COMMONWEALTH of VIRGINIA

Board of Local and Regional Jails

(804) 887-7850
(804) 674-3587 (FAX)

P.O. BOX 26963
RICHMOND, VIRGINIA 23261

Vernie W. Francis, Jr., Chairman
Bobby N. Vassar, Vice Chairman
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Olivia Garland, PhD
Charles Jett
Heather Masters, MD, SFHM, FACP
Joanne Peña
Karen E. Nicely
Rev. Kevin L. Sykes

April 22, 2021

Mr. Jeff Vergakis
Interrim Superintendent
Hampton Roads Regional Jail
2690 Elmhurst Lane
Portsmouth, Virginia 23701

This letter serves as the Jail Review Committee's notice of preliminary findings and recommended penalties. The Committee's findings, although preliminary in nature, are scheduled to be presented to the Board May 19, 2021. Should you desire an informal presentation of facts, to which you are entitled, you will need to so request within 10 days of the receipt of this letter. The details for doing so are included herein. Following that stage in the process, you will have 21 days to object to the preliminary findings or to acquiesce to the facts as generally stated. Should you have any questions, please feel free to contact me at (804) 664-2307.

Thank you,

Ryan C. McCord
Executive Director
State Board of Local and Regional Jails

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Notice of Preliminary Findings and Recommended Penalties

This letter shall serve as the initiation of the violation resolution process which may include hearings and appeals. As alleged above, this hearings and appeal process results from alleged violations discovered by the Jail Review Committee during the course of an investigation into violations of the Board's minimum standards, laws, and/or regulations. This may include violations revealed by the Board's investigation into the death of an inmate and the resulting penalties. As outlined herein, the Jail Review Committee makes certain Preliminary Findings and Recommended Penalties. Any questions or responses should be made in writing to Ryan McCord, Executive Director for the Board of Local and Regional Jails, Virginia Department of Corrections, Cell (804)664-2307. ryan.mccord@vadoc.virginia.gov

A representative of your facility may appear in person or by counsel before the Jail Review Committee for the informal presentation of factual data or proof in connection with the case. This informal presentation shall only occur upon a written request filed by the facility within **10 days** of the Notice of the Preliminary Findings and Recommended Penalties. Your facility may waive its opportunity to appear in person or by counsel or other qualified representative for the informal presentation of factual data or proof in connection with the case. Your facility shall be given **21 days** to file a Notice Objecting to the Preliminary Findings and Recommended Penalties which shall include written submittals outlining in general the factual and legal grounds for the objection.

Your failure to timely and adequately file a Notice Objecting to the Preliminary Findings and Recommended Penalties shall constitute a full or partial admission and acquiescence to the general facts outlined and penalties recommended therein. If not objected in whole or in part, the Jail Review Committee Chairman will present the Preliminary Findings and Recommended Penalties to the full

board at the next meeting for consideration. Please note that the Board is not obligated to exercise its authority to hold all or part of the resulting hearing in closed session.

As you are aware, the Virginia Board of Local and Regional Jails has been in the process of reviewing the death of inmates housed in your facility.[1] The investigation was conducted by an investigator / auditor with the Compliance and Accreditation Unit. A report of that investigation was presented to the Jail Review Committee. As outlined below, the Jail Review Committee made preliminary findings of fact, conclusions of law, and recommend penalties. These are NOT FINAL. Rather, this letter represents the initiation of the process outlined herein. The particulars of the cases are as follow:

PRELIMINARY FINDINGS OF FACT:
Case No: 18-0066, date of death, 12/31/2018

The Jail Review Committee PRELIMINARILY FINDS that on February 22, 2018, Inmate Jakub Michael Plucinski was convicted of Felony Hit & Run in the Chesapeake Circuit Court and sentenced to 12 months incarceration. On March 9, 2018, he was transferred from the Chesapeake City Jail to the Hampton Roads Regional Jail. On April 19, 2018, he was convicted in the Norfolk Circuit Court for Probation Violation pursuant to a previous conviction of Possession of Heroin and sentenced to 8 months incarceration. On December 7, 2018, he was convicted for Probation Violation in the Stafford County Circuit Court pursuant to previous convictions of Credit Card Theft and Failure to Appear and sentenced to an additional 6 months confinement. Inmate Pulcinski's combined jail sentences totaled 2 years and 2 months. Facility records did not indicate a previous confinement in this facility.

Inmate Plucinski was transferred from the Chesapeake City Jail to the Hampton Roads Regional Jail on March 9, 2018. Records from the city jail reflect that he had been incarcerated at that location since February 22, 2018 and suffered from the following medical/mental health conditions: Other Seizures, Constipation, Other Depressive Episodes, Generalized Anxiety Disorder, Spina bifida, Q05 Spina Bifida, Ulcerative Colitis, K51, Essential (primary) Hypertension, Neuromuscular Dysfunction of Bladder, Unspecified, Other Transient Cerebral Ischemic Attacks and Related syndromes.

