dinner at 4:30 p.m. An officer additionally reported that Mr. Mitchell was given his medication at 11:00 a.m. and 10:00 p.m. Mr. Mitchell reportedly refused a shower at 7:17 a.m. The Feeding Roster indicates that Mr. Mitchell was served three meals.

July 30, 2015

A NaphCare nurse created two progress notes regarding Mr. Mitchell. In the first note, the nurse reported that Mr. Mitchell was brought down to the HRRJ clinic for increased swelling to the "bilat[eral] lower ext[remities]." The nurse noted that Mr. Mitchell had been refusing treatment, lab work, and medication lately. The nurse stated that Mr. Mitchell was disheveled, psychotic, and very uncooperative.

In the second note, which is time-stamped eight minutes after the first note, the same nurse reported that Mr. Mitchell was very uncooperative and refused treatment, medications, lab work, and a full assessment. The nurse alleged that Mr. Mitchell was verbally abusive and was using profanity and derogatory language. The nurse noted that Mr. Mitchell had "bilateral distal upper arm" lesions of various healing stages and wrote that the doctor had recommended that Mr.

Mitchell be referred to the emergency department.

A different NaphCare nurse created an "ER referral" note in which she listed Mr. Mitchell's weight, among other vital statistics, at 158 lbs.

Maryview medical records indicate that Mr. Mitchell was admitted to the Maryview emergency department with complaints of ankle swelling. Maryview records show that Mr. Mitchell was diagnosed with a bilateral lower extremity edema, hypoalbuminemia, and elevated transaminase level. A Maryview nurse reported that upon Mr. Mitchell's arrival, he refused to answer questions or give a medical history. Mr. Mitchell was alleged to have refused to provide urine or blood samples initially, but later allowed his blood to be drawn. Maryview records indicate that upon his discharge, Mr. Mitchell was prescribed several medications for asthma, bipolar disorder, and antipsychotics, among other prescriptions, by a doctor at Maryview.

Maryview records indicate that Mr. Mitchell reported that he had had the swelling for a while, but denied having any pain in his lower extremities. Maryview records also contain Mr. Mitchell's apparent statement that he had not seen the doctor in jail, and he did not tell Maryview staff about any additional complaints or symptoms.

Mr. Mitchell's weight was documented by a doctor at Maryview as 65.772 kg, or 145 lbs. The doctor noted that Mr. Mitchell appeared well-developed and well-nourished.

A nurse at Maryview reportedly conducted an abuse and neglect screening on Mr. Mitchell. Mr. Mitchell denied being physically abused or neglected. Mr. Mitchell denied any verbal, sexual, or other abuse.

A log of events occurring in Mr. Mitchell's pod contains no indication that Mr. Mitchell left the pod to be transported to Maryview.

In the Daily Confinement Record, a correctional officer reported that Mr. Mitchell received

breakfast at 5:33 a.m and that he received dinner at 4:14 p.m. The lunchtime entry is scratched through. An officer reported that Mr. Mitchell was given his medication at 10:00 a.m. and 11:45 p.m. The Feeding Roster indicates that Mr. Mitchell was served three meals and reads "COURT."

July 31, 2015

NaphCare medical staff generated a "Segregation Evaluation Refusal Sheet" form detailing an attempt to evaluate Mr. Mitchell. The form was signed as having been witnessed by two employees. The "inmate signature" line does not contain Mr. Mitchell's signature, but contains the notation "refused to sign." A NaphCare nurse also noted in a "segregation note" that Mr. Mitchell refused to have his vitals checked. Another NaphCare nurse noted that Mr. Mitchell was administered his 8:00 a.m. medications.

NaphCare medical staff generated a "Release of Responsibility – Specific Procedure" form detailing an attempt to provide Mr. Mitchell "Bloodwork: CBC, CMP, Albumin, UA." The form was signed as having been witnessed by two employees. The "patient signature" line does not contain Mr. Mitchell's signature, but contains the notation "refuse to sign."

While Mr. Mitchell was being transported to court, several incarcerated persons reported that Mr. Mitchell spat on them. An HRRJ Incident Report was generated based on this incident.

Mr. Mitchell then appeared in the Portsmouth General District Court. An "order for continued custody" indicates that Mr. Mitchell was held without bail while "waiting on a bed at Eastern State Hospital."

An HRRJ Incident Report was also generated based on Mr. Mitchell's alleged conduct following his court hearing. As Portsmouth Sheriff's Deputies attempted to retrieve Mr. Mitchell from a courthouse holding cell after his hearing, they noticed that there was water all over Mr. Mitchell's holding cell. During his transport back to HRRJ, Mr. Mitchell continually banged on

the walls of the transport van. Upon arrival at HRRJ, Mr. Mitchell stated "don't touch me" and moved to the back of the van. Mr. Mitchell was removed from the van, during which time deputies reported that he was passively resistant and verbally non-compliant. After Mr. Mitchell's shackles were removed, he was placed in a wheelchair to escort him to his cell due to his swollen ankles and apparent mental health issues. When correctional officers opened the door to Mr. Mitchell's cell, they observed that the floor was flooded. Officers cleared the water using a wet/dry vacuum and a squeegee and returned Mr. Mitchell to his cell. Officers referred Mr. Mitchell to medical staff for a mental health review based on these post-court incidents. A supervising HRRJ lieutenant reviewed the incident report that officers had generated regarding the post-court incidents and reported that "mental health is aware."

In the Daily Confinement Record, a correctional officer reported that Mr. Mitchell received breakfast at 4:54 a.m. and that he received dinner at 4:14 p.m. The lunchtime entry reads "court." An officer additionally reported that Mr. Mitchell was given his medication at 12:28 p.m. and 9:15 p.m. Mr. Mitchell reportedly refused a shower at 3:23 p.m. The Feeding Roster indicates that Mr. Mitchell was served lunch and dinner. A "C" appears in the box for breakfast.

August 1, 2015

In the Daily Confinement Record, a correctional officer reported that Mr. Mitchell received breakfast at 5:30 a.m., that he received lunch at 11:51 a.m., and that he received dinner at 5:16 p.m. An officer additionally reported that Mr. Mitchell was given his medication at 2:40 p.m. and 10:00 p.m. The Feeding Roster indicates that Mr. Mitchell was served breakfast and lunch, as it does for each of the roughly 25 incarcerated persons on the page.

August 2, 2015

In the Daily Confinement Record, a correctional officer reported that Mr. Mitchell received

breakfast at 5:30 a.m., that he received lunch at 10:22 a.m., and that he received dinner at 5:05 p.m. The medication entries are illegible. The Feeding Roster indicates that Mr. Mitchell was served three meals.

August 3, 2015

In the Daily Confinement Record, a correctional officer reported that Mr. Mitchell received breakfast at 5:40 a.m., that he received lunch at 10:56 a.m., and that he received dinner at 5:39 p.m. An officer additionally reported that Mr. Mitchell was given his medication at 12:20 p.m. Mr. Mitchell reportedly refused a shower at 8:05 a.m. The Feeding Roster indicates that Mr. Mitchell was served lunch and dinner.

August 4, 2015

In the Daily Confinement Record, a correctional officer reported that Mr. Mitchell received breakfast at 5:12 a.m., that he received lunch at 10:39 a.m., and that he received dinner at 5:06 p.m. An officer additionally reported that Mr. Mitchell was given his medication at 9:30 p.m. The Feeding Roster indicates that Mr. Mitchell was served lunch and dinner.

August 5, 2015

In the Daily Confinement Record, a correctional officer reported that Mr. Mitchell received breakfast at 5:15 a.m., that he received lunch at 11:35 a.m., and that he received dinner at 6:20 p.m. An officer additionally reported that Mr. Mitchell was given his medication at 11:20 a.m. Mr. Mitchell reportedly refused a shower. The Feeding Roster for Mr. Mitchell's entire pod is blank.

August 6, 2015

In the Daily Confinement Record, a correctional officer reported that Mr. Mitchell received breakfast at 5:32 a.m., that he received lunch at 11:40 a.m., and that he received dinner at 5:43

p.m. An officer reported that Mr. Mitchell was given his medication at 12:00 p.m. and 9:30 p.m.

August 7, 2015

In the Daily Confinement Record, a correctional officer reported that Mr. Mitchell received breakfast at 5:39 a.m., that he received lunch at 10:35 a.m., and that he received dinner at 4:34 p.m. An officer additionally reported that Mr. Mitchell was given his medication at 12:40 p.m. and 10:10 p.m. Mr. Mitchell reportedly refused a shower at 7:40 a.m.

August 8, 2015

In the Daily Confinement Record, a correctional officer reported that Mr. Mitchell received breakfast at 5:45 a.m., that he received lunch at 10:49 a.m., and that he received dinner at 4:15 p.m. An officer reported that Mr. Mitchell was given his medication at 12:08 p.m. and 8:31 p.m.

August 9, 2015

A NaphCare nurse observed Mr. Mitchell in his cell during "pill pass." The nurse observed "swelling to the BLE (bilateral edema, or swelling on both legs)." The nurse was unable to understand Mr. Mitchell when she asked if he was okay. The nurse told Mr. Mitchell to go lay down and put his feet up, but he continued to sit on the toilet.

In the Daily Confinement Record, a correctional officer reported that Mr. Mitchell received breakfast at 5:30 a.m., that he received lunch at 10:54 a.m., and that he received dinner at 4:27 p.m. An officer additionally reported that Mr. Mitchell was given his medication at 8:41 p.m. The log contains an entry that reads "8-9-15 Refusal hair cut."

August 10, 2015

In the Daily Confinement Record, a correctional officer reported that Mr. Mitchell received breakfast at 5:05 a.m., that he received lunch at 11:16 a.m., and that he received dinner at 4:43 p.m. An officer additionally reported that Mr. Mitchell was given his medication at 10:30 a.m. and

9:15 p.m. Mr. Mitchell reportedly refused a shower at 3:59 p.m.

August 11, 2015

In the Daily Confinement Record, a correctional officer reported that Mr. Mitchell received breakfast at 5:54 a.m., that he received lunch at 10:42 a.m., and that he received dinner at 5:08 p.m. An officer additionally reported that Mr. Mitchell was given his medication at 11:00 a.m. and 8:22 p.m. The Feeding Roster indicates that Mr. Mitchell was served lunch and dinner.

August 12, 2015

NaphCare medical staff generated a "Release of Responsibility – Specific Procedure" form detailing Mr. Mitchell's refusal of "restricted rounds." The form was signed as having been witnessed by two employees. The "patient signature" line does not contain Mr. Mitchell's signature, but contains the notation "Refused."

In the Daily Confinement Record, a correctional officer reported that Mr. Mitchell received breakfast at 4:30 a.m., that he received lunch at 10:48 a.m., and that he received dinner at 4:18 p.m. An officer additionally reported that Mr. Mitchell was given his medication at 10:00 a.m. and 9:30 p.m. The Feeding Roster indicates that Mr. Mitchell was served three meals.

August 13, 2015

In the Daily Confinement Record, a correctional officer reported that Mr. Mitchell received breakfast at 4:30 a.m., that he received lunch at 10:41 a.m., and that he received dinner at 4:26 p.m. An officer additionally reported that Mr. Mitchell was given his medication at 9:40 a.m. and 9:00 p.m. The Feeding Roster indicates that Mr. Mitchell was served three meals.

August 14, 2015

Officers E, F, and L completed HRRJ Staff Statement Forms detailing an encounter they had with Mr. Mitchell. Officers reported that Mr. Mitchell was removed from his cell to clean

feces off the viewing window and wall, and because there was urine on the floor and on his uniform. Mr. Mitchell's cell was cleaned, and he was given a new uniform. Mr. Mitchell refused instructions to return to his cell. According to Officers E and L, they lifted Mr. Mitchell underneath his arms and carried him into his cell, ensuring that his feet did not drag on the floor. Mr. Mitchell was placed in his cell without any further incident. Officer F was operating the doors from the control room in the housing pod during this incident.

In the Daily Confinement Record, a correctional officer reported that Mr. Mitchell received breakfast at 4:58 a.m. and that he received dinner at 4:25 p.m. A correctional officer's name is written in the lunchtime entry space. An officer additionally reported that Mr. Mitchell was given his medication at 1:30 p.m. Mr. Mitchell reportedly refused a shower at 10:21 a.m. The Feeding Roster indicates that Mr. Mitchell was served three meals.

August 15, 2015

In the Daily Confinement Record, a correctional officer reported that Mr. Mitchell received breakfast at 5:49 a.m., that he received lunch at 11:05 a.m., and that he received dinner at 4:18 p.m. An officer additionally reported that Mr. Mitchell was given his medication at 12:15 p.m. The Feeding Roster indicates that Mr. Mitchell was served three meals.

August 16, 2015

In the Daily Confinement Record, a correctional officer reported that Mr. Mitchell received breakfast at 5:36 a.m., that he received lunch at 10:35 a.m., and that he received dinner at 5:28 p.m. All the medication entry boxes read "N/A."

August 17, 2015

An unknown treatment was administered to Mr. Mitchell during segregation rounds. In the Daily Confinement Record, a correctional officer reported that Mr. Mitchell received breakfast at

5:00 a.m., that he received lunch at 10:51 a.m., and that he received dinner at 4:35 p.m. An officer additionally reported that Mr. Mitchell was given his medication at 12:00 p.m. and 10:10 p.m. Mr. Mitchell reportedly refused a shower.

August 18, 2015

In the Daily Confinement Record, a correctional officer reported that Mr. Mitchell refused breakfast at 4:25 a.m., that he received lunch at 10:52 a.m., and that he received dinner at 4:27 p.m. An officer additionally reported that Mr. Mitchell was given his medication at 10:52 a.m. and 8:57 p.m.

August 19, 2015

On the morning of August 19, 2015, Correctional Officer E was distributing breakfast in Mr. Mitchell's pod. Officer E opened the tray slot of Mr. Mitchell's cell door to deliver his tray of food and called Mr. Mitchell's name several times. Mr. Mitchell was unresponsive. At approximately 5:44 a.m., Officer E notified his supervisors of his observations. Supervisors responded and observed Mr. Mitchell on his bunk laying on his right side. A medical emergency code was called over the radio. Once Mr. Mitchell's cell door was opened, officers did not detect a pulse or breathing from Mr. Mitchell. Mr. Mitchell was handcuffed because of his restricted cell status.

Correctional Officer E began chest compressions, and medical personnel and a corrections lieutenant entered the cell to assist at 5:46 a.m. Medical personnel took over chest compressions and breaths. Medical personnel noted that Mr. Mitchell was covered in urine. HRRJ Master Control called Portsmouth Emergency Medical Services at 5:46 a.m. Mr. Mitchell's handcuffs were removed so that HRRJ medical staff could use an automated external defibrillator on Mr. Mitchell. Portsmouth emergency medical technicians arrived at Mr. Mitchell's cell and

pronounced him dead at 5:59 a.m.

An entry in the Daily Confinement Record indicating Mr. Mitchell received breakfast at 5:45 a.m. is scratched through. The log reads "Inmate Released to," underneath which appears "inmate death."

A sergeant with the Portsmouth Sheriff's Office generated an "Internal Incident Report Form" dated "08/19/15" at "0754" hours. The report stated that a supervisor from HRRJ had called the PCJ sergeant to inform him that Mr. Mitchell was reported deceased at HRRJ at 5:59 a.m. the same morning.[11] The report stated that the PCJ sergeant verified Mr. Mitchell's date of birth and social security number with the HRRJ supervisor, and that the PCJ sergeant directed the HRRJ supervisor to call the PCJ records department to inform them of Mr. Mitchell's death.

August 24, 2015

A NaphCare nurse created a "Segregation Note" for Mr. Mitchell, listing, among other vital statistics, his weight at 193 lbs.

[11] The report references the fact that Mr. Mitchell was technically a PCJ inmate who was being housed at HRRJ.

II. Investigation into Jamycheal Mitchell's Incarceration at Portsmouth City Jail

This investigation has revealed no allegations of mistreatment of Mr. Mitchell by PCJ staff. No particular allegations of mistreatment of Mr. Mitchell by Correct Care Solutions were presented to this office. It appears that PCJ transferred Mr. Mitchell to HRRJ under the belief that HRRJ was better equipped to handle a patient with serious mental health concerns.

The Portsmouth sheriff's deputy who booked Mr. Mitchell into PCJ was interviewed on July 1, 2016. That deputy did not specifically remember Mr. Mitchell until being shown a photograph and some booking documents. The deputy did not recall whether he determined Mr. Mitchell's weight by asking Mr. Mitchell, or by using the weight reported on the booking card turned in by the arresting officer. The deputy documented all of Mr. Mitchell's belongings and placed them in a property bag. The deputy reported that it is standard procedure for the booking officer to ask a series of questions which are repeated later by medical staff.

The Correct Care Solutions Health Services Administrator at PCJ was interviewed on July 1, 2016. According to the administrator, Mr. Mitchell was weighed 3 times while at PCJ. The administrator did not know whether Mr. Mitchell was wearing restraints (i.e., handcuffs and chains) when he was weighed. The administrator reported three weights and dates of weighing: April 22, 2015 – 178 lbs.; May 4, 2015 – 186 lbs.; May 5, 2015 – 182 lbs.

III. Investigation into Jamycheal Mitchell's Incarceration at Hampton Roads Regional Jail

A. Interviews of Incarcerated Persons Alleging Abuse of Jamycheal Mitchell

Virginia State Police (VSP) investigators interviewed six witnesses who were formerly incarcerated at HRRJ who gave statements about alleged abuse of Mr. Mitchell by correctional officers. A seventh formerly incarcerated witness was approached by investigators, and that person declined to make a statement. Investigators advised all incarcerated persons that they were not being investigated and that they were free to leave at any time.

1. Interview of Incarcerated Person A

Incarcerated Person A (hereinafter "IP A") was interviewed on June 7, 2016. IP A stated that he worked as a trustee (an incarcerated person with additional privileges such as participating in food delivery) at HRRJ along with Incarcerated Persons B and F during his incarceration. IP A stated that he additionally worked as a trustee with Incarcerated Person H, who he did not identify by name, making him unavailable for interview by VSP.

IP A stated that as an HRRJ trustee, he encountered Mr. Mitchell two or three times a day. IP A reported that early on in his incarceration, Mr. Mitchell could speak intelligibly, but that as time went on, he no longer could effectively communicate. IP A reported that Mr. Mitchell never spoke of being mistreated, and that his speech was "gibberish."

IP A alleged that correctional officers struck Mr. Mitchell on the knuckles with a flashlight or punched him in the hand when Mr. Mitchell placed his hands through the tray slot on his cell door. IP A alleged that Correctional Officer E struck Mr. Mitchell's hands on three or four occasions while angrily directing profanities toward Mr. Mitchell. IP A stated that he observed pepper spray on the walls of Mr. Mitchell's cell while cleaning it on one occasion; however, he stated that he never observed correctional officers pepper spray or deploy a Taser on Mr. Mitchell.

IP A claimed that he observed officers withholding food from Mr. Mitchell, or that officers forced trays of food through Mr. Mitchell's tray slot so that they fell on the floor. IP A refused to specify which officers withheld food from Mr. Mitchell when asked. IP A estimated that Mr. Mitchell did not receive a meal at least once a day.

IP A reported that Mr. Mitchell was never clothed, that his cell had no running water, and that his cell was littered with feces and blood. IP A claimed that he made a request to be removed from his assigned detail because of the condition of Mr. Mitchell's cell, but that he did not specify the conditions as the reason for his request because he was afraid. IP A refused to give the names of other officers and sergeants who allegedly abused Mr. Mitchell because he was afraid. IP A stated that he observed swelling on Mr. Mitchell's right thigh, as if he had been bitten by insects or beaten.

IP A claimed that an incarcerated person whose name he could not remember made an inquiry to HRRJ internal affairs on the date of Mr. Mitchell's death, and then that incarcerated person disappeared. IP A additionally stated that he never had a conversation about Mr. Mitchell's condition with even the good correctional officers whom he liked.

2. <u>Interview of Incarcerated Person B</u>

Incarcerated Person B (hereinafter "IP B") was interviewed on June 6, 2016. IP B stated that he was housed in the same housing pod in HRRJ as Mr. Mitchell. IP B stated that Incarcerated Persons F and H would have information about Mr. Mitchell's treatment while at HRRJ, the same incarcerated persons that IP A had mentioned. IP B reported that he never talked to Mr. Mitchell because Mr. Mitchell didn't talk and was hard to understand. When asked if Mr. Mitchell ever discussed being mistreated by correctional officers, IP B stated that Mr. Mitchell did not speak, ever. IP B claimed to have been the person who was around Mr. Mitchell more than anyone else.