Screening records from the Chesapeake Sheriff's Department indicate Mr. Plucinski's health was classified as "Fair". A special diet was indicated and current prescribed medications were included in those records. He answered "No" to all mental health screening questions. He revealed that he had been an inpatient at Virginia Beach Psychiatric Center in 2017 and had previously taken prescribed Remeron, Lexapro, and Trazadone. He was housed in the medical observation unit while at the Chesapeake Jail and a routine referral for a mental health examination was designated. Dr. Alex Taylor examined Mr. Plucinski on two occasions in the Chesapeake jail during this incarceration. Medical records from Chesapeake Regional Healthcare reflect extensive medical treatment at that facility during his time of incarceration in Chesapeake.

Inmate Plucinski was processed into the Hampton Roads Regional Jail on March 9, 2018. Medical and mental health screening forms completed by the booking officer indicated that Mr. Plucinski answered "No" to all medical and mental health questions. He did report being admitted to the Virginia Beach Psychiatric Center and said he had suicidal thoughts, or a desire to die, in early 2017. He stated to the correctional officer that he uses alcohol, opiates (daily), and opiates/marijuana (once a week). He said his last date of use was the beginning of February of 2018. The officer recommended Mr. Plucinski be assigned to the Transitional Case Management Program due to his history of substance abuse.

Mr. Plucinski underwent a physical examination immediately after the initial screening, and patient problems were listed as follows: Hypertension, not Otherwise Specified; Epilepsy, Unspecified, not Intractable, with Status Epilepticus; Other Transient Cerebral Ischemic Attacks and Related Syndrome.

[1] *See*, Virginia Code § 53.1-69.1 and 6VAC15-20-10 et.seq.

The medications prescribed at Chesapeake City Jail were continued at this facility and were as follows: Gabapentin 300 mg. capsule; Vimpat (Lacosamide) 200 mg. capsule; Carafate (Sucralfate) 1 gram tablet; Keppra (Levetiracetam) 500 mg. tablet; Dicyclomine 20 mg. tablet; Metoprolol Tartrate 25 mg. tablet; Norvasc (Amlodipine) 10 mg. tablet; Dilantin Extended (Phenytoin Sodium Extended) 100 mg. capsule; Clonidine HCI 0.2 mg. tablet; Prilosec OTC (Omeprazole Magnesium) 20 mg. tablet – delayed release.

The registered nurse documented that Inmate Plucinski had a history of cutting and noted scars on his chest. She entered a mental health referral and wrote, "Mental Health referral for HX of cutting and SI. MD referral for CC." He was placed in medical observational housing under medium custody level and with an identified special need for a bottom bunk due to seizure precautions.

Medical records were requested from the Virginia Beach Psychiatric Center at the time of intake and were received on March 12, 2018. Those records confirmed that Inmate Plucinski was admitted to the facility from August 26, 2017 thru September 5, 2017. A statement of psychiatric history reported, "He has four inpatient psychiatric hospitalizations with the last one occurring in 2013 and the first at the age of 15."

The history of present illness was as follows: "This patient is a 31-year-old single Caucasian male who was readmitted to Virginia Beach Psychiatric Center due to need for heroin detoxification as well as recent abuse of cocaine and alcohol. He reports regular thoughts of suicide. He reports history of depression with at least five previous suicide attempts. He has had multiple inpatient hospitalizations in Virginia Psych Center with most recently occurring in 2013. Reports having thoughts of suicide with no specific plan. He reports impaired appetite, and overall inability to care for himself." He reported that his mother committed suicide when he was 10 years old and he was in the house at the time. Substance abuse and mental health issues were indicated on both his maternal and paternal sides, as well as with his brother and sister.

On March 13, 2018, Inmate Plucinski was given an initial behavioral health evaluation. The information contained in the Virginia Beach Psychiatric Center records was documented in this report. The mental health examiner (name illegible) stated, "Long HX of cutting – scars to abs and forearms (last 6 months ago not while in jail.)" The mental status examination identified all specified items as "Appropriate" and rated his insight and judgement as "Fair." The inmate was referred to the psychiatric provider for evaluation.

Psychiatric provider initial evaluation records dated March 21-22, 2018 and progress notes were included in Mr. Plucinski's medical records. Provider evaluation notes state, "Patient with a history of depression and bipolar disorder. He has a history of trauma including finding his mother when he was six after she hung herself. (Other records reflect he was ten years old). He has some depression. His energy has been low. His concentration is bad. He is not feeling helpless or hopeless. He feels guilty about his incarceration. He has a history of seizure disorder and has hallucinated when post ictal. Has had some elevated mood with poor sleep and elevated mood feelings and has been off medications for a while. He denies suicidal or homicidal ideation."

His current status notes in that report reflected a history of poor treatment, family psychiatric history, relevant past medical HX and medications, prior self harm attempts (2 in 2015 – multiple suicide attempts by both hanging and overdose), prior violence toward others, bad temper, and a history of substance abuse (cannabis and opioid abuse – none since incarceration). His appearance, speech, thought form, thought content, and behavior were classified as "Appropriate." His mood was described as "Depressed" and his affect as "Flat." Insight and judgement were classified as "Poor."

Inmate summary notes dated March 27, 2018 state, "Inmate Plucinski is on razor restriction. Inmate Plucinski has cuts all over his chest area. Nurse Hughes put in a special needs for him not to receive a razor." The psychiatrist's diagnosis was listed as Major Depressive Disorder, Severe Recurrent PTSD, and Chronic ADHD Anxiety Disorder, unspecified. The doctor prescribed Lexapro 20 mg. QAM and Remeron 30 mg. QPM.

On April 3, 2018, Inmate Plucinski was transported to a dentist for two extractions. During the process, he began having a seizure, which lasted approximately two minutes. He was treated with Ativan and Deltoid and placed in a safe position. During the next several minutes, he suffered five more seizures, each lasting from one to two minutes. EMS was called during the fifth seizure and upon their arrival, EMS assumed care of the patient. Mr. Plucinski was reported as, "remained postictal with periods of awakening." He was described as being closely monitored with safety precautions kept in place. After being transported to and treated at the Maryview Medical

Center Emergency Room, he was returned to the facility where he was monitored under the direction of Dr. Moreno.

During the month of April, the inmate submitted three routine medical requests, all of which resulted in medical examinations and treatment. On April 16th, Dr. K. Smith identified special needs of the patient as bottom bunk required for seizure disorder, bottom tier, and housing in the infirmary. The reason stated was, "the patient has critical seizure disorder." Inmate Plucinski was taken to the hospital emergency room again on April 16th after suffering multiple seizures over a 15 minute period. Dr. Moreno ordered 1 mg. Ativan IM, which stopped the seizures. He began suffering seizures the next day and was again transported to the Maryview Medical Center Emergency Room for treatment.

Inmate Plucinski was transported to the Norfolk Sheriff's Department on April 19, 2018 for a court appearance. While at the Norfolk Sheriff's Department, he complained of having chest pain. Medical notes state, "Chart reviewed. Pt. assessed by Norfolk Medical RN while at court and returned to security. Pt. reassessed by HRRJ Medical upon return to jail. Pt. stabilized and returned back to Pod by security."

On April 20, 2018, Inmate Plucinski was examined and treated at the medical unit for a urinary infection. Dr. Moreno prescribed Cipro 500 mg. tablets. Progress and treatment notes reveal that he was evaluated and treated at least 12 times during the month. The following day, per instructions from Dr. Moreno, Mr. Plucinski was transported by security to Maryview Hospital due to having a urinary infection and medical staff was unable to assemble a catheter. Behavioral Health Psychiatric follow up notes reflect no significant change to his mental health issues. He was administered all prescribed medications and kept under medical observation.

On April 25, 2018, Inmate Plucinski submitted a request to marry Civilian Sara Marcinko. (Although approved by the Chesapeake CWA on 5/22/2018, they never followed through with the marriage ceremony).

May – 2018 There were no significant medical issues during May. Medical staff continued to monitor Inmate Plucinski, and the doctor examined him on four occasions. Dr. Moreno routinely monitored his symptoms and updated his prescribed medication chart. He was returned to the dentist on May 3rd and completed the extractions. There was no reported change in his mental health evaluations.

Behavioral note dated May 12th stated, "Plucinski has been a big help with a few of the inmates who are in need of special care." On May 21st, he was moved to Housing D-107, which is a regular cell with a medical bed.

On June 4, 2018, Mr. Plucinski was moved to Mental Health General Population. He was still required to have a bottom bunk located on the bottom tier. He suffered another seizure (23 minutes) on June 5th. He awoke in the Medical 12 treatment room and began talking to the nurses. He was described as walking around normally afterwards. Medical treatment was provided in the facility.

On June 5, 2018 at 11:18 p.m., Inmate Plucinski got into an altercation with another inmate. He suffered an abrasion to his right forearm during the incident and was placed in Segregation until June 21, 2018. The doctor ordered he be housed in a camera cell where he could be closely observed for seizures. He was returned to the dentist on June 7, 2018 for a follow up examination. During the month, the medical staff treated him on several occasions. Doctor Moreno examined him at least five times and updated his prescription medication list.

Mental Health weekly segregation rounds were made on June 15, 21, and 28, 2018 with no problems indicated. Behavioral Health progress notes and mental health examinations were conducted twice during the month and reflected no change from previous evaluations. He was given a medical history and physical examination on June 24, 2018, which reported in the same basic information as previously documented.

On July 2, 2018, Mr. Plucinski was re-evaluated, and no changes were reported in his medical condition. Prescription medications were reviewed and extended. He was assigned to bottom bunk/bottom tier medical housing at that time.

On July 10th, he was given a chronic care physical examination and his medications were continued. Mental health progress notes and psychiatric provider follow-up notes reflect no significant changes in his status.