IP B referred to Mr. Mitchell as "Jaymichael" throughout the interview.

IP B related an alleged incident outside Mr. Mitchell's cell in which Officer C told Mr. Mitchell to sit down, and then kicked Mr. Mitchell in the knee when he did not sit down. IP B then stated that directly after the kicking incident, Officer A sprayed Mr. Mitchell in the face with water while other incarcerated persons laughed at Mr. Mitchell and Officer A called Mr. Mitchell mocked him, calling him "dirty." IP B stated that he once saw Mr. Mitchell outside of his cell, appearing to be in pain and starting to cry. IP B alleged that Officer F told Mr. Mitchell "not to start that s***" and dragged him back to his cell by his handcuffs, threatening to pepper spray him if he did not comply. IP B did not see any other correctional officers assault or pepper spray Mr. Mitchell. IP B further advised investigators that he had notified correctional officers in July 2015 that Mr. Mitchell had swollen feet. IP B reported that he had told four different correctional officers about Mr. Mitchell's foot issues.

IP B claimed that Officers E and G would withhold food by placing a tray of food on a table outside of Mr. Mitchell's cell if Mr. Mitchell did not return his tray from the previous meal. IP B alleged that at times, Mr. Mitchell would aggressively attempt to grab his food through the tray slot, prompting correctional officers to strike his arm in order to close the tray slot. IP B claimed that Mr. Mitchell never received water or juice except just before he died. IP B claimed that Mr. Mitchell's cell was filthy, and that there was never running water in the cell except for when he went in to clean the cell. IP B additionally stated that when Correctional Officer G worked, Mr. Mitchell got two trays of food. IP B claimed that he was serving breakfast when he first discovered that Mr. Mitchell had passed on August 19, 2015. IP B advised investigators that Mr. Mitchell did not die of starvation, because he would eat.

IP B stated that he never got money in return for giving information on Mr. Mitchell and

never asked for anything, stating, "that's not the reason I'm doing this." However, IP B reported that he had already spoken to the Washington Post, the Richmond Times-Dispatch, the Virginian-Pilot, and WAVY-10 News about Mr. Mitchell. In a letter to a Washington Post reporter, IP B wrote that "you can use my name but I'd like compensation. . . you can go to touchpay.com or icaredirect.com."

3. Interview of Incarcerated Person C

VSP investigators initially approached Incarcerated Person C (hereinafter "IP C") on June 3, 2016 and informed him that they wanted to ask him some questions about Mr. Mitchell. IP C declined to be interviewed at that time. VSP investigators re-approached IP C and interviewed him on June 15, 2016. IP C mentioned that he believed Incarcerated Persons F and H, the same trustees mentioned by IPs A and B, would have information about the investigation.

IP C claimed he received a letter from a Washington Post journalist but did not respond to it. However, VSP obtained a letter bearing IP C's signature and a date of September 17, 2015, responding to a letter from a Washington Post journalist. In the letter, IP C offered to give information about Mr. Mitchell in return for the journalist "shin[ing] light on [his] situation."

IP C stated that he was housed in a cell in the same pod beside Mr. Mitchell for approximately 5 months. IP C stated that Mr. Mitchell didn't talk, but would ramble incoherently and was hard to understand. IP C reported that Mr. Mitchell never discussed being injured by correctional officers.

IP C reported an incident in which Mr. Mitchell was inadvertently let out of his cell and was running around. IP C stated that correctional officers gave Mr. Mitchell commands to move to the pod door to be handcuffed. IP C then stated that Officer F and another correctional officer handcuffed Mr. Mitchell, dragged him to his cell, and bumped him up against the cell wall, causing

him to cry. IP C alleged that Mr. Mitchell was never given water to drink and didn't have a cup or a spoon. IP C claimed that correctional officers would often not feed Mr. Mitchell if he did not comply with their instructions to step back from the tray slot. IP C stated that correctional officers would always take Mr. Mitchell out of his cell naked and force him to sit on the floor. IP C claimed that Mr. Mitchell's feet were swollen and he had feces and blood smeared all over the toilet. IP C later admitted that he did not actually see the inside of Mr. Mitchell's cell, but that he heard other trustees talking about the cell's condition.

IP C reported that Mr. Mitchell was the only incarcerated person who correctional officers demanded to step away from the tray slot in his cell door. IP C stated that if Mr. Mitchell refused to remove his arms from the tray slot, correctional officers would punch, twist his arm, or hit his arm with a large flashlight. IP C additionally stated that Officers A and H would look out for Mr. Mitchell and provide him extra food. IP C also stated that Mr. Mitchell had no cup and no mattress, and he never saw Mr. Mitchell get water, juice, or tea.

IP C alleged that while cleaning Mr. Mitchell's cell, an unidentified correctional officer sprayed Mr. Mitchell with a solution from a spray bottle. Mr. Mitchell was handcuffed and began to flail. The unidentified correctional officer then allegedly grabbed Mr. Mitchell by the throat and sat him up. IP C also alleged that he had seen Officers C, D, I, J, and K spray water on Mr. Mitchell. When asked if he ever made reports about Mr. Mitchell's condition while he was still living, IP C refused to give a direct answer.

4. Interview of Incarcerated Person D

VSP investigators interviewed Incarcerated Person D (hereinafter "IP D") on June 6, 2016. When investigators initially approached IP D, IP D declined to answer any questions about Mr. Mitchell. As investigators were leaving, IP D stated that he didn't know if any contact other

correctional officers had with Mr. Mitchell resulted in Mr. Mitchell's death. IP D additionally alleged that an unnamed correctional officer kicked Mr. Mitchell in the head and the back of the neck, causing Mr. Mitchell to stop moving. IP D indicated that he was unsure whether the kick was the reason Mr. Mitchell died. IP D volunteered this information without having been asked a question by investigators, and he additionally stated "I saw this for myself." IP D then refused to make any more statements. IP D was additionally approached by different investigators on June 15, 2016. IP D refused to answer any questions at that time.

5. Interview of Incarcerated Person E

Investigators interviewed Incarcerated Person E (hereinafter "IP E") on June 8, 2016. IP E claimed to have been incarcerated at HRRJ from summer of 2015 until sometime in September 2015 on a weapons charge. IP E stated that he periodically laughed and joked with Mr. Mitchell during his hourly recreation on the pod. IP E claimed that Mr. Mitchell would scream for medical assistance and correctional officers would refuse care, and that incarcerated persons would speak up to the correctional officers in attempts to get Mr. Mitchell help. IP E claimed that he spoke with seven different correctional officers in an attempt to get Mr. Mitchell help.

IP E claimed that a sergeant once used pepper spray on Mr. Mitchell because he refused to take a shower. IP E stated that after being pepper sprayed, Mr. Mitchell requested medical attention, and correctional officers threw him down and used restraints as punishment on him. IP E stated that he observed this type of abusive behavior for the entire two-week period he was housed with Mr. Mitchell. IP E alleged that correctional officers withheld blankets and clothing from Mr. Mitchell. IP E claimed that on one occasion, Mr. Mitchell got stuck on the toilet and called out for help, which was refused by correctional officers. IP E reported that he never saw Mr. Mitchell get food, water, or take a tray for the entire two-week period he was housed with Mr.

Mitchell. IP E volunteered that Mr. Mitchell had swollen feet, had no running water, and had blood in his stool.

Investigators later confirmed that IP E was not booked into HRRJ until two days after Mr. Mitchell's death, and that IP E had not been at HRRJ at the same time as Mr. Mitchell.

6. Interview of Incarcerated Person F

Incarcerated Person F (hereinafter "IP F") was interviewed on June 21, 2016. IP F referred to Mr. Mitchell as "Jaymichael" throughout his interview.

IP F claimed that he was housed in the same pod as Mr. Mitchell, but on the floor above. IP F stated that he was a pod worker/trustee in Mr. Mitchell's pod for three weeks prior to Mr. Mitchell's passing, and that he had contact with Mr. Mitchell three times daily. IP F stated that he never had a coherent conversation with Mr. Mitchell, and that Mr. Mitchell could speak clearly, but not carry on a conversation. IP F stated that when feeding Mr. Mitchell, correctional officers would open the tray slot, hand him his tray, and shut the tray slot quickly so Mr. Mitchell would not stick his arm out of the slot. IP F stated that officers' handling of issues involving Mr. Mitchell and the tray slot was no different from how officers would handle any other incarcerated person who put his hands through the tray slot. IP F additionally reported that he never saw correctional officers use pepper spray, an asp, or improper handcuffing on Mr. Mitchell. However, IP F reported that an unidentified correctional officer shut the tray slot door while Mr. Mitchell's arm was still inside it.

IP F reported that Mr. Mitchell rarely received juice because he did not have a cup, but that every single time he served food, Mr. Mitchell always got a food tray. IP F stated that at no time did officers tell him not to give Mr. Mitchell a tray of food. IP F stated that he only gave Mr. Mitchell juice on approximately three occasions, because Mr. Mitchell would destroy his

Styrofoam cup. IP F claimed that Mr. Mitchell had no mattress, shoes, or clothes, because as he recalled, Mr. Mitchell would flood his cell. IP F stated that he never discussed Mr. Mitchell's condition with correctional officers because he didn't want to lose his job as a trustee.

IP F contradicted IP B's claim that IP B had been the first to discover Mr. Mitchell deceased in his cell. IP F was aware of IP B's claim, and raised it on his own in order to inform investigators that he was the one who discovered Mr. Mitchell on the day of his death. IP F was also aware of other incarcerated persons' allegations of assaults and pepper spraying of Mr. Mitchell, but stated that he observed no such abuse. IP F was aware that "a lot of other people did call [another party involved in the case] asking for stuff," but claimed that he did not ask for anything.

7. Interview of Incarcerated Person G

Investigators attempted to interview Incarcerated Person G on June 15, 2016, but that individual refused to be interviewed.

B. Interviews of HRRJ Correctional Officers and Staff

1. Interview of Correctional Officer A

VSP investigators interviewed Correctional Officer A on June 24, 2016. Officer A was alleged by IP B to have sprayed Mr. Mitchell in the face with water on one occasion. Officer A was also reported by IP C to have provided Mr. Mitchell with extra food. Officer A was advised of his Miranda rights and signed a form indicating he understood his rights and wished to make a statement.

Officer A stated that he had only encountered Mr. Mitchell a few times in HRRJ. Officer A advised investigators that he gave Mr. Mitchell extra food when he said he was hungry. Officer A reported that he once had Mr. Mitchell taken out of his cell so that it could be cleaned and so Mr. Mitchell could shower. Officer A stated that he escorted Mr. Mitchell to the shower but didn't

remember if Mr. Mitchell actually took a shower. Officer A stated that Mr. Mitchell often had to be encouraged to come out of his cell, but once he came out, he was fine. Officer A reported that Mr. Mitchell never gave him a hard time. He stated that incarcerated persons called Mr. Mitchell "Lil Weezy" because he was from Louisiana and liked Lil Wayne.

Officer A described Mr. Mitchell's demeanor as sometimes talking and rapping to himself, coupled with outbursts and spitting on the cell window when he walked by Mr. Mitchell's cell. Officer A reported that the outbursts and spitting stopped as Mr. Mitchell got to know him. Officer A stated that Mr. Mitchell never reported any mistreatment to him. Officer A claimed that he had never witnessed or heard of anyone assault, mistreat, or withhold meals from Mr. Mitchell. Officer A stated that to his knowledge, Mr. Mitchell had never smeared feces or urine inside of his cell. Officer A noted that if an incarcerated person smeared feces or urine inside of their cell, HRRJ policy dictated that the incarcerated person was to be temporarily removed from the cell so that it cell could be cleaned. Officer A stated that if he was initially coming on a shift and an incarcerated person's cell was covered in feces or urine, he would not accept the post until the dirty cell was cleaned by the outgoing shift.

When asked if he had ever sprayed Mr. Mitchell with water, or heard of anyone else spraying Mr. Mitchell with water, Officer A said he had not. When asked about the kicking incident related by IP B that allegedly preceded Officer A spraying Mr. Mitchell in the face with water, Officer A reported that no one had kicked Mr. Mitchell in the leg or anywhere else on his person. Officer A stated that he never saw Mr. Mitchell with an unexplained injury, except for the swelling in his legs, which he believed Mr. Mitchell had received treatment for. Officer A stated that if he witnessed a fellow officer mistreat an incarcerated person, he would pull the person to the side and tell them it was wrong; depending on how the officer reacted, he might take it to a

higher level of discipline.

Officer A stated that Mr. Mitchell always had a mattress when he saw him, and that Mr. Mitchell always had pants on but sometimes didn't have his uniform top on. Officer A reported that Mr. Mitchell's cell smelled because he would leave feces and urine in the toilet without flushing. Officer A stated that to his knowledge, Mr. Mitchell had running water in his cell and was not a flood risk. Officer A stated that Mr. Mitchell would never miss a meal, and that he always wanted another tray. He stated that Mr. Mitchell had Styrofoam trays instead of the traditional hard plastic trays because there was no way for Mr. Mitchell to hurt himself with the Styrofoam trays, and there wasn't as much of an issue when Mr. Mitchell didn't return the Styrofoam trays. Officer A stated that he thought that Mr. Mitchell had a rubber spork to eat with like all other incarcerated persons did. Officer A stated that Mr. Mitchell had a Styrofoam cup and received juice, tea, and water like every other incarcerated person in the pod. Officer A denied ever placing a tray of food on a table outside Mr. Mitchell's cell where Mr. Mitchell could see the tray but not reach it.

Officer A denied that an incident involving him, Mr. Mitchell, and Officer D ever occurred. Officer A recalled taking Mr. Mitchell out of his cell with Officer D, but denied that Officer D ever kicked Mr. Mitchell or dragged Mr. Mitchell from his cell naked. Officer A denied squirting Mr. Mitchell with water or chemicals while laughing at him.

Officer A stated that while there were some incarcerated persons who correctional officers would be glad to see go due to the problems they caused, Mr. Mitchell was not that type of person. Officer A confirmed that Mr. Mitchell was not a problematic person to deal with.

2. <u>Interview of Correctional Officer B</u>

VSP investigators interviewed Correctional Officer B on June 24, 2016. Officer B reported that he booked Mr. Mitchell into HRRJ on May 11, 2015, following all of his normal booking

procedures. Officer B reported that he would ask each incarcerated person he booked into HRRJ their name, date of birth, social security number, height and weight, address, phone number, and emergency contacts. Officer B reported that he used a "certified credit sheet" containing individuals' information from a prior booking jurisdiction; however, Officer B reported that he still asked each booking question individually to ensure that the information was current and accurate.

Officer B remembered Mr. Mitchell from dealing with him in the past, having worked in a housing unit where Mr. Mitchell stayed. Officer B reported that he came to know Mr. Mitchell as someone who had to be closely monitored—not because of aggressive behavior, but rather, erratic behavior. Officer B stated that Mr. Mitchell was one of the incarcerated persons that correctional officers tried to look out for by providing him extra trays of food; the reason for this practice was because Mr. Mitchell would often try to eat off of discarded food trays.

3. Interview of Correctional Officer C

VSP investigators interviewed Correctional Officer C on June 24, 2016. Officer C was advised of his Miranda rights and signed a form indicating he understood his rights and wished to make a statement.

Officer C informed investigators that he had contact with Mr. Mitchell in two different housing units. Officer C stated that he had contact with Mr. Mitchell for several weeks in the first housing unit, and then on two occasions in the second housing unit, to which Officer C and Mr. Mitchell had both been transferred. Officer C disclosed that the only communication he had with Mr. Mitchell was regarding meals and medication. Officer C said that Mr. Mitchell clearly had a mental disability, and that Mr. Mitchell's demeanor or mental state was the same in both housing units in which he came in contact with Mr. Mitchell.

Officer C stated that Mr. Mitchell was always cooperative. Officer C denied having kicked or sprayed Mr. Mitchell. Officer C similarly had not witnessed or heard of any correctional officers kicking, spraying, or assaulting Mr. Mitchell. Officer C stated that he did not observe any unexplained injuries to Mr. Mitchell, except for swollen legs. Officer C recalled that Mr. Mitchell had noticeably lost weight from the time he initially came in contact with him in the first housing unit until Mr. Mitchell's transfer to the second housing unit.

Officer C stated that he would always give Mr. Mitchell extra food. He noted that Mr. Mitchell had running water in his cell, but stated that Mr. Mitchell would often leave his toilet unflushed. Officer C stated that Mr. Mitchell's cell often had ripped-up Styrofoam everywhere. Officer C reported that if he observed an incarcerated person with feces on his person, he would never let them just sit there dirty, even if the person had diminished mental capacity. Officer C stated that he would place such an incarcerated person in the shower and get them a new uniform. Officer C stated that during the two times he cleaned Mr. Mitchell's cell in his second housing unit, he never observed feces or urine on his person or in his cell. Officer C reported that he was surprised to hear of Mr. Mitchell's passing, because he had seemed okay the week before.

4. <u>Interview of Correctional Officer D</u>

VSP investigators interviewed Correctional Officer D, a sergeant, on June 29, 2016. Officer D was advised of his Miranda rights and signed a form indicating he understood his rights and wished to make a statement. Officer D stated that he was HRRJ's watch supervisor in August 2015, meaning that he oversaw the daily functions of the jail.

Officer D stated that he had contact with Mr. Mitchell twice: once while supervising trustees as they cleaned Mr. Mitchell's cell, and once to get Mr. Mitchell out of a dirty uniform. Officer D described both of his contacts with Mr. Mitchell as routine. Officer D described Mr.

Mitchell's manner of speech during their first contact as initially rambling, but more lucid as conversation continued. Officer D reported that Mr. Mitchell was never combative, and there would have been no need for anyone to use force on him. Officer D stated that had there been any force used on Mr. Mitchell, an incident report would have been generated per HRRJ policy, and the officers involved would have to be checked by medical staff. Officer D further reported that he talked to Mr. Mitchell about taking his medicine because his leg was swollen, and Mr. Mitchell replied that he wasn't going to take his medicine because he wasn't crazy.

Officer D stated that neither he nor any other staff member had sprayed Mr. Mitchell's face with water or a cleaning solution. Officer D also stated that he was unaware of any other officer spraying an incarcerated person. Officer D reiterated that there was no need to spray or kick Mr. Mitchell, because Mr. Mitchell was cooperative with officers.

Officer D was asked about the second time he came in contact with Mr. Mitchell, and he again stated that neither he nor any other officers punched, kicked, or threw Mr. Mitchell to the ground during that encounter. Officer D again stated that such conduct would be unnecessary because Mr. Mitchell was always cooperative. Officer D stated that he again talked with Mr. Mitchell about taking his medication, but Mr. Mitchell said he wouldn't take his medication because he wasn't crazy, but the correctional officers were.

Officer D observed that Mr. Mitchell was walking normally, and stated that Mr. Mitchell never complained about any medical issues. When asked whether Mr. Mitchell had running water in his cell, Officer D stated that Mr. Mitchell had to have his toilet cleaned and snaked because he put things down it. Officer D stated that incarcerated persons' tray slots would remain closed so that they would not pass items from cell to cell. Officer D stated that if an incarcerated person refused to move his arm so that the tray slot could be closed, a supervisor would be called. When

asked whether Mr. Mitchell was the type of incarcerated person who refused to remove his arm from the tray slot in his cell door, Officer D replied that he was not.

Officer D stated that he had never heard of officers withholding food from Mr. Mitchell. When asked whether he felt that Mr. Mitchell needed any assistance based on his two interactions with him, Officer D stated that he felt that Mr. Mitchell needed to take his medicine.

Officer D, who is also a defensive tactics instructor, was asked if a kick to the back of the knee to get an incarcerated person to sit down was an acceptable use of force. Officer D advised that such a practice was unacceptable, and any officer who employed such a practice would be written up under the jail's standards of conduct policy. Officer D stated that if one of his officers kicked a handcuffed incarcerated person in order to get him to sit down, he would take disciplinary action against the officer and let the jail's executive staff handle the complaint.