On July 20th, Dr. Navnett Sidhu discontinued Lexapro and added Cymbalta 30 mg. to his prescription medication due to patient complaint of an adverse reaction (twitching) caused by Lexapro.

On July 24th, Inmate Plucinski was placed on lock down for "beating on the E-100 slider with his fist after being told that the kitchen had been called for his milk several times.

On July 26th, Inmate Plucinski became involved in a physical confrontation with another inmate that resulted in him being placed on pre-hearing detention and locked down in his cell.

On July 27th, he became irate towards the officer and nurse administering his medication. He refused his noon lunch meal shortly afterwards.

On July 28th, Officer V. Smith reported that he observed Inmate Plucinski with red marks across his lower left arm. He inspected his arms and noted cuts that appeared to be fresh. He was placed on razor restrictions until further notice.

On July 28th at 10:30 p.m., he was moved into segregation and placed on non-acutely suicidal watch with 15-minute staggered rounds indicated. He was issued a safety smock, safety blanket, mattress, and his meals were restricted to styro-tray and finger foods. His cell was required to be searched at every shift change.

On July 29th, a suicide watch assessment was completed with no change indicated.

On July 30th, Inmate Plucinski was re-assessed, and the non-acutely suicidal watch was discontinued with no restrictions. He was issued a paper wrist band without metal due to his long history of cutting behaviors. According to this assessment, Mr. Plucinski engaged in interventions and was willing to accept and complete coping skills worksheets. On July 31st, a post release suicide precautions assessment was completed in which he was classified as "Appropriate" in all categories with no suicidal or homicidal ideations noted.

August 2nd, Mr. Plucinski was examined by Dr. Moreno and prescribed medication for a rash. On August 6th, the doctor prescribed Clonidine HCI 0.2 mg. tablets for the patient's blood pressure. His prescribed medications were reviewed and continued. There were seven behavioral health progress notes and weekly segregation mental health rounds reports during the month of August. There were no changes noted in his mental health evaluations and no problems/issues reported during this time period.

September – 2018; Medical staff examined Inmate Plucinski on several occasions during September for routine follow-up checks. Dr. Moreno examined him weekly and treated him for gastrointestinal issues on September 17, 2018. The doctor reviewed and continued his prescription medications.

On the morning of September 9th, Officer D. Sexton reported that Inmate Plucinski became unruly when the inmate discovered that he had slept though the breakfast meal. When he discovered the trays were gone, he started "kicking and banging" on the doors. He refused to accept a breakfast tray offered to him thirty minutes later and was subsequently locked down for the remainder of the overnight shift. At 10:38 a.m. during the next shift, Officer Jones ordered a lock down, and Inmate Plucinski refused to comply. He was locked down for the rest of that shift. At 2:32 p.m. on the same day, he passed an inappropriate note to Nurse Ledford. Officer Jones confiscated the note and a report was placed in the inmate's file.

On September 15, 2018, Dr. Shah conducted a psychiatric follow-up examination. All categories were rated as "Appropriate," and his intact and judgement were shown to have improved from "Fair" to "Good." The patient reported that Cymbalta has "helped a little," so the dosage was increased. He was described as calm and cooperative during the visit.

On October 7, 2018, Officer D. Jones reported that Inmate Plucinski became aggressive, yelling towards the officer and medical nurse, during the time noon meals were being served in the pod. The officer directed him numerous times to report to his assigned cell, but he continued yelling and disobeyed the orders. Other officers arrived and the inmate complied. The officer reported that "he will be charged with jail violations but will not be placed on restrictive status."

On October 12th, an RN wrote the following special needs instructions, "May move to top tier, per MD, to D-209. Officer K. Tice reported that he informed Inmate Plucinski that he was to be moved to D-209 due to another inmate returning from the hospital and needing a bottom bunk – bottom tier cell. The officer wrote, "Inmate Plucinski refused to go upstairs and was arguing with me about moving even though medical informed him that he could go to the top tier." Additional officers responded and he was placed in D-209.

On October 15th, Inmate Plucinski was given a chronic care periodic examination in which Dr. Moreno noted that he had been seizure free since the last examination and reported no additional medical issues or concerns. His prescriptions were reviewed and maintained. Inmate Plucinski was evaluated by mental health on the same day. All categories on the examination form were rated as "Appropriate," and his intact and judgement were shown to have lowered from "Good" back to "Fair." He reportedly stated continuously during the assessment that, "he does not plan to kill himself and he has too much to live for." He told the provider that he believes he will be discharged in February 2019 and that he is working with his case manager on a discharge plan. The progress notes stated, "Patient is future oriented and focused on his release from HRRJ."

On October 30, 2018, Dr. Moreno examined Mr. Plucinski for patient complaint of gastrointestinal problems. The doctor reviewed his diet and prescription medications, and referred him to Maryview Medical Center for further evaluation. The following day he was transported to the hospital, where he was admitted for treatment.

Inmate Plucinski remained in the hospital for several days with an admission diagnosis of Hematochezia. He was treated by the Gastrointestinal and Liver Specialists of Tidewater, PLLC, and underwent the following procedures: Colonoscopy, EGD, Flexible Sigmoidoscopy. The hospital discharge diagnosis was Pan Ulcerative Colitis to the Right Colon. Pathology results were, "Biopsies from the esophagus show changes of inflammation. This is most likely related to acid reflux, and should improve with medication." Inmate Plucinski continued treatment in the medical department after returning to the facility. His medication was administered as prescribed.

On November 22, 2018, Officer D. Jones wrote, "Inmate Plucinski has been helping Inmate Freeman, Princeton in the pod. He has been a great help." Behavioral Health Psychiatric Provider follow-up notes dated November 25, 2018 state, "Pt. seen for f/u with Ms. Lawson, still c/o depression and requests increase Cymbalta, it helps but does not last long, no SI/HI, no psychosis, calm and cooperative, compliant and no side effects, no anxiety, no psychosis." All categories were rated as "Appropriate," and his intact and judgement were shown to have improved from "Fair" to "Good." Dr. Amit Shah increased Cymbalta from 60 mg. to 120 mg. and ordered a follow up in eight weeks.

Dr. Moreno treated Inmate Plucinski on November 28, 2018 for complaint of skin problems he suffered since returning from the hospital. His prescription medications were reviewed and continued. Dr. Moreno ordered Inmate Plucinski be put on a Renal Diet II (80g protein) on December 11, 2018. LabCorp testing that was completed on December 14th reflected Mr. Plucinski's Dilantin level was elevated. The doctor changed his prescription medication for seizures to correct that issue.

A follow-up behavioral health structured progress note dated December 12, 2018 at 5:00 p.m. was submitted by LCSW (name illegible) that stated, "Follow-up due to lockdown." Mr. Plucinski's speech was described as "Pressured" and his mood was shown as "Anxious." His Insight and Judgement were described as "Poor," and his Behavior as "Agitated." The chief complaint was described as, "I need to call my girlfriend. She was sexually assaulted; I can't reach her. Consulted with Sgt. Frey. Phone call denied." This was the last mental health record in his medical file.

Rashida Powell-Hutson, Forensic Clinician II for Chesapeake Integrated Behavioral Healthcare, submitted a written statement confirming that she worked with Mr. Plucinski, who was a client in the Community Oriented Re-Entry (CORE) Program at Hampton Roads Regional Jail. She advised that he was screened into the CORE Program in April 2018, and she had met with him periodically for monitoring, follow-up, and clinical status checks. On December 13th, she wrote, "I met with Mr. Plucinski for a face-to-face which was my last contact with him. Mr. Plucinski reported feelings of frustration due to information he had previously learned about his fiancé. Mr. Plucinski insisted he was taking all medications as prescribed but did mention a decreased appetite. Mr. Plucinski reported feelings of guilt about what happened to his fiancé and was trying to stay focused. Mr. Plucinski denied suicidal and homicidal ideation. However, I encouraged him to notify an officer should those feelings arise and he agreed to do so."

On December 15, 2018, Officer T. Langhorst reported, "After quiet time, Inmate Plucinski, Jakub asked to be locked down for a few hours. I then secured Inmate Plucinski's door. Quiet time was over and door released at 1428. During a round, the inmate asked that his door be opened around 1511. I forgot to release his door and at approximately 1530, Inmate Plucinski began yelling and banging on his door. When his door was opened,

Inmate Plucinski began yelling that I did not open his door because he was white and that I (Officer Langhorst) must not like white people. He then stated that he would be putting me in the kiosk at which point I stated he was free to do so. I gave Inmate Plucinski a warning that if he continued yelling, he would go back to his cell and really be locked down."

The patient was examined by Dr. Moreno on December 26, 2018 and was scheduled for a follow-up with the Gastrointestinal and Liver Specialists of Tidewater, PLLC. According to HRRJ administrative investigative report, Dr. Sarah Determan detailed Inmate Plucinski's mental health history as follows: "Inmate Plucinski was diagnosed with Major Depressive Disorder-Recurrent/Mild and Post Traumatic Stress Disorder." She noted the following mental health issues/concerns: Plucinski experienced recurrent depressive episodes and PTSD; Plucinski had a history of psychiatric hospitalizations (approx. 5-10); 2013 Plucinski sustained a head injury from an automobile accident; Significant substance use (heroin, alcohol, marijuana, and Adderall); History of suicide attempts (more than 5 attempts); 2016 attempted suicide by overdosing on Tylenol and Benadryl; 2017 heroin and alcohol detox; 7/28/2018 to 7/30/2018 placed on suicide precautions after engaging in non-suicidal, and self-injurious behavior.

11/25/2018, last evaluation by mental health professionals; during his incarceration period, Plucinski never endorsed suicidal ideation, plan, or intent. According to Dr. Determan, Inmate Plucinski was in complete compliance with his psychiatric prescribed medications for October, November, and December 2018.