5. <u>Interview of Correctional Officer E</u>

VSP investigators interviewed Correctional Officer E on September 28, 2016. Officer E signed an Advice of Rights form indicating that he waived his rights and wished to speak with investigators. Officer E stated that he was in field training during Mr. Mitchell's incarceration and was assigned to Mr. Mitchell's pod for the entire time Mr. Mitchell was there and up until his death. Officer E remembered Mr. Mitchell, but stated that Mr. Mitchell did not talk very often. Officer E described Mr. Mitchell as appearing to be mentally ill.

Officer E noted that Mr. Mitchell was receiving his meals on Styrofoam trays, but that incarcerated persons, not officers, served the meals. Officer E never watched Mr. Mitchell eat, but recalled giving him an extra tray of food on occasion. Officer E reported Mr. Mitchell's swollen foot to two sergeants and the medical department, and according to him, the medical staff responded and transferred Mr. Mitchell to an outside medical appointment.

On one occasion, Officer E let Mr. Mitchell out of his cell to take a shower. Mr. Mitchell came out of his cell naked and refused to return. Other officers responded and had to escort Mr. Mitchell back to his cell. Officer E stated that Officer F was involved in that incident, along with one other officer whom Officer E could not recall. Officer E denied that anyone struck, kicked, or threw Mr. Mitchell to the ground during that incident. Officer E stated that Mr. Mitchell was not in trouble during the incident and did not resist being taken back to his cell.

Officer E stated that Mr. Mitchell never complained of being abused by other correctional officers because he did not talk. Officer E reported that he never had to order Mr. Mitchell to remove his arms from the tray slot, because he usually had to call Mr. Mitchell to the tray slot to get him to take his meals. Officer E denied ever punching or striking Mr. Mitchell's arms with a flashlight or any other object to get Mr. Mitchell to remove his arms from the tray slot. Officer E stated that he never carried a flashlight while working in the pod.

Officer E never observed another correctional officer verbally or physically abuse or withhold food from Mr. Mitchell. He reported that no incarcerated person reported abuse of Mr. Mitchell to him, because Mr. Mitchell was in segregation and did not interact with other incarcerated persons. Officer E stated that he would personally escort nurses to each cell to make medication rounds, and that he did not recall Mr. Mitchell ever refusing medication. Officer E stated that Mr. Mitchell would take his medication because it was for his foot. Officer E reported that medical staff would always attempt to talk to Mr. Mitchell and get him to take his medication, but he never watched to see if Mr. Mitchell took his medication once it was given to him.

6. Interview of Correctional Officer F

VSP investigators interviewed Correctional Officer F, a sergeant, on September 27, 2016. Officer F signed an Advice of Rights form indicating that he waived his rights and wished to speak

with investigators. Officer F stated that he was one of the housing unit supervisors in Mr. Mitchell's initial housing unit, but that he had no recollection of Mr. Mitchell while he was there.

Officer F additionally interacted with Mr. Mitchell in a different housing pod on August 14, 2015. Officer F stated that he responded to the pod after being informed that Mr. Mitchell's cell door had inadvertently been opened, and a naked Mr. Mitchell had gotten out and refused to go back to his cell. During the time that Mr. Mitchell was out of his cell, he sat and talked to other incarcerated persons while his cell was cleaned. Officer F told Mr. Mitchell it was time to go back to his cell, and Mr. Mitchell refused. Officer F and Officer L put their arms under Mr. Mitchell's armpits, lifted him up, and dragged him back to his cell.

Investigators asked Officer F if he ever told Mr. Mitchell "Don't start that s***" or cursed at him after he sat down and refused to go back to his cell. Officer F replied that he did not, and stated that he never uses profanity toward any incarcerated person. Officer F also stated that he did not observe any other officer spray Mr. Mitchell during the incident, as he and Officer L never left Mr. Mitchell's side and did not observe any spraying. Officer F stated that no one kicked Mr. Mitchell to the ground, or kicked him in the back of the leg. Officer F stated that he would never allow an incarcerated person to be physically abused.

Officer F stated that he did not know whether there were clothes in Mr. Mitchell's cell, but there had to have been water since there was water on the cell floor. Officer F stated that he was unaware of Mr. Mitchell having been on a water restriction, since all water restrictions had to be approved through a supervisor such as himself. He stated that water restrictions were not to last more than 72 hours per HRRJ policy. He noted that it was not uncommon for incarcerated persons to be on a water restriction. Officer F had not heard of any other officers physically abusing or withholding food or medicine from Mr. Mitchell. Officer F reported that he had never been advised

that Mr. Mitchell was not getting his medication, because medical personnel were supposed to document each time an incarcerated person refused their medication.

7. Interview of Correctional Officer G

VSP investigators interviewed Correctional Officer G on September 27, 2016. Officer G signed an Advice of Rights form indicating that he waived his rights and wished to speak with investigators. Officer G interacted with Mr. Mitchell many times during his incarceration at HRRJ. Officer G reported that he didn't realize Mr. Mitchell had mental health issues until he tried speaking to him and received responses that were different than most other incarcerated persons. Officer G reported that Mr. Mitchell would not go out to recreation like all the other incarcerated persons and that he couldn't force Mr. Mitchell to go out for recreation. Officer G reported that during recreation, Mr. Mitchell would remain in his cell, saying "give me my tray" and asking for more food even though he already had received a tray of food.

Officer G gave Mr. Mitchell extra food on several occasions. He reported that sometimes, Mr. Mitchell would try to bite hands or knock trays away when officers reached into Mr. Mitchell's cell to give him food. Officer G found that if he delivered food to Mr. Mitchell, as opposed to an incarcerated person, Mr. Mitchell was more cooperative. Officer G additionally reported that Mr. Mitchell always had water available in his cell. Officer G stated that Mr. Mitchell appeared generally healthy, and that he was surprised that Mr. Mitchell could eat as much as he did. Officer G noted that Mr. Mitchell appeared to have lost some weight after his housing assignment changed. Officer G reported one incident in which Mr. Mitchell had to be removed from his cell because he threw feces around and put feces in the air vent. During the incident, an incarcerated person cleaned the cell while officers stood with Mr. Mitchell outside.

Officer G reported that Mr. Mitchell never made any complaints to him about the jail. He

asked Mr. Mitchell if he felt alright on several occasions, and Mr. Mitchell would reply "no." Officer G never observed another officer withhold food from Mr. Mitchell, and he reported that he never did so himself. Officer G never observed another officer place food on a table in front of Mr. Mitchell's cell to taunt him, and he reported that he never did so himself. Officer G reported that he never heard of anyone abusing Mr. Mitchell. He noted that he observed Mr. Mitchell refuse his morning medications on multiple occasions, and stated that Mr. Mitchell would take his medications on weekends but not during the week for some reason. Officer G stated that he would advise the oncoming shift if Mr. Mitchell had refused his medications.

Officer G advised investigators that he would never tolerate abuse of Mr. Mitchell or any other incarcerated person. He stated that officers would always keep Mr. Mitchell's cell clean and would make sure he had a clean uniform to wear. Officer G reported that he never had to strike Mr. Mitchell, and that he never saw anyone else strike him. Officer G stated that despite Mr. Mitchell's strange behavior, he found him easy to work with.

8. <u>Interview of Correctional Officer H</u>

VSP investigators interviewed Correctional Officer H, a sergeant, on September 28, 2016. Officer H signed an Advice of Rights form indicating that she waived her rights and wished to speak with investigators. Officer H stated that at the time of her interview, as well as while Mr. Mitchell was incarcerated at HRRJ, she was an Assistant Watch Commander. As an assistant watch commander, she was to be notified if any significant events occurred involving incarcerated persons during her shifts. Officer H supervised all housing units at HRRJ during Mr. Mitchell's incarceration.

Officer H recalled one observation of Mr. Mitchell as she spoke to the incarcerated person in the cell next to Mr. Mitchell. Officer H reported that Mr. Mitchell did not attempt to interact

with her or get her attention, but that when an incarcerated pod worker stepped in front of his window, he told the worker to move because he was blocking his view. Officer H was unaware of any times when Mr. Mitchell had to be removed from his cell for hygiene purposes; she stated that removal of an incarcerated person from a cell for cleaning did not require supervisor notification.

Officer H stated that no employees under her supervision reported any unusual incidents involving Mr. Mitchell. Officer H additionally stated that she had not heard from any incarcerated persons or employees of mistreatment, abuse, or withholding of food from Mr. Mitchell.

9. Interview of Correctional Officer I

VSP investigators interviewed Correctional Officer I on October 6, 2016. Officer I signed an Advice of Rights form indicating that he waived his rights and wished to speak with investigators.

Officer I advised investigators that he recalled cleaning Mr. Mitchell's cell two times. He found Mr. Mitchell to be compliant and passive when he cleaned his cell. Officer I never saw anyone force Mr. Mitchell to the ground, choke him, or spray him. Officer I noted that only incarcerated pod workers had spray bottles for use in cleaning the cells, and that officers did not have spray bottles. Officer I stated that there was no need for officers to be physical with Mr. Mitchell. Officer I had not heard of any incidents of abuse or withholding of food involving Mr. Mitchell. Officer I noted that it was remarkable to observe Mr. Mitchell's obvious weight loss while at HRRJ.

10. Interview of Correctional Officer J

VSP investigators interviewed Correctional Officer J on October 12, 2016. Officer J was advised of the purpose of the interview and agreed to speak to investigators. Officer J was no longer employed with HRRJ at the time of his interview. He had resigned in December 2015 after

two years of employment at HRRJ.

Officer J recalled assisting in cleaning Mr. Mitchell's cell twice. He stated that the cleanings were done early in the morning. Officer J remembered Officers A, C, D, I, K, and N being present during the cell cleanings. Officer J stated that Mr. Mitchell was cooperative and no officer had to use any force to get him handcuffed and out of his cell. He reported that the only time officers had to touch Mr. Mitchell was to assist him to one of the tables in the pod while he was handcuffed.

Officer J never observed anyone spray Mr. Mitchell with water or any type of cleaning solution. He stated that neither he nor any other officer kicked Mr. Mitchell in the back of the leg or kicked him to force him to the ground. He never observed another officer drag or physically abuse Mr. Mitchell.

Officer J never had to physically remove Mr. Mitchell's arm from the tray slot. He never struck Mr. Mitchell's arm with a fist or flashlight to get his arm out of the tray slot. Officer J advised investigators that Mr. Mitchell was difficult to understand, but that he spoke to Mr. Mitchell about taking his medications. He recalled Mr. Mitchell refusing his medications on two occasions. Officer J recalled that Mr. Mitchell was very slender and his feet were swollen.

11. <u>Interview of Correctional Officer K</u>

VSP investigators interviewed Correctional Officer K on October 12, 2016. Officer K signed an Advice of Rights form indicating that he waived his rights and wished to speak with investigators.

Officer K was assigned to Mr. Mitchell's second housing unit, and he reported that Mr. Mitchell's cell was often dirty. He stated that officers would often have to remove Mr. Mitchell from his cell to clean it before the officers got off their shift in the morning. Officer K stated that

Mr. Mitchell's cell had to be cleaned so often because he would clog his toilet and flood his cell. Officers would have Mr. Mitchell exit his cell while incarcerated pod workers cleaned up the water and bleached the cell to sanitize it. Mr. Mitchell would be given a clean uniform. Officer K reported that he helped clean Mr. Mitchell's cell on at least four occasions. Officer K stated that Mr. Mitchell was uncooperative and refused everything officers did to try to help him. Officer K stated that Mr. Mitchell was never aggressive, but often passively or verbally resisted.

Officer K recalled an incident in which he and Officer C had to force Mr. Mitchell to sit down. Officer K stated that once Mr. Mitchell sat down, he began to roll around. Officer K stated that he and Officer C did not kick, spray, drag, or use profanity toward Mr. Mitchell during that incident. He stated that Mr. Mitchell was always cooperative except for that one incident. He reported that after the incident, Mr. Mitchell was escorted back to his cell without further issue.

Officer K had never discussed alleged physical abuse of Mr. Mitchell with any other officers. He reported that he was unaware of any officers withholding food from Mr. Mitchell. Officer K recalled that Mr. Mitchell always got his tray of food, and that he specifically remembered this because due to his segregation and mental health status, Mr. Mitchell got a Styrofoam tray that was different from the normal plastic trays the other incarcerated persons received. Officer K stated that it appeared Mr. Mitchell was losing weight even though he was eating. He asked the nurses about the weight loss, and they advised it was because Mr. Mitchell would not take his medication.

Officer K stated that he never had a full conversation with Mr. Mitchell, but he would say yes to receiving another tray of food and say no to his medication. He stated that Mr. Mitchell never complained about the way officers treated him, and that his main problem was his swollen feet and refusal to take his medications. Officer K stated that Mr. Mitchell was not a "problem

child," and that he was sad to see him go.

12. Interview of Correctional Officer L

VSP investigators interviewed Correctional Officer L on October 27, 2016. Officer L signed an Advice of Rights form indicating that he waived his rights and wished to speak with investigators.

Officer L stated that the only contact he had with Mr. Mitchell was on August 14, 2015, when Officer F requested his help in getting Mr. Mitchell to return to his cell. When Officer L responded to Mr. Mitchell's pod, he observed that Officer F had handcuffed Mr. Mitchell, who then sat down at one of the pod tables. Mr. Mitchell was yelling to other incarcerated persons about canteen food items while incarcerated pod workers cleaned his cell. Officers asked Mr. Mitchell to return to his cell when the pod workers were done cleaning it. Mr. Mitchell refused and sat down on the floor. Officers L and F then picked Mr. Mitchell up under his arms, shoulder to shoulder, and walked him back to his cell. The officers put Mr. Mitchell on his bed and removed his handcuffs.

Officer L denied spraying Mr. Mitchell with any type of solution, water, or chemicals. He stated that he did not observe any officer spraying Mr. Mitchell. Officer L additionally stated that there was no need for an officer to have kicked Mr. Mitchell to the ground or kicked him in the back of the leg. Officer L had never heard of another officer physically abusing Mr. Mitchell or withholding food from him, as this was Officer L's first contact with Mr. Mitchell.

13. Interview of Correctional Officer M

VSP investigators approached Correctional Officer M, a sergeant, on September 27, 2016. VSP investigators informed Correctional Officer M of the purpose of the interview, and Officer M acknowledged an Advice of Rights form that was read to him. Officer M elected to consult an

attorney and did not make a statement on September 27, 2016.

At the request of our office, VSP investigators re-approached Officer M on November 30, 2016. Officer M was read an advice of rights card, and he acknowledged his rights and agreed to speak to investigators.

Officer M was the housing unit manager for HRRJ housing unit 3 in July and August 2015. He encountered Mr. Mitchell during meal service and cell cleanings. Officer M reported that he took special attention to make sure Mr. Mitchell's cell was clean and that he was fed properly. He stated that he never observed Mr. Mitchell being denied a tray of food. Officer M stated that Mr. Mitchell could be standoffish with supervisors if he did not like them.

Officer M could not recall if Mr. Mitchell had running water in his cell, but stated that if Mr. Mitchell's water had been turned off, as the supervisor, he would have been notified. Officer M never had any physical contact with Mr. Mitchell. He never observed any officers assault, kick, drag, or throw Mr. Mitchell to the ground. He was unaware of any incidents involving Mr. Mitchell refusing to remove his arm from the tray slot, and he never saw an officer punch or strike Mr. Mitchell's arm with a flashlight. Officer M stated that no officers or incarcerated persons expressed concerns for Mr. Mitchell's physical or mental well-being before he passed away.

14. <u>Interview of Correctional Officer N</u>

VSP investigators interviewed Correctional Officer N on October 8, 2016. Officer N was advised of the purpose of the interview and agreed to speak to investigators. Officer N was no longer employed with HRRJ at the time of his interview. Officer N worked for HRRJ for 5 years before his employment ended.

Officer N described Mr. Mitchell as appearing to be mentally ill. Officer N stated that Mr. Mitchell was an individual with whom one could have a conversation, but who wanted to do his

own thing. Officer N assisted in feeding Mr. Mitchell on several occasions and advised investigators that Mr. Mitchell always received a tray of food. Officer N gave Mr. Mitchell an extra tray of food multiple times. Officer N never refused Mr. Mitchell a tray of food or knew of other officers doing so.

Officer N noted that when he first met Mr. Mitchell, he appeared healthy, but as time went on, he began to get smaller. Officer N consulted with HRRJ medical staff and then took Mr. Mitchell to the medical clinic along with Officer I. Officer N reported that while at the clinic, Mr. Mitchell became aggressive and refused to have his vitals taken or his blood drawn. Officer N additionally reported that he and other officers observed that Mr. Mitchell's legs were swollen. He stated that he reported Mr. Mitchell's condition to the medical staff. Officer N stated that the only incarcerated person to express concern for Mr. Mitchell was the person in the cell beside him.

Officer N never observed another officer physically abuse Mr. Mitchell. He stated that Mr. Mitchell's cell was cleaned almost every day, and that he had running water and a uniform in the cell. Officer N stated that Mr. Mitchell would often take the uniform off and stand in the cell naked. Officer N reported that although Mr. Mitchell hung his arm out of the tray slot in the cell door a couple times, he never had to physically remove it. He reported that he never punched or struck Mr. Mitchell's arm with a flashlight or another object to get Mr. Mitchell to remove his arm from the tray slot. Officer N stated that he recalled medical personnel checking on Mr. Mitchell and attempting to provide him with medications, but that Mr. Mitchell refused the medications.

15. <u>Interview of Correctional Officer O</u>

On September 28, 2016, VSP investigators approached Correctional Officer O and attempted to interview him. Investigators informed Officer O of the purpose of the interview and read him an Advice of Rights form. Officer O signed and acknowledged the form and stated that

he only wished to speak in the presence of his attorney. At the request of our office, VSP investigators re-approached Officer O on November 23, 2016. Officer O acknowledged an advice of rights card and waived his rights.

Officer O stated that he didn't have any interactions with Mr. Mitchell, but that he participated in cleaning Mr. Mitchell's cell once. During the cleaning, Mr. Mitchell was escorted out while incarcerated pod workers cleaned the cell. Mr. Mitchell was then escorted back to the cell. Officer O stated that no one struck, kicked, sprayed, or assaulted Mr. Mitchell during the cell cleaning.

Officer O reported making regular rounds in Mr. Mitchell's pod, and stated that he was involved in feeding Mr. Mitchell from time to time. He reported that Mr. Mitchell would occasionally grab his Styrofoam trays in a rough manner, and in that case, Officer O would personally feed Mr. Mitchell. Officer O stated that he never denied Mr. Mitchell a meal and occasionally provided him with an extra lunch if it was available.

Officer O never had to physically remove Mr. Mitchell's hands from the cell door tray slot, and he never slammed the door shut, or punched, struck, or hit Mr. Mitchell's hands. He never observed any of his subordinate officers punch or strike Mr. Mitchell's arms with a flashlight. Officer O denied having any physical contact with Mr. Mitchell. He denied ever hearing other incarcerated persons, incarcerated pod workers, or officers report concerns for Mr. Mitchell's well-being. Officer O never observed another officer kick or push Mr. Mitchell to the ground. He never witnessed another officer spray Mr. Mitchell or drag him back to his cell.

Officer O recalled that medical personnel offered Mr. Mitchell medication on their rounds up to a certain point, but that they eventually stopped offering him medication. Officer O noted that he observed medical personnel attempt to give Mr. Mitchell his medications approximately

five times. Each time, Mr. Mitchell would refuse the medication by ignoring the medical staff or refusing to get off his bunk. Officer O stated that Mr. Mitchell appeared to be in need of mental health attention, and that he never saw mental health personnel checking on Mr. Mitchell. According to Officer O, Mr. Mitchell never asked for medical attention.

16. Interview of Correctional Officer P

VSP investigators interviewed Correctional Officer P on October 5, 2016. Officer P signed an Advice of Rights form indicating that he waived his rights and wished to speak with investigators. Officer P recalled that he did not see Mr. Mitchell until a few days before his death. He recalled that Mr. Mitchell kept a dirty cell and would not flush his toilet unless asked to do so.

Officer P reported that he would occasionally speak to Mr. Mitchell and check on his welfare. He did not recall speaking to any incarcerated pod workers about Mr. Mitchell's condition. He stated that no incarcerated pod workers ever expressed a concern for Mr. Mitchell's well-being.