It is noted that Rashida Powell-Hutson, Forensic Clinician II for Chesapeake Integrated Behavioral Healthcare, reported meeting with Inmate Plucinski the last time on December 13, 2018. Records of CORE meetings are not included in medical records so the frequency of those encounter are unknown.

On December 31, 2018 at approximately 1:55 p.m., Officer Alaysia Riddick was conducting the 1:45 p.m. head count in HU1 - Pod 1, when she observed Inmate Plucinski with "what appeared to be a ripped sheet tied around his neck hanging from the towel rack." Officer Riddick initiated a 10-52, Code Blue (medical emergency, victim not breathing). Medical and security staff immediately responded to and entered the cell. They cut the sheet, lowered Mr. Plucinski down from his position to the floor, and began CPR. The AED was applied and advised no shock. CPR was continued with AED assessments until Portsmouth Fire/EMS arrived at 2:04 p.m. and EMS members took over the life-saving efforts. Inmate Plucinski was pronounced dead by EMT Andrea Vahey at 2:28 p.m. on December 31, 2018.

Dr. Elizabeth Kinnison, Assistant Chief Medical Officer, performed an autopsy and classified Mr. Plucinski's Manner of Death as Suicide, with the Cause of Death being Hanging. Blood test results revealed no detection of Ethanol and/or no other drug and/or drug classes.

Hampton Roads Regional Jail provided captured video footage, security rounds documentation, and a summary of their administrative findings which are as follows:

> "Prior to Inmate Plucinski's death, during the day shift on Monday, December 31, 2018 from 0700 – 1355, HU-1/1 pod manager, Officer Riddick physically completed nine of the thirteen required well-being checks for the timeframe in HU-1/1. Although Officer Riddick documented security inspections/well- being checks in the database, she failed to conduct four physical rounds in accordance with facility policy." The time-line provided was as follows:

1. 09:49 – Entered security inspection completed, but did not physically complete the well-being check. Officer Riddick, observed on the floor interacting with the inmates did not conduct a complete well-being check of the pod.
2. 11:25 - Entered security inspection completed, but did not physically complete the well-being check. Officer Riddick, observed issuing meal trays, did not conduct a complete well-being check of the pod.
3. 11:50 - Entered security inspection completed, but did not physically complete the well-being check. Officer Riddick, observed conducting rounds with the infirmary nurse as she took vitals of the inmates assigned to restrictive housing did not conduct well-being check of the pod.
4. 13:00 - Entered security inspection completed, but did not physically complete the well-being check. Officer Riddick returned from lunch break and relieved MJO Edmonds by escorting Dr. Determan on mental health rounds. There was no well-being check conducted for the first portion of the 13:00 hour.

Officer Riddick made her last completed well-being check on Inmate Plucinski at 12:29 p.m. When she returned from lunch at 1:00 p.m., she entered the pod and accompanied Dr. Determan on mental health rounds. The officer discovered Inmate Riddick hanging at approximately 1:55 p.m., while she was conducting head count in HU1 - Pod 1. The discovery was made 1 hour and 26 minutes after the last completed well-being check.

The HRRJ administrative report stated the following:

> "Please Note: Officer Riddick graduated from the Hampton Roads Criminal Justice Training Academy, located in Newport News, Virginia on December 6, 2018. Riddick stated that prior to graduating from the academy; she trained in HU-1/1 (typically managed by seasoned, highly competent officers) in the presence of a field-training officer. Since graduating from the academy, Riddick has been assigned as the HU-1/1 pod manager. Although she failed to complete all security inspections/well-being checks for HU-1/1 during the day shift on December 31, 2018, Officer Riddick was observed conducting various other pod related duties. Officer Riddick, the lone officer assigned to HU-1/1, interacted with the inmates assigned to the pod, conducted pill pass, segregation medial rounds, (2) meal servings, canteen deliveries, and mental health evaluation rounds with Dr. Determan. There were also two 15-minute watches assigned to the pod. Officer Riddick obviously attempted to multi-task by managing all aspects of the pod."
>
> "Corrective Action: Appropriate corrective/disciplinary action was taken for personnel found to be in violation of departmental policies and procedures as well as the Minimum Standards for the Virginia Board of Corrections. Staff have been educated that well-being checks take priority when conducting tasks and responsibilities in the housing units. This will apply unless exigent circumstances occur. Any deviation is to be properly documented in the jail management system."
>
> The Superintendent also reported that Policy 10.4 (Inmate Supervision) has been revised and now states, "when relieving an officer on post for any reason you must conduct a well-being check immediately upon assuming the post. When the officer returns, he/she must immediately make a well-being check."

Officer Riddick stated that she interacted with Inmate Plucinski during the morning pill pass on December 31, 2018, and it did not appear that he needed assistance. She said that during her shift, Plucinski appeared to act normal as he interacted with other inmates, accepted his meal trays, and appeared to watch television. She stated that he made no mention of wanting to harm himself and never requested mental health assistance.