Officer P stated that he never had to strike, punch, or physically remove Mr. Mitchell's arm from his tray slot during the feeding process. He had heard rumors from incarcerated persons that other officers were abusing Mr. Mitchell, but stated that no officers were abusing Mr. Mitchell. Officer P stated that he never withheld food from Mr. Mitchell or any other incarcerated person. Officer P was unaware of any medical staff ever having refused medication to Mr. Mitchell, and he stated that he recalled Mr. Mitchell refusing medication in his first housing assignment.

Officer P discovered Mr. Mitchell deceased in his cell on August 19, 2015. He stated that he initially opened Mr. Mitchell's tray slot and saw that Mr. Mitchell was in the bed and did not look right. An incarcerated pod worker placed Mr. Mitchell's breakfast on his tray slot, and Mr. Mitchell did not come to get it. Officer P then went back to Mr. Mitchell's cell and observed him

still lying in the bed. He called for Mr. Mitchell to wake up, and he did not. Officer P called for another officer to respond, and the two opened Mr. Mitchell's cell door, went in, and handcuffed Mr. Mitchell per jail policy. Officer P determined that Mr. Mitchell was not breathing. He called for medical assistance and performed chest compressions until he was no longer able to continue. Medical personal arrived shortly after and relieved him.

17. Interview of HRRJ Internal Affairs Sergeant

VSP investigators interviewed the HRRJ Internal Affairs Sergeant on August 16, 2016. The Internal Affairs sergeant told investigators that upon review, no hard copy request forms and no automated requests through the jail's kiosk system were ever submitted by other incarcerated persons regarding alleged mistreatment of Mr. Mitchell. The Internal Affairs sergeant additionally indicated that the first allegation of mistreatment of Mr. Mitchell, to the knowledge of the Internal Affairs department, occurred on August 20, 2015, the day after Mr. Mitchell's death.

C. Attempt to Interview NaphCare Staff

On November 23, 2016, at our office's request, VSP investigators attempted to obtain consent from a NaphCare attorney to interview essential NaphCare staff known to have encountered Mr. Mitchell at HRRJ. The attorney representing NaphCare and the various employees who encountered Mr. Mitchell told investigators that due to ongoing civil litigation, the following employees would not be making statements: an intake nurse, the jail mental health director, the jail's medical director, a medical social worker, two registered nurses, a mental health nurse practitioner, and a licensed practical nurse. VSP investigators asked the attorney to provide them with a letter documenting her refusal to allow VSP to interview her clients. The attorney refused to provide such a letter.

At the request of our office, VSP re-approached NaphCare, and NaphCare later agreed to

make two employees available for limited interviews: the aforementioned intake nurse in April 2017, and the Director of Nursing in May 2017.

D. Review of Security Footage

HRRJ provided security footage from August 14, 2015 and August 19, 2015. Neither video has sound. All videos are grainy and play in a detached, frame-by frame fashion. Neither officers nor incarcerated persons are identifiable except by general appearance due to the low quality of the video.

The videos show the inside of Mr. Mitchell's "pod" at HRRJ. HRRJ has several "housing units," and each housing unit contains several pods. A pod consists of a large, open area with metal tables, a television, telephones, and showers called the "dayroom." Cells line the walls on the perimeter of the dayroom. There are stairs connecting the lower level of cells to an upper level of cells.

The August 14, 2015 footage shows that the dayroom of Mr. Mitchell's pod is empty. Mr. Mitchell's cell is visible. In the 60 to 90 minutes preceding Mr. Mitchell's accidental release and exit from his cell, Mr. Mitchell is seen almost constantly at the window. Mr. Mitchell's cell door opens as the video timestamp reaches 12:06 p.m., and Mr. Mitchell comes out of the cell naked. Mr. Mitchell takes what appears to be a Styrofoam tray and places it on the ground and proceeds to wander around the common area. Mr. Mitchell exits the frame. Less than ten minutes later, incarcerated pod workers bring a mop and a rolling bucket to Mr. Mitchell's cell and appear to clean the cell. A correctional officer stands outside Mr. Mitchell's cell to supervise the cleaning. Mr. Mitchell is not in the frame during the cleaning, but correctional officers can be seen standing in the bottom right corner of the frame in the common area. The cleaning lasts approximately ten minutes. An incarcerated person is on screen interacting with correctional officers as officers

return Mr. Mitchell to his cell and the cell door closes. A different incarcerated person stands in front of Mr. Mitchell's cell door for several minutes after Mr. Mitchell returns to his cell. A short time later, an officer later makes an observation round within the pod.

HRRJ provided security footage of Mr. Mitchell's pod from August 19, 2015 between midnight and 11:35 a.m. Although the video begins at midnight on August 19, the listed start time is August 18, 2015 at 11:00 p.m. Investigation revealed that the timestamp is one hour behind real time.

Between midnight and 5:00 a.m. on Mr. Mitchell's pod, all lights within the cells were out. The pod was lit by a series of overhead lights. Incarcerated pod workers can be seen within the pod sweeping and mopping. At 12:22 a.m., a correctional officer makes an observation round, during which he looks inside every cell he passes. The officer stops briefly at Mr. Mitchell's cell, looks in, and continues on his round. A different officer makes an observation round, looking inside every cell he passes. The officer passes by Mr. Mitchell's cell at 12:48 a.m. Another officer passes by Mr. Mitchell's cell on a round at 1:26 a.m. At 2:13 a.m., an officer passes by Mr. Mitchell's cell on a round. The officer retraces his steps and looks into Mr. Mitchell's cell again, this time for several seconds. At 2:42 a.m., an officer passes by Mr. Mitchell's cell on a round. At 3:11 a.m., an officer passes by Mr. Mitchell's cell and stops briefly to look in. the officer returns to Mr. Mitchell's cell and looks into the cell again for several seconds. At 3:29 a.m., an officer passes by Mr. Mitchell's cell on a round. A guard passes by Mr. Mitchell's cell on a round at 4:01 a.m. The guard briefly doubles back to look into Mr. Mitchell's cell, and then continues on his round. During this video, some incarcerated persons can be seen at their windows. However, no movement or activity can be seen within Mr. Mitchell's cell at any time.

At 5:01 a.m., the lights come on in all the cells. The first person to appear on the floor

outside the cells is a correctional officer who visits the incarcerated person in the cell directly above Mr. Mitchell's at 5:18 a.m. The officer continues to interact with the incarcerated person in the cell to the immediate left on the second floor, and so on down the line of cells. The officer has a clipboard in hand and appears to be making notations. The officer comes downstairs to Mr. Mitchell's level and repeats the same procedure, stopping at each cell, appearing to interact with the incarcerated person inside, and making notations on a clipboard. When the officer reaches the third cell from the end (Mr. Mitchell's cell is the farthest cell to the right in the video), the officer no longer goes to the door of the cells to interact with the incarcerated person inside. The officer appears to pass by Mr. Mitchell's cell while looking inside at approximately 5:25 a.m.

At 5:37 a.m., a correctional officer appears, accompanied by two incarcerated pod workers. The three, presumably serving breakfast, stop at each cell, open each tray slot, and place breakfast trays through. The group grows as more incarcerated pod workers, pulling a cart containing a large drink dispenser, come into the frame. At approximately 5:39:25 a.m., a correctional officer comes to the window of Mr. Mitchell's cell. The nearest incarcerated pod worker to Mr. Mitchell's cell is interacting with the incarcerated person in the cell directly to the left. Up to this point, no incarcerated pod workers have approached Mr. Mitchell's cell.

The correctional officer remains directly in front of the window of Mr. Mitchell's cell until 5:41:51, while incarcerated pod workers congregate at the neighboring cell to the left of Mr. Mitchell. The correctional officer backs up and exits the frame. Several seconds later, the officer returns to the frame and resumes his position immediately in front of the window of Mr. Mitchell's cell. By 5:41:21 a.m., incarcerated pod workers have begun to congregate outside of Mr. Mitchell's cell and look in the cell. At 5:42:43, all incarcerated pod workers back away from Mr. Mitchell's cell and resume serving breakfast. The correctional officer who had been standing at the window

of Mr. Mitchell's cell walks to the left down the line of cells, away from Mr. Mitchell's cell. An incarcerated pod worker approaches the window of Mr. Mitchell's cell and looks in at 5:43 a.m. The worker remains at Mr. Mitchell's window until 5:43:18, at which time two officers return to the window. A new correctional officer approaches the window at 5:44:00.

Between 5:44 and 5:46, the incarcerated pod workers file to the other side of the pod to begin serving breakfast to the upper floor while a single officer remains near Mr. Mitchell's cell. The single officer leaves the frame, and officers and incarcerated persons continue serving breakfast on the upper floor at 5:47. At 5:47:19, another officer approaches the window of Mr. Mitchell's cell and looks in. At 5:47:46, the officer looks up toward the officers serving breakfast on the 2nd floor and appears to communicate with them. The officer remains at the window of Mr. Mitchell's cell alone until another officer approaches at 5:49:15. A third officer approaches at 5:49:40. At 5:49:49, Mr. Mitchell's cell door opens. Officers fully open the cell door and enter the cell at 5:50:00. All three officers exit the cell briefly almost immediately after entering, and a single officer re-enters the cell at 5:50:35. Different officers enter and exit the cell until what appears to be a member of jail medical staff arrives and enters the cell at 5:52:40 a.m. a group of medical personnel with equipment on a cart enter the frame and approach Mr. Mitchell's cell at 5:52:55. During the next few minutes, many officers and other personnel congregate outside Mr. Mitchell's cell, making it impossible to see inside.

Officers and medical personnel continue to come and go, and a machine with its screen illuminated appears in the frame at 6:01:08. EMTs with a stretcher enter the frame at 6:06:53, and they exit with an empty stretcher at 6:07:53. Around the same time, the congregated officers and medical personnel exit Mr. Mitchell's cell and mill about in the common area. The congregated personnel leave the common area at approximately 6:09, and the area appears to return to normal

operations. Mr. Mitchell's cell door slides closed at 6:09:58. Other personnel, including Portsmouth Police investigators and an investigator from the Office of the Chief Medical Examiner, enter the cell to make observations and take photographs. At 10:06:10, Mr. Mitchell's body is removed from the cell.

E. Interviews Regarding Mr. Mitchell's Signatures on Medical Documents

During a meeting with Mr. Mitchell's family in March 2017 to provide an update on the status of our investigation, the family viewed some of the handwritten signatures that appeared on Mr. Mitchell's medical records that NaphCare provided to our office. The handwritten signatures appeared on Mr. Mitchell's intake screening documents. These documents comprised Mr. Mitchell's medical and mental health history that he allegedly provided to an intake nurse. Mr. Mitchell's family claimed that some signatures on Mr. Mitchell's intake screening documents were not his. We requested that VSP investigate this claim.

1. Interviews of Employees who Witnessed or Obtained Mr. Mitchell's Signature

On May 24, 2017, VSP investigators interviewed the NaphCare nurse who conducted Mr. Mitchell's HRRJ intake screening. The nurse stated that she conducted anywhere from one to twenty intake screenings per day. This nurse had no independent memory of Mr. Mitchell except what she had seen on the news, and she stated that there did not exist video recording equipment in the intake area that could have refreshed her memory. She also did not remember Mr. Mitchell's signature. The nurse explained that incarcerated persons had to sign a signature pad each time the intake screening program prompted them. She could not recall if the intake screening program would auto-populate a new signature block with a previous version of an incarcerated person's signature. The nurse denied having ever signed, forged, or altered an incarcerated person's signature on a medical screening form. The nurse stated that incarcerated persons sometimes did

not understand the intake screening forms or refused to sign them. If an incarcerated person refused to sign the intake screening forms, a refusal form would have been filled out, and the person would be placed on lockdown. The incarcerated person would be prompted daily to sign the intake screening forms until they were completed. The HRRJ Assistant Superintendent was also interviewed, and she stated that due to HIPAA regulations, the intake screening rooms did not have video surveillance.

On April 27, 2017, VSP interviewed the officer who completed an HRRJ classification record for Mr. Mitchell. The HRRJ classification record purportedly bears Mr. Mitchell's signature. The officer who prepared the classification record acknowledged that her signature appeared on the record as a witness to Mr. Mitchell's signature. The officer denied signing Mr. Mitchell's name to any classification documents or having ever done so for another incarcerated person.

A Portsmouth sheriff's deputy who processed Mr. Mitchell into the Portsmouth City Jail was also interviewed by VSP investigators on May 5, 2017. The deputy stated that he remembered Mr. Mitchell physically signing the PCJ intake form because he watched him from the intake window. After being presented with a copy of Mr. Mitchell's PCJ intake form, he stated that he witnessed Mr. Mitchell sign the form and then signed his own signature beside it. The deputy denied forging Mr. Mitchell's signature on the intake form and stated that he had never written an incarcerated person's signature on any Portsmouth Sheriff's Office documents.

2. Examples of Mr. Mitchell's Known and Questioned Signatures

VSP investigators provided our office with Mr. Mitchell's known signatures in the form of his Virginia Department of Motor Vehicles records. These records contain the signature Mr. Mitchell provided on his application for a Virginia Identification card. Mr. Mitchell's known

signature also appears on the Virginia Uniform Summons he signed after being arrested on April 21, 2015, as well as on a court document from his appearance the next day. The Virginia Department of Forensic Science formerly employed handwriting comparison analysts, but that service was no longer available by the time our investigation began. Included in this section are copies of all signatures that appear on documents provided to our office by PCJ, HRRJ, or NaphCare. All signatures other than Mr. Mitchell's have been redacted.

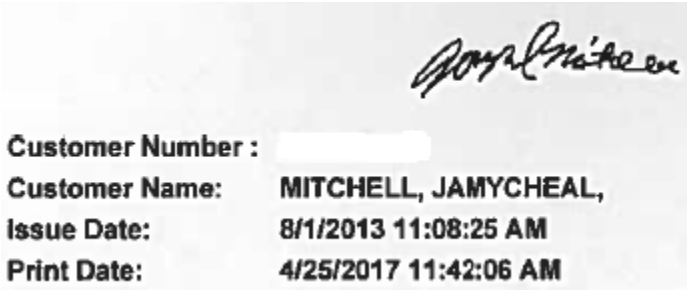
Mr. Mitchell's Known Signatures from a DMV Application on May 28, 2009

CERTIFICATION AND SIGNATURES

I certify that I am a resident of Virginia, that I have provided all information, including my social security number, if applicable, that my appearance, for purposes of my DMV photograph, represents how I generally appear in public, and that all information given in this application is accurate. I understand that it is a criminal violation to knowingly make a false statement on this application

APPLICANT NAME (print)	APPLICANT SIGNATURE	DATE (mm/dd/yyyy)
Jamycheal Mitchell		5-28-09

Mr. Mitchell's Known Signatures from a DMV Application on August 1, 2013



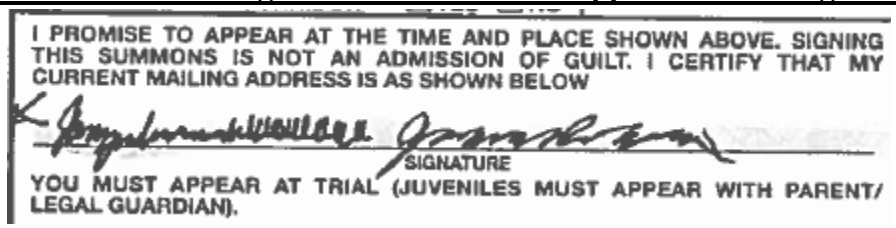
Customer Number :
Customer Name: MITCHELL, JAMYCHEAL,
Issue Date: 8/1/2013 11:08:25 AM
Print Date: 4/25/2017 11:42:06 AM

CERTIFICATION

I certify and affirm that I am a resident of Virginia, that all information presented in this application is true and correct, that any documents I have presented to DMV are genuine, and that my appearance, for purpose of my DMV photograph, is a true and accurate representation of how I generally appear in public. I make this certification and affirmation under penalty of perjury and understand that knowingly making a false statement on this application is a criminal violation.

APPLICANT NAME (print)	APPLICANT SIGNATURE	DATE (mm/dd/yyyy)
Jamycheal Mitchell		8-1-13

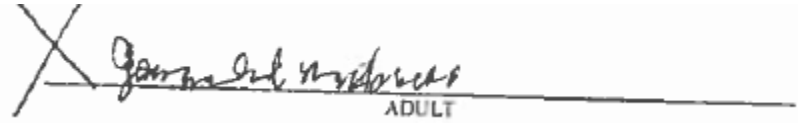
Mr. Mitchell's Known Signatures from a DMV Application on August 1, 2013


I PROMISE TO APPEAR AT THE TIME AND PLACE SHOWN ABOVE. SIGNING THIS SUMMONS IS NOT AN ADMISSION OF GUILT. I CERTIFY THAT MY CURRENT MAILING ADDRESS IS AS SHOWN BELOW

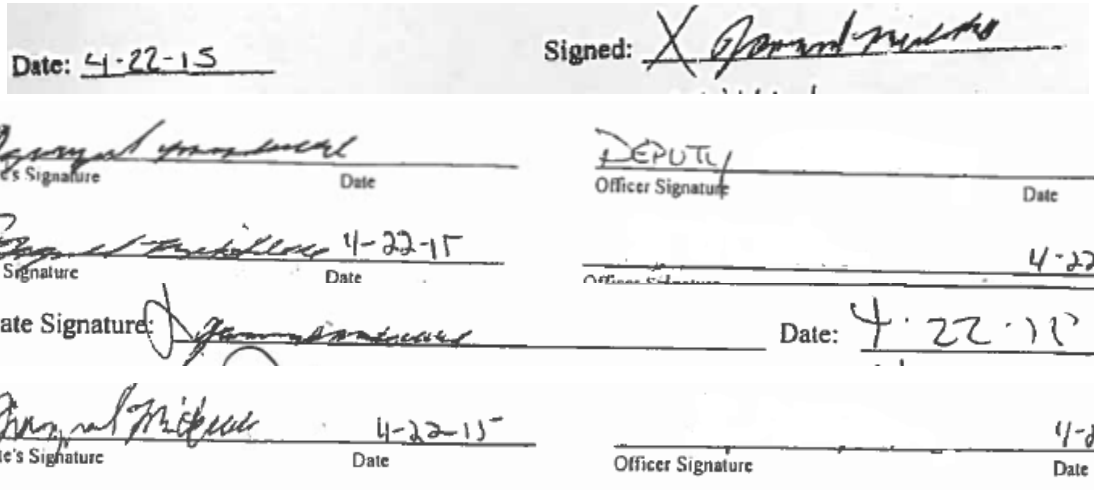
SIGNATURE

YOU MUST APPEAR AT TRIAL (JUVENILES MUST APPEAR WITH PARENT/ LEGAL GUARDIAN).

Mr. Mitchell's Known Signature from a Court Document on April 22, 2015


ADULT

Mr. Mitchell's Questioned Signatures from PCJ Documents on April 22, 2015


Date: 4-22-15 Signed:

Inmate's Signature Date

DEPUTY
Officer Signature Date

Inmate's Signature 4-22-15
Date

4-22-15

Inmate Signature: Date: 4.22.15

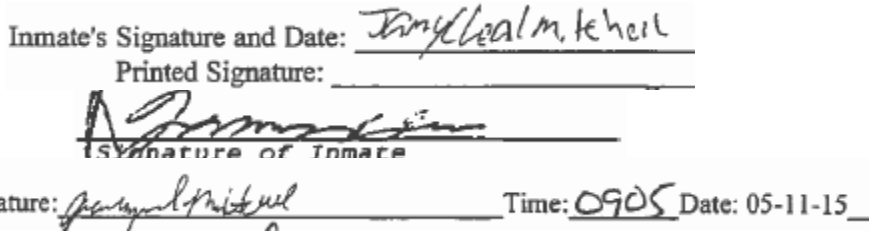
Inmate's Signature 4-22-15
Date

Officer Signature 4-22-15
Date

Mr. Mitchell's Questioned Signatures from the HRRJ Intake Screening Documents of May 11, 2015


Patient Signature

Mr. Mitchell's Questioned Signatures from Other HRRJ Documents


Inmate's Signature and Date:
Printed Signature:
Signature of Inmate

Inmate's Signature: Time: 0905 Date: 05-11-15

INMATE SIGNATURE X _____ DATE 05-11-15

Inmate Signature _____ **Date** 5/11/15

Inmate Signature: _____ Date: 5-11-15

Inmate Signature: _____ Date: 5-11-15

Inmate Name: _____ **Inmate Signature:** _____ **Date:** _____

_____
Patient Signature

5-12-15/0114
Date/Time

Inmate Signature: _____ **Print Name:** _____ **Date:** _____

IV. Autopsy Report and Medical Examiner Interviews

A. Autopsy Report

Assistant Chief Medical Examiner Dr. Wendy Gunther performed an autopsy on Mr. Mitchell on August 19, 2015. Dr. Gunther's general external examination of Mr. Mitchell revealed that he was "nearly cachectic[12]," and that the outline of his ribs and clavicles was visible through his skin. Dr. Gunther noted that Mr. Mitchell's upper extremities showed muscle atrophy. Dr. Gunther noted hyperpigmentation of creases in Mr. Mitchell's palms, along a ridge of both thumbs, across both wrists, and in the gums beside the teeth. Mr. Mitchell's back had "innumerable hyperpigmented and hypopigmented mostly oval scars, with a few linear." Dr. Gunther noted that Mr. Mitchell's left upper arm and both lower extremities showed "small, tense, bullous lesions over scattered hair follicles," with no surrounding inflammation. Dr. Gunther reported that Mr. Mitchell's knees had "innumerable scars," with the left knee having more than the right knee.

Dr. Gunther made several pathological diagnoses with regard to Mr. Mitchell's autopsy. She diagnosed Mr. Mitchell with a probable cardiac arrhythmia (causing death in bed) from wasting syndrome of unknown etiology[13], a possible sickle cell trait, and several other minor possible diagnoses. Dr. Gunther noted several possible causes of the cardiac arrhythmia: inanition[14] of an unclear etiology, Addison syndrome[15], and diabetes mellitus[16] or diabetes insipidus[17].

[12] Cachexia is a state of "general ill health with emaciation, usually occurring in association with cancer or a chronic infectious disease." It can also be defined as "physical wasting with loss of weight and muscle mass due to disease."
[13] Etiology refers to a disease's cause or origin.
[14] Inanition is "exhaustion caused by a lack of nourishment."
[15] Addison syndrome is a type of adrenal insufficiency wherein the adrenal glands do not produce enough of certain hormones, resulting in muscle weakness, weight loss, and loss of appetite, among other things.
[16] Diabetes mellitus is a blood sugar disorder that adversely affects the way the body uses and processes the energy from food.
[17] Diabetes insipidus is a rare condition in which the body's antidiuretic hormone levels are imbalanced, leading to extreme thirst and the inability of one's kidneys to control urine output.

Dr. Gunther produced a "Case Summary and Comment" at the end of her autopsy report. She noted that Mr. Mitchell's attorney forwarded her letters describing control of Mr. Mitchell's behavior by withholding food. Dr. Gunther noted that the history of Mr. Mitchell's weight loss at HRRJ was not consistent with cachexia solely due to inflicted starvation. Dr. Gunther additionally noted that an autopsy "cannot tell whether a thin person refused to eat, was denied food, or ate ravenously and lost weight because of an unidentified natural disorder; or some combination of the three." Dr. Gunther wrote that many natural disorders, including type I diabetes mellitus and Addison syndrome, can cause weight loss in a person who eats ravenously. Dr. Gunther stated that both diabetes mellitus and Addison syndrome were less likely to have caused weight loss in Mr. Mitchell's case based on factors she discovered during the autopsy.

Dr. Gunther noted several factors indicating the presence or absence of diabetes mellitus and Addison syndrome, and the observed factors made it much less likely that Mr. Mitchell had diabetes when compared to the likelihood that he had Addison syndrome. Dr. Gunther deemed the manner of death (i.e. suicide, homicide, natural cause) undetermined because she could not say whether inflicted starvation played a role in Mr. Mitchell's death. Dr. Gunther concluded that the cause of Mr. Mitchell's death was unclear, but she still suspected Addison syndrome. Dr. Gunther categorized the formal cause of Mr. Mitchell's death as a wasting syndrome of unclear etiology that caused death during sleep, most likely via the mechanism of a cardiac arrhythmia.

B. <u>Interviews of Assistant Chief Medical Examiner Wendy Gunther, MD</u>

VSP investigators interviewed Dr. Wendy Gunther on June 29, 2016. Investigators initially presented Dr. Gunther with scenarios of alleged abuse and asked Dr. Gunther if the autopsy revealed any injuries consistent with the alleged abuse. Investigators asked Dr. Gunther about the following scenarios: correctional officers striking Mr. Mitchell's arms with a flashlight or closed

fist when he stuck them through the tray slot; correctional officers dragging Mr. Mitchell naked to his cell and throwing him against a wall on August 14, 2015; and correctional officers kicking Mr. Mitchell in the back of the leg after Mr. Mitchell refused to sit down.

Dr. Gunther noted that the only external injury she observed to Mr. Mitchell's body was an abrasion or small scrape to his right cheek. Dr. Gunther was unable to speculate as to the cause of the scrape, and she classified it as a '1/4" superficial abrasion or faint contusion.' Dr. Gunther referred investigators to notes made by a Medical Examiner's Office Investigator indicating that the investigator observed Mr. Mitchell in his cell after his death and noted no visible signs of recent trauma or injury to Mr. Mitchell's hands or body. Dr. Gunther reiterated her opinion that Mr. Mitchell may have suffered from undiagnosed Addison syndrome.

Investigators presented Dr. Gunther with the allegation that correctional officers withheld meals and water from Mr. Mitchell on a regular basis because of his behavior and noncompliance with instructions. Dr. Gunther stated that Mr. Mitchell did not die from "not eating." Dr. Gunther referred investigators to her original conclusion in her autopsy report: that Mr. Mitchell died from "probable cardiac arrhythmia accompanying wasting syndrome of unknown etiology." Dr. Gunther reiterated that this cause of death did not indicate in any way that Mr. Mitchell died of starvation. Investigators asked Dr. Gunther if withholding of meals would have contributed to Mr. Mitchell's death. Dr. Gunther responded that in her opinion, no amount of food would have kept Mr. Mitchell from passing away.

At our office's request, VSP investigators conducted an additional interview with Dr. Gunther on September 1, 2016. We requested that VSP question Dr. Gunther about the size of Mr. Mitchell's heart as it related to potential intentional starvation. Dr. Gunther stated that Mr. Mitchell's heart was small relative to his body size. She believed that Mr. Mitchell's heart had

shrunk because his body was not producing certain hormones needed to sustain life, and not due to a lack of food. She additionally stated that Mr. Mitchell's other organs were of normal size. Dr. Gunther noted that Mr. Mitchell's body mass index at the time of his death was 19.5; she stated that in her experience, a person who had been starved would have a body mass index of 15 or less. Dr. Gunther also noted that Mr. Mitchell had muscle tissue in his chest, arms, and legs. She stated that a person who was being starved would lose muscle tissue in those areas because the body would naturally conserve the heart muscle. Dr. Gunther reiterated her conclusion that Mr. Mitchell did not die of starvation, but rather that his body wasted away from disease, likely undiagnosed Addison syndrome.

V. Subsequent Investigation into NaphCare, Inc.'s Care of Mr. Mitchell

After the Virginia State Police completed three rounds of additional investigative tasks requested by our office, we fully reviewed all records collected by VSP. Our office reviewed the medical records generated by NaphCare, Inc., the medical services provider for the Hampton Roads Regional Jail during Mr. Mitchell's incarceration. That review revealed that numerous NaphCare employees had encountered Mr. Mitchell during his incarceration. VSP was initially denied full access to the NaphCare employees who encountered Mr. Mitchell due to pending civil litigation, so in order to fully investigate whether NaphCare employees' actions toward Mr. Mitchell constituted a crime, our office petitioned the Portsmouth Circuit Court to empanel a special grand jury. The request was denied.

Despite the denial of our office's motion to empanel a special grand jury, NaphCare agreed to make its employees available for interviews and to provide our office with Mr. Mitchell's complete medical and mental health records. Our office sent a request to interview NaphCare employees via U.S. Mail and e-mail on June 7, 2017. Those interviews began in September 2017 and continued through November 2018. NaphCare employees were not administered an oath to tell the truth under penalty of perjury during these interviews, and they were free to leave or terminate the interview at any time. This office therefore cannot speak to the accuracy or veracity of any NaphCare employees' statements.

In July 2017, Mr. Mitchell's aunt signed a medical records release form authorizing our office to receive Mr. Mitchell's complete medical records, lab reports, and mental health treatment records from NaphCare. In August 2017, attorneys for NaphCare produced medical records to our office that they identified as being responsive to the July 2017 medical records release form.

The medical records produced by the attorneys for NaphCare largely mirrored those

obtained by VSP from HRRJ during the initial VSP investigation. However, there was a significant discrepancy in the completeness of the charting between the VSP-obtained records and those disclosed by NaphCare's attorneys. Both VSP and NaphCare provided our office with what is ostensibly Mr. Mitchell's entire medical chart. The chart contains innumerable sections of boxes into which medical service providers place an electronic check mark for different categories of observations, such as assessments of mental state, mood, cognition, appearance, etc. The VSP-obtained records show virtually no checks in any of the various boxes for different categories of observations, yet the records provided to our office by NaphCare's attorneys demonstrate much more complete charting and checking of the various boxes.

Our office was limited to interviewing NaphCare employees at the pace at which NaphCare's attorneys made the employees available. We attempted to schedule interviews with all necessary witnesses as quickly as possible. Despite multiple follow-up contacts to attempt to move the process along, our office had to reach out to attorneys for NaphCare on no less than ten separate occasions to reestablish contact after requests to schedule interviews went unanswered for weeks, and in some cases, months. To date, not all NaphCare employees who encountered Mr. Mitchell at HRRJ have been interviewed due to pending civil litigation and/or non-responsiveness by attorneys for NaphCare.

Our office identified 22 individuals who might have relevant information about Mr. Mitchell's medical care and mental health treatment at HRRJ:

A. The intake nurse who compiled Mr. Mitchell's initial vital statistics upon his transfer from Portsmouth City Jail to HRRJ
B. The medical social worker who conducted Mr. Mitchell's initial mental health evaluation upon his transfer from PCJ to HRRJ

C. The Medical Director for HRRJ during Mr. Mitchell's incarceration

D. The Director of Nursing for HRRJ during Mr. Mitchell's incarceration

E. The Health Services Administrator for HRRJ during Mr. Mitchell's incarceration

F. The Mental Health Director for HRRJ during Mr. Mitchell's incarceration who conducted daily "close observation" rounds to monitor Mr. Mitchell's mental state

G. Three medical assistants, two registered nurses, and one medical social worker who conducted "segregation rounds" and observed Mr. Mitchell's condition

H. Two registered nurses who diagnosed Mr. Mitchell with leg swelling and referred him to the emergency room

I. A mental health nurse practitioner who made decisions about Mr. Mitchell's medication regimen and created progress notes documenting Mr. Mitchell's mental state

J. One registered nurse who placed two medication orders for Mr. Mitchell

K. Four licensed professional nurses and two registered nurses who observed Mr. Mitchell during pill pass and attempted to deliver Mr. Mitchell's medications

NaphCare's attorneys produced 14 of the 22 requested individuals for interviews, but failed to make the Mental Health Director and several nurses available. All but one employee interviewed in person. Some of the NaphCare employees interviewed did not have any interactions with Mr. Mitchell that impacted his medical or mental health care while at HRRJ. The following summary details the most significant encounters between NaphCare employees and Mr. Mitchell.

A. Interview of Nurse A

On September 15, 2017, Portsmouth Commonwealth's Attorney's Office investigators interviewed Nurse A, a registered nurse. Nurse A reported that she believed the policy regarding refusals of medication was for the pill pass nurse to email or otherwise advise a charge nurse or a

doctor of the refusal. Nurse A stated that if a pill pass nurse noticed that an incarcerated person had not taken medications more than four to five times, a charge nurse was to be notified. Nurse A reported that she was the supervisor over the nurses and medical assistants who conducted pill pass.

Nurse A reported one encounter with Mr. Mitchell where she claimed that Mr. Mitchell "refused" lab work. Nurse A stated that she went with a correctional officer to Mr. Mitchell's cell and attempted to engage with Mr. Mitchell. She recalled that Mr. Mitchell just stared, and shook his head no. Nurse A asked Mr. Mitchell if he understood what was going on, and Mr. Mitchell shook his head but did not verbalize an answer.

B. Interview of Nurse B

On October 15, 2018, Portsmouth Commonwealth's Attorney's Office investigators interviewed Nurse B, a mental health nurse practitioner. Nurse B saw Mr. Mitchell and prescribed him mental health medications, in addition to conducting two psychiatric assessments of Mr. Mitchell. Nurse B eventually discontinued Mr. Mitchell's psychotropic medications because he was not taking them.

Nurse B described Mr. Mitchell as "grossly disorganized and disheveled" and "generally psychotic." In Nurse B's opinion, Mr. Mitchell was "incompetent." Nurse B qualified his classification of Mr. Mitchell as incompetent by noting that he couldn't make that decision, and that it had to come from a judge. Nurse B also blamed HRRJ for Mr. Mitchell's condition, stating that the jail did unintentional self-harm to Mr. Mitchell by allowing him to stand up all day at the window in his cell door. Nurse B reported that Mr. Mitchell spat and cursed at him during an interaction between the two in July 2015.

C. Interview of Nurse C

On October 15, 2018, Portsmouth Commonwealth's Attorney's Office investigators interviewed Nurse C, a nurse practitioner. Nurse C commented that presumably as a result of frequently standing at his cell door, Mr. Mitchell developed an edema, or swelling, in both legs. Nurse C evaluated Mr. Mitchell's edema on July 30, 2015 and initially classified it as the most serious type of edema one could have. Upon being interviewed on October 15, 2018, Nurse C stated that he had grossly exaggerated the nature of Mr. Mitchell's edema. He revised his opinion of the seriousness of the edema downward to a less serious grade. Nurse C was unable to say when or why he changed his opinion about the seriousness of Mr. Mitchell's edema, but he attributed the change in opinion to the fact that his medical experience developed and increased over time.

Nurse C also stated that the jail's medical director evaluated Mr. Mitchell and recommended that Mr. Mitchell be sent to the emergency room for the edema. When the medical director was interviewed, however, he denied ever having personally examined Mr. Mitchell, but confirmed that he referred Mr. Mitchell to the emergency room of an outside hospital. Nurse C stated that he ordered that Mr. Mitchell's edema be re-evaluated in five days. NaphCare produced no records showing any such re-evaluation.

During the interview, Nurse C was asked to examine his entries in Mr. Mitchell's chart of medical records. Nurse C claimed at times to independently recall certain interactions with Mr. Mitchell, but during other lines of questioning, his knowledge of Mr. Mitchell appeared not to be the product of his independent recollection, but rather, based solely on reading the medical chart notes he previously made. Our office is unable to conclude whether any of Nurse C's statements were the product of his personal knowledge. Considering Nurse C's inconsistency about whether he had any personal knowledge of Mr. Mitchell, it is concerning that he revised his diagnosis of

Mr. Mitchell long after his death. Additionally, NaphCare produced no medical records detailing the nurse's revised opinion of Mr. Mitchell's edema.

In one of Nurse C's notes on Mr. Mitchell's chart, he opined that Mr. Mitchell was psychotic, disorganized, and disheveled. When Nurse C was asked what he did to address Mr. Mitchell's psychosis, he cut the questioner off and stated with frustration, "Mr. Mitchell is going to the ER. That is my concern at this point. At this point, Mr. Mitchell has all these medical problems, he has all these psychotic problems, he's going to the ER." Nurse C's employment contract with NaphCare at HRRJ ended on July 30, 2015, the same day Mr. Mitchell was referred out to the emergency room. Nurse C had been filling in on a temporary contract while the usual nurse practitioner was out on medical leave.

NaphCare produced no records detailing any follow-up treatment on Mr. Mitchell's edema once he returned to HRRJ. Similarly, no records were produced showing that any special attention was given to Mr. Mitchell based on Nurse C's opinion that Mr. Mitchell was psychotic. The combination of interview statements and NaphCare's medical records indicate that Mr. Mitchell was referred to the emergency room solely for the edema, and not for any mental health reasons.

D. Review of NaphCare Policies and Procedures Regarding Medications

Our office examined the written NaphCare policies regarding medications in effect during Mr. Mitchell's incarceration. The policies contained a wide range of directives. NaphCare employees involved in the administration of medications were admonished that "[a]ccurate documentation is a major responsibility of medication administration. All medications administered should be clearly documented on the eMAR[18] at the time of administration."[19]

[18] Or Electronic Medication Administration Record.

[19] The NaphCare electronic medical records produced to our office by NaphCare contain one notation that Mr. Mitchell was administered his medication. They contain five notations that Mr. Mitchell refused medications.

NaphCare employees were also admonished via the policy handbook that "[i]f a health care staff member, while administering medications, observes or receives a report of a potential serious health problem, a referral should be made to an advanced clinical provider." NaphCare employees were further directed by the policy manual that "[a]t the conclusion of medication administration, the staff will run a missed medication report[20] on all eMARs to determine which medications were not administered because the inmate did not come to pill call. Attempts will be made to determine why and (sic) inmate did not receive any life sustaining medications and to administer them at a later time if possible. All medications administered should be documented to the eMAR."

2015 NaphCare policy regarding refusals of medication further states as follows: "Inmates who do not report for medication administration will be identified by using the missed med report in TechCare. A missed med report should be run at the end of pill pass to ensure that all medications have been administered. Correctional staff should locate all inmates who failed to receive medications and have them report to the medical unit for their medication. If the inmate is in segregation or out of the facility for an appointment our court, health care staff should be notified immediately."

The policy on refusals of medication further notes that "[i]f the inmate refuses medication, attempts will be made to have the inmate sign a refusal. If unable to obtain a written refusal from the inmate, the health care staff member will sign a refusal and obtain a signature from the correctional officer or another nurse as a witness. If the inmate continues to refuse medication the policy for non-adherence/refusal will be followed. Health care staff will also document the refusal on the eMAR."

NaphCare policy provided procedures for involuntarily medicating incarcerated persons:

[20] The records produced to our office by NaphCare, which NaphCare represented as being responsive to our executed authorization form requesting "Complete Medical Records," contain no such missed medication report.

"Generally, inmates have the right to refuse medication. Inmates may be required to take medication only under the following circumstances: 1. If the inmate has been mandated by court order to receive medication; 2. If the inmate's behavior is acutely dangerous to self, others, or to the security of the institution 3. In cases in which treatment is medically necessary and the inmate has been found to be incompetent by a judge in a civil court." The same policy also states that "[i]nvoluntary psychotropic medication may be administered according to mental health policy and procedure."

NaphCare policy gave employees instructions on how to deal with patients who were non-adherent to medication regimens: "When it is determined that an inmate is non-adherent, a counseling session[21] will be scheduled with a nurse who will identify and address reasons for non-adherence and this session will be documented in TechCare. . . The number of missed doses will be documented as part of the non-adherence counseling session in TechCare . . . If the inmate refuses or is non-compliant with psychotropic medication, a referral to the mental health department will be provided for additional counseling regarding non-compliance."

With respect to the evaluation and counseling by the mental health department for medication-noncompliant incarcerated persons, NaphCare policy dictated that "[t]he nurse will provide counseling and education to the inmate regarding the rationale for the medication and the possible risks of not adhering with the medication therapy as ordered . . . Inmates with serious medical conditions, who are persistently non-adherent despite counseling sessions, may be evaluated for discontinuation of medication. The advanced clinical provider will consider the risks of discontinuing the medication given the inmate's pattern of non-adherence."

Then-existing NaphCare policy also directed mental health staff to assign a priority status

[21] Mr. Mitchell's records indicate that NaphCare staff attempted to have several counseling sessions with him, with negative results.

to each incarcerated person with regard to risk of decompensation.[22] The policy directed mental health nurses to interview incarcerated persons who were chronically non-adherent to medication regimens and document interventions no less than monthly. NaphCare policy also contains guidelines for the involuntary administration of psychotropic medications in emergency situations, directing employees to either follow state statutes regarding their involuntary administration or to follow any explicit court orders mandating their administration.