LPN Ebony Easter stated that she also interacted with Inmate Plucinski during the morning pill pass. She stated that he appeared to act as normal and made no mention of wanting to harm himself.

Officers Darita Sexton, Tahjma Langhorst, and Tymiescia Chase were among the last officers to work closely with Inmate Plucinski prior to the date of his death. All three provided written statements that collectively identified Mr. Plucinski as having anger management issues and a bad temper, but all stated he never gave any indication that he wanted to harm himself. Officer Chase stated that he mentioned his fiancé from time to time but he did not seem out of ordinary the last day she had worked in his pod.

Four fellow inmates submitted written statements as follows:

> Inmate L. C. Grant wrote, "I observe Inmate Plucinski get upset and anger a few times, in doing so punching the wall and storming off to his cell (F208) with that being said I think Inmate could have been saved due to a complete round, which was incomplete due to an officer not being focus. He never mention that he wanted to end his life."
>
> Inmate Antonio Knight wrote, "I observed Jacob was very hurt by his girlfriend multiple days. She stop picking up. He would hit wall in day room. Yell in the phone. I sense he was bothered plus he was a good friend so I would talk to him about his situation. He would explain and I would give him advice but I guess it didn't help. I did not hear him mention anything about suicide."

Inmate M. Threat wrote, "He was on the phone and when he got off he was upset, and then I overheard him saying that his father was taking him off his will. The phone call was on Sunday, December 30, when this happened. He never said anything about hurting himself."

Inmate E. Shaw wrote, "Mr. Plucinski indicated that he was having trouble with his fiancé. He also complained that his Dilantin dose was not correct. Mr. Plucinski never mentioned to me anything about thinking about suicide."

The HRRJ administrative report detailed the following history of Inmate Plucinski's incarceration.

"Inmate Plucinski was booked into the facility on Friday, March 9, 2018. During this incarceration period, Plucinski received nine facility charges; (3) assaults (one involving staff), (2) refusals to obey direct orders from staff, (2) creating disturbances, (1) being in the cell of another, and (1) possession of contraband. On one notable behavior log entry from 7/29/2018, an officer documented observing fresh red marks on Inmate Plucinski's lower left arm; HRRJ staff subsequently placed Plucinski on razor restriction. Inmate Plucinski had one documented inmate listed as a keep separate/enemy due to an incident that occurred on 7/26/2018."

The following information was reportedly established from letters and telephone calls audio:

Plucinski and Fiancé Sara Marcinko appeared to have serious complications with their relationship. Plucinski expressed trust issues by often accusing his fiancé of cheating and being dishonest. He also complained that she did not answer his phone calls with regularity. According to the Securus Secure Call Platform during this incarceration period, Plucinski successfully connected on 725 out of 1,861 phone calls to her listed number.

On December 24, 2018, the relationship complications appeared to escalate when his fiancé accused him of using family and friends to track her movements and monitor her social media accounts. During conversations with his father, brother, sister, and fiancé, Plucinski appeared extremely emotional and often appeared to cry uncontrollably.

On December 30, 2018 during a conversation with his father, Plucinski expressed the inability to cope with the conditions of his relationship with his fiancé.

On December 31st, he expressed the same concern when speaking with his brother.

A suicide note without a timestamp, addressed to Tom P. (speculated to be Inmate Plucinski's brother), was recovered from the cell. The Portsmouth Police Department investigated this incident and classified the death as a suicide.

Contract medical services are provided to Hampton Roads Regional Jail by Well Path Medical Providers, formally named Correction Care Solutions. The medical provider provides one full-time doctor, two nurse practitioners, mental health staff, and a dentist four days a week. The contract provides for 62.5 full-time employees, which includes registered nurses and licensed practical nurses. Jail policy requires a registered nurse to always be on duty, and at night and on weekends, at least seven licensed practical nurses are always on duty.

The physician is on call 24 hours daily. When medical attention is needed, the initial evaluations and routine care are provided by the nursing staff. If the problem is more severe, the patient care is advanced to nurse practitioners or the physician, depending upon the severity of the condition. Based upon the training of the nurses, it is at their discretion at what point the doctor should be consulted. A sliding scale is used for treatment of diabetic inmates that is approved by the doctor and medical director. A blood glucose level of more than 420 requires that the doctor be notified immediately. In situations deemed an emergency, EMS is contacted and the inmate patients are transported to Bon Secours Maryview Medical Center in Portsmouth.

This jail receives inmates with serious medical problems from the surrounding cities of Chesapeake, Hampton, Newport News, Norfolk, and Portsmouth. The facility is staffed with medical personnel who can more effectively treat inmates with serious medical and mental health issues than the local member jurisdictions.