E. Analysis of Close Observation Evaluation Records

Mr. Mitchell was placed on "Close Observation" upon his transfer from PCJ so that mental health providers could monitor his mental status. As previously discussed, NaphCare's attorneys did not make the HRRJ mental health director available for interview. Regardless, the close observation evaluation records completed by the mental health director and other NaphCare employees are illuminating. The close observation evaluations take the form of "SOAP" notes. These "SOAP" notes called for the mental health director to make a subjective evaluation of Mr. Mitchell, an objective evaluation, an assessment, and to develop a plan.

Mr. Mitchell was on close observation from May 11, 2015 until June 3, 2015, a total of 24 days. NaphCare only produced records for 20 days of close observation evaluations. The mental health director conducted 15 close observation evaluations on Mr. Mitchell. Nurse A conducted four evaluations, and a medical social worker conducted one evaluation. The forms themselves contain little room for any detailed observations. In the assessment portion of each close observation evaluation, the mental health director wrote Mr. Mitchell's level of orientation. There are four general areas of orientation: person (your identity), place (where you are), time (day, month, or year), and situation (describing why you are where you are).

[22] Our office was provided no such priority list for the time period encompassing Mr. Mitchell's incarceration.

Only the mental health director included Mr. Mitchell's level of orientation on her close observation evaluations; the registered nurse and medical social worker did not. Because NaphCare's attorneys did not make the HRRJ mental health director available for interview, we do not know if the mental health director evaluated Mr. Mitchell for three orientation factors or all four as described above. Regardless, none of the mental health director's close observation evaluations indicate that Mr. Mitchell was "oriented x4." On six occasions, the mental health director wrote that Mr. Mitchell was "oriented x1."

The mental health director's close observation evaluation of Mr. Mitchell on May 29, 2015 simply reads "In court" on the S, O, and A portions of the SOAP note. NaphCare produced no records indicating that the mental health director ever attempted to conduct an in-person evaluation of Mr. Mitchell on that day. Nurse A also conducted several close observation evaluations of Mr. Mitchell. Nurse A's close observation evaluation from May 31, 2015 contains nothing whatsoever in the "analysis" portion of the form. On that form, the nurse's "Observation" of Mr. Mitchell merely reads "Observed."

Nurse A's close observation evaluation from May 25, 2015 contains the following notations: S: Patient in the Shower. O: Patient in the Shower. A: Unable to assess. P: Continue on close observation. NaphCare did not produce a close observation evaluation form for May 24, 2015, so it is unclear if Mr. Mitchell was ever seen on that day. Nurse A's close observation evaluation from May 23, 2015 contains the following notations: S: Pt naked in cell. O: Not observed. A: Unable to assess. P: Continue on close observation.

VI. Analysis

A. Alleged Assault & Battery and Physical Abuse

1. Charging Statutes

In evaluating claims that correctional officers assaulted, battered, or physically abused Mr. Mitchell, this office must consider whether the alleged acts meet the criteria of Va. Code § 18.2-57(A) or § 18.2-369 (A) and (B). § 18.2-57(A) criminalizes assault and battery, and § 18.2-369 criminalizes abuse of incapacitated adults.

"Any person who commits a simple assault or assault and battery is guilty of a Class 1 misdemeanor . . ." Va. Code § 18.2-57(A). The Virginia Code does not define "assault" or "battery," but case precedent does. An assault is "an attempt or offer, with force and violence, to do some bodily hurt to another." *Adams v. Commonwealth*, 33 Va. App. 463, 468 (2000). A battery is an unlawful touching of another. It is not necessary that the touching result in injury to the person. Whether a touching is a battery depends on the intent of the actor, not on the force applied. *Id.*

The abuse and neglect statute prohibits the following acts:

> (A) It shall be unlawful for any responsible person to abuse or neglect any incapacitated adult as defined in this section. Any responsible person who abuses or neglects an incapacitated adult in violation of this section and the abuse or neglect does not result in serious bodily injury or disease to the incapacitated adult is guilty of a Class 1 misdemeanor.
>
> (B) Any responsible person who abuses or neglects an incapacitated adult in violation of this section and the abuse or neglect results in serious bodily injury or disease to the incapacitated adult is guilty of a Class 4 felony. Any responsible person who abuses or neglects an incapacitated adult in violation of this section and the abuse or neglect results in the death of the incapacitated adult is guilty of a Class 3 felony.

Va. Code § 18.2-369. The abuse and neglect statute additionally defines several terms relevant to our inquiry:

> "Abuse" means knowing and willful conduct that causes physical injury or pain or knowing and willful use of physical restraint, including confinement, as punishment, for convenience or as a substitute for treatment, except where such conduct or physical restraint, including confinement, is a part of care or treatment and is in furtherance of the health and safety of the incapacitated person.
>
> "Incapacitated adult" means any person 18 years of age or older who is impaired by reason of mental illness, intellectual disability, physical illness or disability, advanced age or other causes to the extent the adult lacks sufficient understanding or capacity to make, communicate or carry out reasonable decisions concerning his well-being
>
> "Neglect" means the knowing and willful failure by a responsible person to provide treatment, care, goods or services which results in injury to the health or endangers the safety of an incapacitated adult.[23]
>
> "Responsible person" means a person who has responsibility for the care, custody or control of an incapacitated person by operation of law or who has assumed such responsibility voluntarily, by contract or in fact
>
> "Serious bodily injury or disease" shall include but not be limited to (i) disfigurement, (ii) a fracture, (iii) a severe burn or laceration, (iv) mutilation, (v) maiming, or (vi) life-threatening internal injuries or conditions, whether or not caused by trauma.

Id. § 18.2-369(C).

For purposes of this analysis, this office will assume that Mr. Mitchell was "incapacitated" within the meaning of § 18.2-369. This office will also assume that correctional officers who encountered Mr. Mitchell during the ordinary course of their employment at HRRJ were "responsible persons" under § 18.2-369.

2. Facts Relevant to Claims of Battery & Physical Abuse

i. Aggravating facts (facts supporting criminal charges)

1. IP A alleged that Correctional Officer E struck Mr. Mitchell's hands on three or four unspecified dates while angrily directing profanities toward Mr. Mitchell.

2. IP B alleged that on an unspecified date, Officer C kicked Mr. Mitchell in the knee when

[23] A more complete discussion of alleged criminal neglect can be found later in this report in part VI.B.

he did not sit down. IP B also alleged that immediately after Officer C kicked Mr. Mitchell in the knee, Correctional Officer A sprayed Mr. Mitchell in the face with water while incarcerated persons laughed at Mr. Mitchell and Correctional Officer A called Mr. Mitchell "dirty." IP B stated that on an unrelated, unspecified date, Officer F told Mr. Mitchell "not to start that s***" and dragged him back to his cell by his handcuffs, threatening to pepper spray him if he did not comply. IP B claimed that on several unspecified dates, unidentified correctional officers struck Mr. Mitchell's arm to clear and close the tray slot.

3. IP C alleged that if Mr. Mitchell refused to remove his arms from the tray slot, unidentified correctional officers would punch, twist his arm, or hit his arm with a large flashlight. IP C alleged that Officers C, D, I, J, and K sprayed water on Mr. Mitchell on unspecified dates.

4. IP D alleged that an unnamed correctional officer kicked Mr. Mitchell in the head and the back of the neck on an unspecified date.

5. IP E claimed that on an unspecified date, an unidentified correctional sergeant used pepper spray on Mr. Mitchell, and that unidentified correctional officers later threw Mr. Mitchell down and used restraints as punishment on him.

6. IP F alleged that on an unspecified date, an unidentified correctional officer shut the tray slot door while Mr. Mitchell's arm was still inside it.

ii. Mitigating facts (facts undermining the claims)

1. Officer A claimed that he had never witnessed or heard of anyone assault or mistreat Mr. Mitchell. Stated that he had never sprayed Mr. Mitchell with water or heard of anyone else spraying Mr. Mitchell. When asked about the kicking incident related by IP B that allegedly preceded Officer A spraying Mr. Mitchell in the face with water, Officer A reported that no one had kicked Mr. Mitchell in the leg or anywhere else on his person.

2. Officer C denied ever kicking or spraying Mr. Mitchell.

3. Officer D stated that Mr. Mitchell was not the type of person who refused to remove his arm from the tray slot in his cell door. Officer D additionally reported that neither he nor any other staff member had sprayed Mr. Mitchell's face with water or a cleaning solution. Officer D also stated that he was unaware of any other officer spraying an incarcerated person.

4. Officer E denied ever punching or striking Mr. Mitchell's arms with a flashlight or any other object to get Mr. Mitchell to remove his arms from the tray slot. Officer E stated he never carried a flashlight while working in the pod.

5. Officer G reported that he never had to strike Mr. Mitchell, and that he never saw anyone else strike him.

6. Officer I never saw anyone force Mr. Mitchell to the ground, choke him, or spray him.

7. Officer J stated that Mr. Mitchell was cooperative and no officer had to use any force to get him handcuffed and out of his cell. He reported that the only time officers had to touch Mr. Mitchell was to assist him to one of the tables in the pod while he was handcuffed. Officer J never observed anyone spray Mr. Mitchell with water or any type of cleaning solution. He stated that neither he nor any other officer kicked Mr. Mitchell in the back of the leg or kicked him to force him to the ground. He never observed another officer drag or physically abuse Mr. Mitchell. Officer J never had to physically remove Mr. Mitchell's arm from the tray slot. He never struck Mr. Mitchell's arm with a fist or flashlight to get his arm out of the tray slot.

8. Officer K recalled an incident in which he and Officer C had to force Mr. Mitchell to sit down. Officer K stated that once Mr. Mitchell sat down, he began to roll around. Officer K stated that he and Officer C did not kick, spray, drag, or use profanity toward Mr. Mitchell during that incident. He stated that Mr. Mitchell was always cooperative except for that one incident. He

reported that after the incident, Mr. Mitchell was escorted back to his cell without further issue.

9. Officer M was unaware of any incidents involving Mr. Mitchell refusing to remove his arm from the tray slot, and he never saw an officer punch or strike Mr. Mitchell's arm with a flashlight.

10. Officer N reported that although Mr. Mitchell hung his arm out of the tray slot in the cell door a couple times, he never had to physically remove it. He reported that he never punched or struck Mr. Mitchell's arm with a flashlight or another object to get Mr. Mitchell to remove his arm from the tray slot.

11. Officer O never had to physically remove Mr. Mitchell's hands from the cell door tray slot, and he never slammed the door shut, or punched, struck, or hit Mr. Mitchell's hands. He never observed any of his officers punch or strike Mr. Mitchell's arms with a flashlight.

12. Officer P stated that he never had to strike, punch, or physically remove Mr. Mitchell's arm from his tray slot during the feeding process.

13. IP A, an essential witness in the potential case against correctional officer E, did not specify dates on which correctional officer E allegedly hit Mr. Mitchell's hands.

14. IP B, an essential witness in the potential cases against correctional officers A, C, and F, had already spoken to the Washington Post, the Richmond Times-Dispatch, the Virginian-Pilot, and WAVY-10 News about Mr. Mitchell. In a letter to a Washington Post reporter, IP B requested compensation in return for allowing the reporter to use his name in an article. IP B reported that he hoped to get a sentence reconsideration in return for testifying against another person in an unrelated case. IP B did not specify the date of the incident involving Officers A and C or the incident involving Officer F. IP B did not specifically identify the officers who allegedly struck Mr. Mitchell's hands or the dates on which these alleged assaults occurred.

15. IP C did not identify specific officers who allegedly struck Mr. Mitchell's hands through

the tray slot or the dates on which these alleged assaults occurred. An essential witness in the potential cases against Officers C, D, I, J, and K, IP C did not provide dates on which those officers allegedly sprayed Mr. Mitchell. IP C wrote a letter to a Washington Post reporter stating that he would provide the reporter with information about Mr. Mitchell in return for the consideration of the reporter shining light on his situation.

16. IP C additionally claimed to have knowledge of certain mistreatment of Mr. Mitchell, namely, incidents and conditions inside Mr. Mitchell's cell. It is unlikely that IP C had the opportunity to see or hear many of the alleged incidents he related. Incarcerated persons housed in Mr. Mitchell's pod were generally on segregation for disciplinary reasons or otherwise were on close observation for mental health concerns. In either case, incarcerated persons in housing unit 3, pod 1 remained on a 23-hour lockdown and would not have been permitted to roam the pod or go into other incarcerated persons' cells. IP C admitted that at least part of his allegations against officers related to the condition of Mr. Mitchell's cell were hearsay, specifically, his claims regarding the condition of Mr. Mitchell's cell.

17. IP D did not specify which officer allegedly kicked Mr. Mitchell in the back of the head and neck or the date on which this alleged assault occurred.

18. IP E was not booked into HRRJ until days after Mr. Mitchell's death. IP E admitted to having spoken to one of Mr. Mitchell's representatives before to speaking to VSP investigators. IP E's reports of alleged pepper spraying of Mr. Mitchell, his swollen feet, the alleged denial of food and water, and the lack of running water in his cell somehow mirror claims made by IPs A, B, C, and F. It is likely that IP E discussed alleged mistreatment with other incarcerated persons, as IP E had no opportunity to observe the things he claimed to have seen.

19. IP F identified IPs A and B as his fellow pod workers/trustees. IP F stated that he never

saw any correctional officers assault Mr. Mitchell.

20. No incarcerated person who alleged that Mr. Mitchell was assaulted or abused provided the date on which the assault or abuse allegedly occurred.

21. Correctional officers A, C, D, E, I, J, and K explicitly or implicitly denied the allegations of assault or physical abuse that were made against them.

a. Officer A denied spraying Mr. Mitchell.

b. Officer C denied kicking Mr. Mitchell, and Officer A, who was alleged to have been present when Officer C allegedly kicked Mr. Mitchell, stated that no one had kicked Mr. Mitchell. Officer K, who was also present during the alleged kicking incident, stated that he and Officer C did not kick, spray, drag, or use profanity toward Mr. Mitchell during the incident. According to Officer K, Mr. Mitchell was always cooperative except for that one incident. Officer K stated that after the incident, Mr. Mitchell was escorted back to his cell without further issue.

c. Officer D stated that neither he nor any other staff member had sprayed Mr. Mitchell's face with water or a cleaning solution. Officer D was unaware of any other officer spraying an incarcerated person.

d. Officer E reported that he never observed a correctional officer verbally or physically abuse or withhold food from Mr. Mitchell.

e. Officer I never saw anyone force Mr. Mitchell to the ground, choke him, or spray him.

f. Officer J never observed anyone spray Mr. Mitchell with water or a cleaning solution.

g. Officer K stated that he did not kick, spray, drag, or use profanity toward Mr. Mitchell during the incident involving Officer C and reported by IP B.

3. Analysis under the Assault & Battery and Physical Abuse Statutes

The claims of assault and battery and physical abuse are marred by credibility conflicts.[24] On one side are jail incarcerated persons levying accusations of abuse against those charged with keeping them confined. Several factors bolster the incarcerated persons' statements. Their potential fear of retribution by correctional officers against whom they might testify lends credibility to their accusations. It would make little sense for incarcerated persons who have no choice but to be around the same correctional officers to fabricate claims against the officers and then potentially be subject to retribution. Additionally, the majority of the incarcerated persons interviewed also generally appear to have had the *opportunity* to observe the alleged abuses. Negative dynamics at play in the incarcerated persons' statements include a potential desire to retaliate against correctional officers and the potential coordination of their testimony with other incarcerated persons and outside sources.

On the other side of this case are correctional officers alleged to have abused a mentally challenged incarcerated person. This office is aware of the potential that the officers interviewed could have collaborated to coordinate their statements and hide systematic violations of incarcerated persons' rights. This is not to suggest that this investigation discovered evidence that the officers interviewed were untruthful or coordinated with their colleagues; we are simply aware of the potential for both incarcerated persons and correctional officers to have coordinated and tainted their testimony with regard to this case.

These alleged assaults by correctional officers cannot be said to have occurred on any particular date.[25] The incarcerated witnesses' inability or unwillingness to provide the dates on

[24] Neither incarcerated witnesses nor correctional officers were under oath when speaking with investigators. This office therefore cannot speak to the veracity of the witnesses' statements.

[25] Virginia law regarding charging documents requires prosecutors to state with specificity the date of offense on which a crime allegedly occurred.

which these offenses occurred, although potentially inadvertent, negatively impacts their credibility and the success of potential criminal charges. Additionally, witnesses' failure to identify certain officers who allegedly abused Mr. Mitchell is critical. While one can initiate a civil lawsuit by suing "John Doe," the Commonwealth cannot charge an individual with a crime without knowing the individual's name. The Commonwealth therefore begins evaluating these allegations of assault and physical abuse without knowing when some of the offenses occurred or by whom they were committed.

The correctional officers' statements are bolstered their uniform denials of any assaults or abuse of Mr. Mitchell, but negative dynamics in play include officers' desire to avoid criminal liability, as well as their potential to have coordinated their statements with other officers. Most of the correctional officers interviewed by VSP were advised of their *Miranda* rights and made aware of the criminal investigation into their alleged conduct. Those who were not *Mirandized* were non-essential officers who were not alleged to have committed any crimes.

If this office took the word of every potential defendant who summarily denied the charges against him, no one would ever be prosecuted in Portsmouth. This office recognizes that potential criminal defendants often say what they believe investigators want to hear in order to help their own case. Additionally, the question of which side has more witnesses is never the end of the prosecutorial determination. The quality and specificity of the witnesses' testimony, their motivation to testify, and their credibility must be considered.

This office recognizes the seriousness of these alleged assaults. Citizens of the city of Portsmouth have the right to expect and demand that employees in positions of power, such as correctional officers, are not abusive or assaultive. However, we must not only evaluate the evidence supporting the potential charges, but the mitigating evidence and whether probable cause

exists in every case.

The report issued by the medical examiner in this case shows no injuries consistent with the alleged assaults and physical abuse described by the incarcerated persons who spoke with VSP investigators. Notably, a medicolegal death investigator indicated in his report that upon observing Mr. Mitchell in his cell after his death, there were no visible signs of recent trauma or injury to Mr. Mitchell's hands or body. While the medical examiner cannot rule out older alleged traumas inflicted at HRRJ that would have healed before his death, for the reasons explained more fully above, the evidence supports no claims of assault, battery, or abuse. This office therefore cannot conclude that any alleged physical abuse satisfied the element of "serious bodily injury" to Mr. Mitchell or contribution to his death, as contemplated by § 18.2-369(B). Additionally, while the abuse and neglect statute allows for criminal charges even when the alleged abuse or neglect does not cause serious bodily injury or death, the evidence does not support claims of battery or physical abuse against Mr. Mitchell, making the filing of misdemeanor abuse charges under § 18.2-369(A) inappropriate.

B. <u>Alleged Criminal Neglect</u>

Under § 18.2-369(C), "'[n]eglect' means the knowing and willful failure by a responsible person to provide treatment, care, goods or services which results in injury to the health or endangers the safety of an incapacitated adult. As previously discussed, an "incapacitated adult" is any person 18 years of age or older who is impaired by reason of mental illness, intellectual disability, physical illness or disability, advanced age or other causes to the extent the adult lacks sufficient understanding or capacity to make, communicate or carry out reasonable decisions concerning his well-being.

§ 18.2-369 also includes several affirmative defenses that are relevant to our inquiry into

whether NaphCare or HRRJ staff criminally neglected Mr. Mitchell. If proven, an affirmative defense excuses a person from guilt under a criminal statute. The statute provides in relevant part that

> No responsible person shall be in violation of this section whose conduct was (i) in accordance with the informed consent of the incapacitated person or a person authorized to consent on his behalf; (ii) … (iii) … (iv) … or (v) a bona fide, recognized or approved practice to provide medical care.

§ 18.2-369(D).

1. Allegation of criminal neglect due to starvation inflicted by denial of meals

In determining whether correctional officers committed felony neglect against Mr. Mitchell under § 18.2-369 by starving him in such a manner that caused him injury or death, the medical examiner's statement regarding Mr. Mitchell's weight loss is especially relevant: "Autopsy cannot tell whether a thin person refused to eat, was denied food, or ate ravenously and lost weight because of an unidentified natural disorder; or some combination of the three." At the time the medical examiner conducted the autopsy of Mr. Mitchell and produced her report, she had not been confronted with statements from certain incarcerated persons and correctional officers indicating that Mr. Mitchell was fed consistently and ate ravenously. Our office supplied this information to Dr. Gunther in a supplemental interview.

Correctional officers and incarcerated persons alike agree that Mr. Mitchell was given extra trays of food. Officer G specifically stated that he would give Mr. Mitchell extra food until he couldn't eat anymore. Various correctional officers recalled that Mr. Mitchell's most frequent mode of communication was asking "where's my [food] tray," and that they would often provide him with an extra tray of food in order to get him to give back old trays.[26] No officers admitted to

[26] However, the incarcerated witnesses and correctional officers were inconsistent about whether incarcerated persons or correctional officers served meals.

intentionally withholding meals from Mitchell, and several officers denied the contention that they would place meals just out of reach on a table outside of Mr. Mitchell's cell. In a recorded phone call between IP B and one of Mr. Mitchell's representatives, IP B gave an opinion that Mr. Mitchell did not die of starvation, because he would eat. Additionally, no evidence exists in this case to suggest that Mr. Mitchell refused to eat or went on a hunger strike.

However, the records regarding Mr. Mitchell's administration and consumption of meals are inconsistent. HRRJ and/or NaphCare staff produced three different types of documents that purported to detail Mr. Mitchell's food and medication delivery and/or consumption: Behavior/Suicide Watch reports (which were only generated between May 11, 2015 and June 1, 2015 while Mr. Mitchell was on close observation), Daily Confinement Records, and partial Feeding Rosters. The Behavior/Suicide Watch reports contain sections in 15-minute intervals at which officers were to write down their observations of Mr. Mitchell, as well as a section where officers were to indicate whether Mr. Mitchell had not consumed breakfast, lunch, or dinner. The Daily Confinement Records contain blocks for breakfast, lunch, and dinner in which officers were to write the time that meals were provided to Mr. Mitchell. The Feeding Rosters contain check boxes that officers were to fill in when Mr. Mitchell was served a meal. None of these forms required officers to specify whether 1) the incarcerated person was observed ingesting food or medication, or 2) the incarcerated person was merely provided with food or medication. Any observations about whether Mr. Mitchell actually ingested food or medication are contained solely on the Behavior/Suicide Watch reports.

These forms are all handwritten by correctional officers. The Feeding Rosters contain only checkboxes, but the Daily Confinement Records and Behavior/Suicide Watch reports require officers to write times and lengthier observations. A significant number of the handwritten notes

are almost completely illegible.

The records of Mr. Mitchell's weight are also extremely inconsistent. Our office is unable to conclude with certainty what his actual weight during his incarceration was. Mr. Mitchell's weight was reported in the following fashion between April and August 2015:

- April 10, 2015: 160 pounds (Maryview)
- April 22, 2015: 178 pounds (PCJ)
- April 28, 2015: 182 pounds (PCJ)
- May 4, 2015: 186 pounds (PCJ)
- May 5, 2015: 182 pounds (PCJ)
- May 11, 2015: 178 pounds (HRRJ)
- July 30, 2015: 158 pounds (HRRJ)
- July 30, 2015: 145 pounds (Maryview)
- August 24, 2015: 193 pounds (HRRJ)

Mr. Mitchell undoubtedly lost weight during this time period, but the most credible account is that he initially weighed 160 pounds shortly prior to his April 22, 2015 incarceration, and that he weighed 145 pounds roughly 20 days prior to his death. Mr. Mitchell was apparently weighed by Maryview and NaphCare on the same day, July 30, 2015, but there is an inexplicable 13-pound discrepancy between those two weights. Our office inquired as to whether Mr. Mitchell's weight measurements at HRRJ included the weight of any shackles or restraints he may have been wearing, but NaphCare personnel uniformly stated that they only recorded incarcerated persons' weight without shackles on.

A significant question raised by Mr. Mitchell's fluctuating weight is why a NaphCare employee made an official entry in Mr. Mitchell's chart showing a robust weight of 193 pounds

five days after his death. Our investigation was unable to answer this question, and it is unclear whether reports of Mr. Mitchell's alleged starvation were made public prior to this chart entry being made.

The medical examiner's statements about the cause of Mr. Mitchell's death are unequivocal: Mr. Mitchell did not die from "not eating." According to Dr. Gunther, no amount of food would have kept Mr. Mitchell from passing away. The medical examiner importantly noted that Mr. Mitchell's body mass index at the time of his death was 19.5, and that in her experience, a person who had been starved would have a body mass index of 15 or less.

With no reason to question the weights Maryview listed for Mr. Mitchell, it seems that he likely lost around 15 pounds over more than three months during his incarceration. This moderate weight loss is most consistent with his apparent affliction by a wasting syndrome of unknown etiology, according to the medical examiner. For that reason and for those mentioned above, there is insufficient evidence to support felony or misdemeanor neglect charges based on the claim that Mr. Mitchell was denied meals.

2. Allegation of criminal neglect due to substandard living conditions

Various incarcerated persons reported that Mr. Mitchell's cell was filthy and had feces and urine everywhere. Incarcerated persons also reported that Mr. Mitchell never had a uniform and was constantly naked. These individuals also stated that Mr. Mitchell never had running water, and that he was never given recreation time.

Correctional officers indicated that Mr. Mitchell was provided a uniform, but that there were issues with keeping Mr. Mitchell dressed. Officers reported that Mr. Mitchell might remove his top, or take off the uniform entirely. Officers reported that Mr. Mitchell stuffed his uniform into his toilet at times. Officer G and other officers noted that Mr. Mitchell was afforded the

opportunity to have recreation time like other incarcerated persons, but that Mr. Mitchell always stayed in his cell and asked for more food. Consistent with staying in his cell, many entries in Mr. Mitchell's daily confinement records indicate that he refused any recreation time.

The Behavior/Suicide Watch reports generated during Mr. Mitchell's close observation status consist of 44 spreadsheet-type forms, each of which itself contains 54 rows in which officers were to write the results of their 15-minute checks. Excluding ten total blank rows, officers made a total of 2,366 individual entries on these forms. 907 of the entries, or 38.3%, indicate that Mr. Mitchell was standing at or near his cell door. Because the close observation rounds only occurred every fifteen minutes, we cannot say whether this means that Mr. Mitchell spent a total of 13,605 continuous minutes (907 entries x 15 minutes per entry) standing at his cell door. Regardless, it is undeniable that Mr. Mitchell was on his feet for long periods of time every day.

These records comprise approximately 524 hours during which Mr. Mitchell was on close observation. Mr. Mitchell was reportedly asleep for roughly 112 of those hours (meaning that the box titled "awake" on the form was blank). He was therefore asleep for approximately 21.3 percent of the first three weeks of his incarceration, or an average of 5.3 hours per day. This statistic is distorted by the fact that Mr. Mitchell spent some days sleeping for most of the day, and spent several consecutive days awake at different times.

Mr. Mitchell never accepted recreation time between May 11, 2015 and June 2, 2015, and he does not appear to have left his cell during that time except for it to be cleaned, to take an occasional shower, to go to one medical visit, to go to the emergency room, and to go to court once. The use of administrative segregation by HRRJ in Mr. Mitchell's case, which functioned as 23-hour-daily solitary confinement, almost certainly affected his mental health and contributed to

his decompensation.[27]

HRRJ officers appeared to be somewhat conscientious about the condition of incarcerated persons' cells. Officers reported that if a cell was dirty, they either would not leave work or would not assume responsibility for the new shift unless the cell was cleaned first. Indeed, some officers indicated that they did not want to be responsible for any punishment or reprimand they might receive for allowing an incarcerated person to maintain a dirty cell. Regardless of the officers' motivation for cleaning cells, the end result was that they claimed that cells would get cleaned, and that incarcerated persons would not be forced to live in a filthy environment.

HRRJ's lax record-keeping standards during Mr. Mitchell's incarceration likely allowed the pertinent details about Mr. Mitchell's condition to be overlooked. It is additionally problematic that correctional officers knew Mr. Mitchell stood at his cell door for hours on end or to stay awake for days at a time, and apparently did little to help him.

Mr. Mitchell was on suicide watch as a precaution. Although he allegedly told PCJ officials about a suicidal thought, he denied any suicidal ideation in his HRRJ intake screening. Because he was transferred from PCJ on "suicide watch," HRRJ kept him on the same status. PCJ and HRRJ apparently developed an institutional consensus that placing this mentally ill individual on "suicide watch" was the best thing, or possibly the only thing to do for a difficult patient such as Mr. Mitchell. But "suicide watch" or "close observation" likely did not help Mr. Mitchell, who was arguably never suicidal at HRRJ. It was a square peg forced into the round hole that was Mr.

[27] See, e.g., "The Ninth Circle of Hell: An Eighth Amendment Analysis of Imposing Prolonged Supermax Solitary Confinement on Inmates with a Mental Illness," 90. Denv. L. Rev. 1 (2019) (noting that "[h]ousing inmates with a mental disorder in prolonged supermax solitary confinement deprives them of a minimal life necessity because this setting poses a significant risk to their basic level of mental health . . . In addition, placing such inmates in supermax confinement constitutes deliberate indifference to their needs because this setting subjects this class of readily identifiable and vulnerable inmates to a present and known risk by knowingly placing them in an environment that is uniquely toxic to their condition . . . Whether it is called torture, a violation of evolving standards of human decency, or cruel and unusual punishment, truly 'a risk this grave-this shocking and indecent-simply has no place in civilized society.'"

Mitchell's serious mental illness. It did not appear to add to his quality of life or to address any of his mental health problems. It was a mechanism by which to keep Mr. Mitchell alive at a bare minimum level of functionality. While keeping Mr. Mitchell effectively in solitary confinement likely compounded his mental illness, there is insufficient evidence to support felony or misdemeanor neglect charges based on the claim that Mr. Mitchell was allowed to live in substandard conditions.

3. Allegation of criminal neglect due substandard medical and mental health care

NaphCare, Inc. is a correctional medical services provider that assumes the responsibility for caring for the inmates at various correctional facilities on a contract basis. The medical records as well as correctional officer statements indicate that Mr. Mitchell was repeatedly seen by NaphCare medical and mental health personnel, and that those personnel attempted to provide medication and treatment to Mr. Mitchell almost every day during his incarceration. Mr. Mitchell's close observation status dictated that he be checked on by a correctional officer or a member of NaphCare staff every fifteen minutes for the first 24 days of his incarceration at HRRJ. Pill pass also occurred every day at the jail, and jail records indicate that Mr. Mitchell apparently had medication made available to him almost every day during his incarceration.

NaphCare's internal structure while operating inside HRRJ appeared to be divided between a medical division and a mental health division. After multiple hours of interviews of NaphCare employees assigned to both divisions, scant evidence emerged to suggest that the divisions communicated between one another to develop a unified plan to coordinate Mr. Mitchell's care. Because NaphCare's attorneys failed to make all requested witnesses available to our office in a timely manner or at all, we cannot say if any particular employee was primarily responsible for overseeing Mr. Mitchell's care. Most employees had no independent recollection of Mr. Mitchell

except what they had seen and heard in the news and the information that appeared in Mr. Mitchell's medical records.

Interviews with NaphCare employees revealed a cluttered accountability structure wherein employees who encountered Mr. Mitchell were sometimes not fully informed about NaphCare policies governing their duties. Employees who were charged with administering medications to patients like Mr. Mitchell had conflicting views on what their responsibilities were with respect to the chain of reporting for incarcerated persons who refused medications and treatment.

On at least 24 occasions, all of which occurred on different days during his incarceration, a NaphCare form was generated indicating that Mr. Mitchell refused a treatment or medication at HRRJ. Some treatments included blood work, while others included basic vitals checks. NaphCare policy in place during Mr. Mitchell's incarceration specified that all refusals of health evaluations and treatments were to be documented and signed by the patient. If the patient refused to sign the documentation of the refusal of the evaluation or treatment, the policy further directed NaphCare staff to write "patient refuses to sign" in the signature line and obtain the additional signature of a witness. NaphCare policy dictated that the witness must be a member of the health care staff. Each refusal document appears to have been prepared according to NaphCare policy and was signed by at least one witness.

However, no NaphCare employees could consistently articulate the type of conduct they might deem to be a refusal of medication or treatment.[28] Interviews of the various nurses and medical assistants further confirmed that Mr. Mitchell regularly refused necessary mental health medications and other medical tests. Interviews of the various employees responsible for dispensing these mental health medications to Mr. Mitchell showed that these employees were

[28] I.e., whether a person specifically said the words "I refuse" or a nonverbal patient with mental health issues simply did not respond or acted out, causing the provider to deem them to have refused

unsure of the procedures in place to notify superiors that action was needed because of an incarcerated person's repeated refusals of the medication. It was therefore unclear if Mr. Mitchell was deemed to have refused medication or treatments simply because he was rendered unable to communicate due to his mental illness.

Mr. Mitchell's court-appointed psychiatric evaluator found him to be incompetent to stand trial. It appears that Mr. Mitchell could not validly give informed consent to receive or refuse medical treatment, and that his refusals of treatment and medication were similarly uninformed. However, medical personnel cannot force treatment or medications upon an individual except under extraordinary circumstances. Mr. Mitchell was scheduled to be transferred to Eastern State Hospital, where he could potentially be involuntarily treated and medicated. NaphCare staff did not have the power or the right to force Mr. Mitchell to submit to treatment or take his medication, but they did have the responsibility to adequately care for him.

NaphCare staff could and should have inquired earlier and more often into how to transfer Mr. Mitchell into a treatment environment better suited to deal with his deteriorating mental state. Mr. Mitchell's obvious mental deficiencies simply could not be adequately addressed by the medical staff at a correctional facility. It was plainly obvious to most who encountered Mr. Mitchell that he was unable to communicate, care for himself, or maintain a clean living environment. NaphCare staff attempted time and again to provide medical treatment and mental health services to the incompetent Mr. Mitchell, to no avail.

By accounts of some NaphCare employees, Mr. Mitchell was difficult to deal with when he encountered employees with whom he was not familiar. Jail medical personnel certainly deal with difficult and resistive patients in an often-thankless environment. But whatever the environment was inside HRRJ, it did not excuse NaphCare staff from taking action to stabilize Mr.

Mitchell. NaphCare employees who had the potential to directly and positively impact Mr. Mitchell's general well-being and mental state seemed unwilling to attempt to overcome Mr. Mitchell's mildly resistive nature and give him the treatment and attention he needed, or to otherwise ensure that their superiors were aware of Mr. Mitchell's decompensation. It is also apparent that on NaphCare's watch, Mr. Mitchell, who was likely incompetent to make informed medical decisions, was allowed to refuse his essential mental health medication and other medical treatments over and over.

Thus, Mr. Mitchell fell into a vicious cycle:

1. He regularly refused medication and treatments due to his mental illness, continuing the trend observed by his mother in April 2015 prior to his incarceration
2. His mental state deteriorated due to a lack of proper medication
3. When NaphCare employees attempted to re-educate him about the importance of maintaining his medication, he was likely unable to understand the information due to his deteriorating mental state
4. His deteriorating mental state caused him to lash out at NaphCare employees because he likely did not understand that they intended to help him
5. NaphCare service providers felt no need to give him additional or special medical or mental health attention because they incorrectly perceived him to be voluntarily noncompliant with treatment
6. NaphCare discontinued his medications because he was not taking them
7. He eventually died, likely as the result of an undiagnosed and untreated medical condition that no prior medical personnel had ever detected

Only on July 30, 2015, roughly 80 days into his incarceration at HRRJ and roughly 20 days

before his death, did any single NaphCare employee finally act upon the realization that Mr. Mitchell's mental state was so compromised as to necessitate his involuntary removal from HRRJ and placement in a psychiatric facility. In light of repeated reports of profane and bizarre outbursts, refusal of mental health medications, diagnosed psychosis, and smearing of feces on walls, the lack of institutional consensus or action about the severity of Mr. Mitchell's mental health concerns shocks the conscience.

In June 2017, our office requested to interview (among other employees) the employee who served as NaphCare's Mental Health Director during Mr. Mitchell's incarceration who was ostensibly responsible for the care of all patients with mental health concerns at HRRJ. Out of all the NaphCare employees identified by our office as having encountered Mr. Mitchell, the mental health director had the most frequent contact with Mr. Mitchell, producing near-daily reports about Mr. Mitchell's mental status while he was under close observation. NaphCare attorneys informed us that this individual was the subject of a protective order in the federal lawsuit over Mr. Mitchell's death, and had certain constraints that made it difficult for her to interview in person. NaphCare attorneys never produced this individual to our office, and a January 10, 2019 email request to interview the mental health director and other witnesses went unanswered.[29]

The mental health director's close observation evaluations of Mr. Mitchell contained pedestrian amounts of information that give us no great insight into her assessment of Mr. Mitchell. However, Nurse A completed several close observation evaluations of Mr. Mitchell that were shocking in their lack of information. On one occasion, Mr. Mitchell was in the shower when Nurse A attempted to evaluate him. The nurse simply wrote that she could not assess Mr. Mitchell because he was in the shower. On another occasion, Mr. Mitchell was naked in his cell when Nurse

[29] This was approximately the tenth such request since June 2017.

A attempted to evaluate him. The nurse simply wrote that she could not assess Mr. Mitchell because he was naked.

NaphCare produced no documentation indicating that Nurse A tried to evaluate Mr. Mitchell after he got out of the shower on May 25, 2015. Similarly, no evidence was produced indicating that Nurse A tried to evaluate Mr. Mitchell after he got dressed on May 23, 2015. This employee's behavior is illustrative of the legions of NaphCare employees who were paid to care for people like Mr. Mitchell yet appeared to have neither the time nor commitment to wait for Mr. Mitchell and attend to his mental health concerns on his terms.

Close observation or suicide watch is meant for incarcerated persons who have clear and persistent suicidal or homicidal ideations. None of Mr. Mitchell's records indicate that he was suicidal except the PCJ report from the first day of his incarceration. The records for the subsequent days and weeks indicate that Mr. Mitchell regularly and repeatedly denied any suicidal thoughts. The medical social worker who conducted Mr. Mitchell's initial evaluation at HRRJ noted that he was transferred on suicide watch from PCJ, and that he denied suicidal ideations. In the days leading up to Mr. Mitchell's removal from close observation at HRRJ on June 3, 2015, there are no indications that his condition was improving. It appears that the mental health director simply took the seriously mentally ill Mr. Mitchell off close observation without instituting any additional or extraordinary mental health treatment to ensure his well-being while he awaited transfer to Eastern State Hospital.

Because NaphCare did not produce all requested witnesses for interview, only through secondary reporting[30] has this office been able to determine that the NaphCare mental health director at HRRJ apparently attempted to secure a temporary detention order for Mr. Mitchell's

[30] Specifically, the Investigation Report issued by the Office of Internal Audit of the Virginia Department of Behavioral Health and Developmental Services.

immediate transfer to a psychiatric facility on July 31, 2015. Accounts of this process suggest that Mr. Mitchell was in court on July 31, 2015 when the evaluator for the temporary detention order attempted to meet with him. The evaluator was from the Portsmouth Community Services Board. The evaluator was apparently unable to complete the assessment, and there is no evidence to suggest that the mental health director or another evaluator ever followed up with Mr. Mitchell to continue the temporary detention order process. NaphCare additionally produced no records suggesting that its employees followed up on and/or re-initiated the temporary detention order request after Mr. Mitchell could not initially be evaluated. Regardless, the remedy of a temporary detention order was legally impossible and ineffectual under then-existing Virginia law because a finding of incompetence to stand trial and a competency restoration order had already been issued for Mr. Mitchell by the Portsmouth General District Court.[31]

Between the attempt to secure a temporary detention order in late July and Mr. Mitchell's death on August 19, 2015, medical records examined by our office are devoid of any additional attempts to address Mr. Mitchell's mental health outside of the usual attempts to administer Mr. Mitchell his medications and segregation rounds. This lapse in attention to Mr. Mitchell's mental state is notable, given that the most senior mental health employee working for NaphCare at HRRJ apparently believed his mental health was so poor as to necessitate a request that he be

[31] The process of securing a temporary detention order for an inmate is governed by Va. Code § 19.2-169.6. In 2015, that code section excluded inmates who were subject to the provisions of Va. Code § 19.2-169.2 from being able to be removed from jail pursuant to a temporary detention order. § 19.2-169.6 formerly read as follows: "Any inmate of a local correctional facility *who is not subject to the provisions of § 19.2-169.2* may be hospitalized for psychiatric treatment at a hospital designated by the Commissioner of Behavioral Health and Developmental Services as appropriate for treatment of persons under criminal charge . . ." (emphasis added) § 19.2-169.2 governs the treatment of individuals found incompetent to stand trial, of which Mr. Mitchell was one. Mr. Mitchell was therefore subject to the provisions of § 19.2-169.2, so he could not be removed from HRRJ on a temporary detention order in 2015. This unfortunate anomaly operated to forbid the temporary involuntary treatment of incompetent inmates so as not to redouble resources used to treat the incompetent inmate. The offending provision was removed by the 2017 amendment to § 19.2-169.6, which deleted the language "who is not subject to the provisions of § 19.2-169.2" from the statute.

involuntarily detained for his own health and safety 20 days prior to his death.

VII. Summary and Recommended Best Practices

The death of Jamycheal Mitchell in Hampton Roads Regional Jail was tragic and likely avoidable. However, whether this tragedy is attributable to the alleged criminal actions of HRRJ personnel and/or NaphCare employees depends on numerous factors and requires a complete picture of all evidence and witness accounts. In the absence of a complete picture due to various obstacles placed in the way of our investigation, we have elected to evaluate this case based on the evidence our investigation was able to uncover to date.

The incarcerated persons who provided information about alleged abuses of Mr. Mitchell varied in their credibility. None of these individuals appear to have come forward with information about Mr. Mitchell *before* his death. Each incarcerated person came forward after having the opportunity to learn of the large-scale inquiries into this case. Some incarcerated persons related incidents involving officers allegedly assaulting and abusing Mr. Mitchell, at times claiming to have information that they did not have the opportunity to observe. Their statements regarding Mr. Mitchell's eating habits are contradicted by the nearly unanimous recollection of the officers that Mr. Mitchell was fed consistently, regularly asked for more food, often received extra food, and yet somehow still lost weight. Additionally, correctional officers acknowledged that they had certain nonviolent encounters with Mr. Mitchell as reported by incarcerated persons, but disputed the allegations that Mr. Mitchell was kicked, sprayed, assaulted, or verbally abused during those encounters.

Straying outside the world of mere inconsistencies, we conclude that if IP E were permitted to testify on behalf of the Commonwealth at a potential criminal trial, we would be suborning perjury. IP E made a wide range of statements about alleged abuse of Mr. Mitchell. Jail records show that IP E was not incarcerated at HRRJ at the same time as Mr. Mitchell. At best, IP E's

allegations are hearsay, and at worst, they are a fabrication.

The potential witnesses to these alleged crimes who are or were incarcerated at HRRJ are imperfect, as are the officers alleged to have abused Mr. Mitchell. However, various incarcerated persons' requests for favorable treatment in return for their testimony undermine their credibility, as do their discussions of their testimony among themselves and with reporters.

This office recognizes that law-enforcement officers are sworn to protect and defend the public. However, when law-enforcement officers are accused of committing crimes, they are not entitled to favorable treatment. They are not presumed to be more credible than the incarcerated persons in this case merely because they are law-enforcement officers. This office has similarly evaluated the credibility of the officers' statements, their motive to provide the information that they did, and their possible coordination of their statements among fellow officers.

Each officer that VSP investigators approached agreed to waive his or her *Miranda* rights and provide information, notwithstanding two officers who initially invoked their right to an attorney but later gave statements, as well as some officers who were interviewed via telephone and were not *Mirandized*. Officers' attitudes toward Mr. Mitchell ranged from concern to indifference to mild annoyance. Each officer was confronted with wide-ranging allegations of abuse, and no officers admitted to the abuses they were alleged to have committed. Officers sometimes reported that Mr. Mitchell might have "outbursts" of spitting or profanity, but all officers who had extended opportunities to interact with Mr. Mitchell described him as compliant and easy to work with, stating that there was no need to be forceful with him.

Under its contract with this region's municipalities, HRRJ receives incarcerated persons from other local jails who have the most severe medical and mental health problems. Because of this, a higher standard of conduct should be expected from HRRJ officers. All correctional officers

receive training in dealing with incarcerated persons in crisis and who have mental health diagnoses, but trainings cannot teach compassion. If one HRRJ officer had enough compassion for Jamycheal Mitchell to take up his cause, demand that he be properly treated for his clear bouts of mania, psychosis, and refusals of medication, to generate the appropriate emergency reports documenting their requests, and to not rest until Mr. Mitchell was stabilized and his decompensation was reversed, this report would be unnecessary. No HRRJ officers appear to have looked on Mr. Mitchell with disdain or anger; rather, an implicit sense of pity and resignation tinged their interviews. We should expect more from those charged with caring for those who have had their liberty taken away and who may not even understand why.

Before he was incarcerated, Mr. Mitchell's mother told Portsmouth Police that Mr. Mitchell had lost weight due to not eating.[32] Reports that Mr. Mitchell was fed and even overfed while at HRRJ are credible. When viewed in isolation, the reports of ravenous eating accompanied by simultaneous weight loss make little sense. However, when viewed in conjunction with the medical examiner's conclusion that Mr. Mitchell died from an unknown wasting disorder (possibly Addison syndrome), his weight loss gains appropriate context. The totality of the evidence therefore shows that Mr. Mitchell was likely deteriorating mentally and physically before he went into custody, meaning that the actions and inactions of correctional officers and NaphCare staff potentially contributed to but likely did not directly cause Mr. Mitchell's weight loss or death.

NaphCare's conduct with respect to Mr. Mitchell is significantly more culpable than that of any other actor involved in this case. We cannot impose a duty on correctional officers to perform an oversight function on incarcerated persons' medical and mental health care – that is merely an aspirational goal. But NaphCare had a duty to ensure that the incarcerated persons for

[32] Portsmouth Police acted appropriately in referring Mr. Mitchell for a Temporary Detention order during their April 2015 contact with him, highlighting the importance of Crisis Intervention Training (CIT) for police officers.

which it was responsible received the appropriate care. The public can and should demand that a correctional facility's medical services provider police its employees and go the extra mile for seriously mentally ill patients. NaphCare arguably did not do so in Mr. Mitchell's case. It followed all its usual policies and procedures that are in place for patients who understand policies and procedures. Jamycheal Mitchell probably did not understand informed consent or the consequences of refusing treatment, and our office has seen no evidence that NaphCare took any extra steps to ensure that he did.

VSP obtained what it believed to be Mr. Mitchell's complete medical records from HRRJ, who produced them on NaphCare's behalf.[33] Upon examination of these records, which were sparse, our office believed that we did not have Mr. Mitchell's full NaphCare records. We later obtained what NaphCare represented to us as being Mr. Mitchell's full NaphCare records, and examination of those records revealed that they were much more complete then the records VSP had initially obtained. We specifically noted that where NaphCare's chart for Mr. Mitchell had many boxes checked and written observations noted, the VSP-obtained chart for Mr. Mitchell had virtually no boxes checked or written observations noted. We questioned NaphCare employees about this discrepancy, and no employee was able to offer an explanation.

Mr. Mitchell was arrested in April 2015 for allegedly stealing a 2-liter bottle of Mountain Dew, among other cheap snacks. A mental health nurse practitioner who encountered Mr. Mitchell stated during an interview and wrote in a chart note that he brought a bottle of Mountain Dew into an attempted evaluation of Mr. Mitchell. The nurse stated and wrote that Mr. Mitchell wanted his Mountain Dew, but that he would not give it to him. The nurse stated and wrote that after he refused to give Mr. Mitchell his Mountain Dew, Mr. Mitchell left the evaluation and did not get

[33] The custodian of medical records, an HRRJ employee, verified that the records concerning Mr. Mitchell that were given to VSP were full and complete.

any further mental health attention. We are unaware if existing policies or regulations would have allowed the nurse to give him the bottle of Mountain Dew, but perhaps if Mr. Mitchell had been given the bottle of soda he clearly wanted, he may have been more receptive to psychiatric treatment on that day.

The public can and should demand that NaphCare would comply with the criminal investigation into its employees' actions in a timely manner. The company failed to do so, and its dilatory conduct prolonged this investigation unnecessarily. Commonwealth's Attorney Stephanie Morales directly supervised the scheduling of interviews of NaphCare employees, regularly corresponding with NaphCare's lead attorney. In August and September 2017, NaphCare initially appeared to be invested in resolving this investigation quickly. NaphCare's lead counsel took the initiative to proactively contact our office to begin the interviews in September 2017.

Thereafter, NaphCare became unresponsive. The Commonwealth's Attorney's emails to NaphCare's lead counsel went unanswered for weeks and even months. It took NaphCare roughly 18 months to produce 14 of 22 requested individuals for interview, and some essential witnesses were never produced. This pace was unacceptable, as Ms. Morales explained many times to NaphCare's lead counsel via email. Attached as an appendix to this report are over one hundred pages of email correspondence between Commonwealth's Attorney Stephanie Morales and the lead attorney for NaphCare. The emails illustrate NaphCare's initial cooperation, subsequent non-responsiveness, and our office's constant efforts to expedite the investigation and close the wound opened by Jamycheal Mitchell's death.

Over the 100 days of Mr. Mitchell's incarceration, HRRJ and NaphCare records show that medical or correctional employees came in contact with Mr. Mitchell daily. The records show that HRRJ and NaphCare employees knew or had reason to know that Mr. Mitchell had a serious

mental illness and needed someone to intervene on his behalf in a manner that went above and beyond these employees' usual level of care for incarcerated persons.

After considering the relevant statute regarding abuse of incapacitated adults and its affirmative defenses, we are still missing a great deal of information that would make clear whether probable cause exists to charge specific persons for specific events and whether an affirmative defense applies. This case is a sad referendum on how people in positions of power and responsibility become cogs in an unfeeling wheel, immune to the plight of the weakest and most vulnerable among us.

A. Best Practices for Correctional Health Care Providers and Local Jails

This investigation has brought to light the fog of inaction that can paralyze correctional health care providers and correctional staff when confronted with an individual like Mr. Mitchell. Our office is not charged with investigating whether Mr. Mitchell's care at HRRJ violated the United States Constitution, but we would be remiss if we did not note the United States Department of Justice's finding that HRRJ's continuity of care for incarcerated persons was constitutionally deficient.[34] We make no claims about the constitutionality of the actions of NaphCare or HRRJ, but this investigation has certainly revealed that the continuity of care for Mr. Mitchell was incomplete and broken.

Correctional health care providers should hire and retain individuals who will not accept a deficient status quo regarding continuity of care similar to the one apparently in existence during Mr. Mitchell's incarceration. That flawed paradigm apparently involves the attempted administration of traditional medical and mental health care to a seriously mentally ill person who cannot process, accept, or benefit from such.

[34] See "Investigation of the Hampton Roads Regional Jail (Portsmouth, Virginia)," available at https://www.justice.gov/crt/case-document/file/1121176/download

HRRJ has updated their policies and procedures, including the way they investigate in-custody deaths as a direct result of this case, a necessary measure.[35] Their internal affairs department was fully forthcoming with this office's multiple records and interview requests. Regardless, HRRJ must hold its officers to a higher standard of recordkeeping and report-writing. HRRJ reports must be updated to state with specificity whether incarcerated persons have actually ingested their food and medications, in contrast to the state of affairs during Mr. Mitchell's incarceration. Mr. Mitchell's HRRJ forms are silent as to whether Mr. Mitchell consumed and swallowed his medications and food during his incarceration. This distinction is critical. We call upon HRRJ to reform its record-keeping processes for administration of medications and consumption of meals so they reflect whether an incarcerated person actually ingested medication and actually consumed food.

Correctional health care providers and jail supervisors should update their policies and procedures to obligate their employees to affirmatively investigate whether incarcerated persons in their custody and under their treatment have been found incompetent to stand trial and/or have custodial mental health and/or competency restoration orders (CROs) in place.[36] The public should be able to expect that local jails will expedite the transfer of incarcerated persons subject to such orders to the appropriate mental health care facility.

Correctional health care providers should update their policies and procedures to mandate that when an incarcerated person has been found incompetent to stand trial, an unchanging, dedicated mental health provider be assigned to that person to promote continuity of treatment and consistency of observation of the individual. This practice will ensure that incarcerated persons

[35] This finding was confirmed by the United States Department of Justice in its report of investigation.
[36] HRRJ's attention to this issue since Mr. Mitchell's death has reduced the time that inmates subject to CROs spend in jail.

with mental health concerns to not fall through the system's cracks.

Incarcerated persons must not be permitted to decompensate and die while under the care of a correctional health care provider. These providers should update their policies and procedures to establish standard evaluations[37] to identify grossly decompensated individuals who can no longer undertake self-care, understand the nature and consequences of refusing treatment, or intelligently communicate their medical history or wishes for treatment while incarcerated. A person who is difficult to communicate with should not be overlooked and denied the benefit of appropriate diagnoses and essential treatment because correctional health care providers fail to make reasonable efforts to understand them.

Correctional health care providers should also update their policies and procedures to obligate their employees to collaborate with the family members of an incarcerated person suffering from serious mental illness who is unable to intelligently communicate about medical and mental health treatment decisions.[38] Medical records privacy is strictly governed by federal law, but there are exceptions for individuals who are incapacitated due to mental illness.[39] HIPAA[40] permits correctional health care providers to "share [a] patient's information with family, friends, or others involved in the patient's care or payment for care, as long as the health care provider determines, based on professional judgment, that doing so is in the best interests of the patient."

HIPAA also arguably permits correctional health care providers to collaborate with family

[37] NaphCare's then-existing policies and procedures contained a protocol for identifying decompensated individuals, but no such records were produced to our office pertaining to Mr. Mitchell.
[38] There is no evidence that NaphCare attempted to collaborate with Mr. Mitchell's family about his mental illness during his incarceration at HRRJ.
[39] See "HIPAA Privacy Rule and Sharing Information Related to Mental Health" at https://www.hhs.gov/sites/default/files/hipaa-privacy-rule-and-sharing-info-related-to-mental-health.pdf
[40] Otherwise known as the Health Information Portability and Privacy Act, which governs medical providers' dissemination of protected health information (PHI); see also 45 CFR § 164.510

members of incarcerated persons regarding their refusal of necessary mental health medications. When a decompensated incarcerated person repeatedly refuses medication and the administration of psychotropic medication would arguably reverse the decompensation, correctional health care providers should first seek a temporary detention order or its equivalent so that the person may be evaluated and treated in a facility better suited to deal with patients with serious mental illnesses. If such a remedy is not available, correctional health care providers should consider 1) initiating communication with the decompensated person's immediate family or available relatives regarding the decompensation and discuss treatment options, 2) obtain approval from the person's family to seek to involuntarily treat them, and 3) after receiving approval, affirmatively seek the legal right to involuntarily medicate the decompensated person.

B. Proposed Criminal Justice Reform: Instituting Mental Health Dockets

Jail is not the appropriate place to house the mentally ill, but we recognize that the mentally ill unavoidably spend time in local jails across the Commonwealth. The criminal justice system must also be reformed to appropriately address the needs of seriously mentally ill individuals who are charged with crimes. The court system, as well as local prosecutors and defense attorneys, can and should perform an oversight function when it comes to the safety and well-being of incarcerated persons who have mental illnesses. The criminal justice system can and should initiate a cooperative effort in which prosecution takes a back seat to ensuring the well-being and treatment of individuals who may be in a cycle of mental-illness-induced crime.

Our society takes a step backwards when people needlessly die in jail. We call upon local jurisdictions to establish mental health dockets to monitor vulnerable individuals and ensure that they do not fall into the system's many cracks. We additionally call upon local jurisdictions to consider initiating drug court and veterans' court dockets to address the unique needs of those

underserved populations.

C. Proposed Legislative Reforms

Our jurisdiction has a standing multijurisdictional grand jury, and we considered using that body to investigate this case after our request to empanel a special grand jury was denied. However, the authority of a multijurisdictional grand jury to investigate crimes is limited to a certain list.[41] A multijurisdictional grand jury is not empowered to investigate violations of Va. Code § 18.2-369, and we call upon the General Assembly to amend § 19.2-215.1 to grant multijurisdictional grand juries such authority.

The official position of the Commonwealth of Virginia should be to disincentivize jail medical services providers from allowing incarcerated persons to fall into the same cracks and loopholes in their systems as Jamycheal Mitchell did. According to interviews of NaphCare employees, Jamycheal Mitchell appeared to have given informed consent and indicated that he understood the consequences of refusing medical and mental health treatments. Mr. Mitchell later died at HRRJ after refusing virtually all the treatments offered to him. He likely did not understand what could happen to him if he refused these treatments, yet under the existing scheme of § 18.2-369, companies like NaphCare can avoid criminal liability by claiming they followed proper informed consent procedures.

The affirmative defense of informed consent contained in Va. Code § 18.2-369 is logically flawed. The section defines an incapacitated person an adult "who is impaired by reason of mental illness . . . to the extent that they lack sufficient understanding or capacity to make, communicate, and carry out reasonable decisions concerning [their] well-being." Yet the same code section allows those who neglect incapacitated persons to defend against criminal liability by claiming

[41] The list is found in Va. Code § 19.2-215.1.

that the incapacitated person gave their informed consent to be treated as they were. Mentally incapacitated persons cannot give informed consent.

One incarcerated person who dies in custody after decompensating due to a serious mental illness is one too many. To prevent jails from becoming the end of the line for the mentally ill, the General Assembly should begin with the adoption and passage into law of a statutory definition of "serious mental illness," a proposal that has been offered in past legislative sessions but never has passed. We further call upon the General Assembly to pass into law section § 18.2-369.1 as described below and limit the defense of informed consent as it pertains to certain classes of individuals:

Jamycheal's Law (Va. Code § 18.2-369.1)

Neglect of Incapacitated Adult; Limitation of Defense of Informed Consent

In any prosecution initiated under § 18.2-369 for the neglect of an incapacitated adult, it shall not be a defense that a responsible person acted in accordance with the informed consent of an incapacitated person when the incapacitated person is confined in a local, regional, or state correctional facility and the incapacitated person (a) is the subject of a competency restoration order by a court of competent jurisdiction; or (b) has been diagnosed with a serious mental illness.

Incarcerated persons with serious mental illnesses like Jamycheal Mitchell are often helpless to carry out their own wishes. They sometimes cannot communicate clearly or understand the complexities of medical and mental health decision-making. We call upon the General Assembly to make a strong statement that what happened to Jamycheal Mitchell should never happen again in this Commonwealth by creating a clear statutory definition of serious mental illness. We further implore the General Assembly to remove the shield of informed consent from those who are responsible for ensuring the safety and well-being of society's most vulnerable members and urge the passage of proposed § 18.2-369.1.

This report, containing our detailed account of what happened to Jamycheal Mitchell in his final months, is based on everything discovered as a result of the investigative work completed by the Virginia State Police and the Portsmouth Commonwealth's Attorney's Office, conducted at the request of Commonwealth's Attorney Stephanie Morales. It provides a full account of the information and evidence this office unearthed, and makes clear that many questions remain unanswered due to the unavailability of the most material witnesses to the case. We are still missing a great deal of information that would make clear whether probable cause exists to charge specific persons for specific events and whether an affirmative defense applies; however, without the aforementioned information, no charges can be sought at this time. Our efforts in obtaining more information from the remaining eight witnesses, including the most vital witness employed by NaphCare, have been met with resistance and obstacles. In the interest of making what happened to Jamycheal available to the public and seeking change in his memory to ensure this never happens again, this report, along with its recommendations, must serve as a strong stance against systemic disregard for the most vulnerable among us.

This report intentionally omits the word "inmate" or "prisoner," except where quotations from jail documents use those words. We recognize that jail or prison is sometimes an appropriate punishment for those who allegedly commit crimes. However, this office and each of its prosecutors subscribe to the belief that a person is not the sum of the crimes they have committed or poor choices they have made. It is very seldom that a person is beyond rehabilitation or does not deserve efforts to help them make different choices in life. Referring to human beings who are in custody for crimes they allegedly committed as "inmate" or "prisoner" dehumanizes them and likely allows correctional officers and medical staff to distance themselves from the human

empathetic aspect of their care and treatment. We therefore refer in this report to any witness or individual who was in jail during our investigation as an "incarcerated person."

Jamycheal Mitchell had an identity, personality, and life completely distinct from the label "inmate" or "prisoner." He was a human being who happened to be incarcerated, not a terrible criminal who should have been allowed to waste away in solitary confinement. This report is a call for change under the law and a change in the hearts and minds of all those tasked with serving our incarcerated community who suffer from mental health-related issues.

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