A mortality review is performed within thirty days of every in-custody death. The following personnel are designated participants in those reviews: HRRJ Staff - (then) Superintendent Hackworth, Assistant Superintendent Walz, Major Cowan, Captain Ellis, Captain Bhagirath, Captain Barnes, Lt Phillips, Medical Staff

- Doctor Moreno, Health Services Administrator, Director of Nursing, Assistant Director of Nursing, Bill Kissel Sr., VP, Doctor Rhodes, Regional Medical Director, Lori Peters, Regional Manager, Stefan Cange, Legal Counsel

The health care provider maintains custody of the mortality review reports and they are not available for review. Superintendent Hackworth stated verbally during telephone interview that there were no recommendations for changes in policy or procedures at the conclusion of this mortality review.

Case No: 19-0013, date of death, 4/19/2019

The Jail Review Committee PRELIMINARILY FINDS that on January 28, 2019, the Chesapeake Police Department arrested Inmate Victor Rhea Fountain for Assault & Battery (Misdemeanor) and Malicious Assault to Law Enforcement/Fire X3 (Felonies). On February 13, 2019, he was transferred from the Chesapeake Correctional Center to the Hampton Roads Regional Jail, where he was ordered held without bond pending a preliminary hearing scheduled for February 27th in the Chesapeake General District Court. There is no record of Inmate Fountain being previously incarcerated in this facility.

Inmate Fountain's medical records from the Chesapeake Correctional Center were transferred to Hampton Roads Regional Jail, which identified his medical conditions and prescribed medications. HRRJ intake screenings, physical examination, and review of his medical records revealed that Inmate Fountain suffered from prostate cancer and hypertension. Intake RN Kathryn Topham wrote, "Pt. stated that other than previously stated Hx, he was in good health. His vital signs were within normal limits and the rest of his assessment and interview were unremarkable." RN Topham deemed housing in general population with a bottom bunk to be appropriate.

The inmate answered "No" to all mental health questions, but proclaimed to suffer from Bipolar Disorder. According to the HRRJ internal investigative report, mental health professional, Dr. S. Determan, reported that Mr. Fountain had no history of mental health issues, to include Bipolar Disorder. Dr. Determine did not prescribe mental health medications.

Mr. Fountain was classified as a maximum-security inmate and assigned to HU-3/2, C-212 – General Population, with a bottom bunk required, where he remained until his death on February 23, 2019.

Medical records were obtained from Dr. Harland Stresing, Chenault-Ostroff Urological Associates in Chesapeake, which confirmed a diagnosis of widespread metastatic disease from prostate cancer. The medical records detail diagnosis, surgery, and treatment from January 8, 2016 through September 11, 2018. On February 14th, LPN Johnson contacted the medical office and learned that Mr. Fountain was administered a Lupron injection twice a year and was not due for the next injection until March 11, 2019.

Dr. Dale Moreno ordered continuation of the medical treatment from Chesapeake Correctional Center prescribed the following medications: Milk of Mag 473 ml., Colace Docusate Sodium) 100 mg., Prednisone Dose Pak 5 mg., Tamsulosin (Flomax) 4 mg., Abiraterone 500 mg., Zocor (Simvastatin) 20 mg., Aspirin 325 mg., Norvasc (Amlodipine) 5 mg.

There was limited medical documentation with the exception of the administration of medication and meals until February 22, 2019, when Inmate Fountain was taken to the medical department with complaints of abdominal pain. Captured video footage revealed he arrived in medical at 3:46 a.m. that morning.

LPN Harris added progress notes as follows:

> 4:48 a.m.: "Pt. A&Ox3, resp. even and unlabored. Pt. c/o ABD pain, abd soft not tender, hypoactive BS x2 quads. V/S stable, HRR at 45-49 bpm. LBM 2/21/19. MOM given, will refer to MD. Hx of Prostate CA."
>
> 4:54 a.m.: Dr. Moreno prescribed Motrin IB (Ibuprofen) 200 mg. tablet; give 1 tablet by mouth now for 1 days. Per nursing protocol.
>
> 5:07 a.m.: "Pt. remains in medical HR Brady at 51 bpm. Motrin given. Will continue to monitor.
>
> 6:30 a.m.: "Pt. exit medical at 5:07 a.m. 0515 in stable condition. Pt. belching, BSx4 quads active. No c/o C/P voiced at this time. Will continue to monitor as needed.

On February 22, 2019, Dr. Moreno ordered continuation of the prescribed medications.

According to records, Inmate Fountain was compliant with prescribed medications with the exception of February 22nd. RMA Spain documented that Inmate Fountain refused all prescribed medications during morning pill pass. According to the refusal of treatment form signed by RMA Spain and Officer Gibbs, RMA Spain documented there was no reason given for Fountain's refusal. She checked the option on the form confirming that she explained the possible consequences of worsening medical conditions to Fountain and she included a written notation that the patient was educated. This refusal occurred after Inmate Fountain returned to his cell from the medical department where he was treated earlier that morning.

RMA Tekeema Spain added the following progress notes on February 23, 2019:

"Approximately 1030 patient took his medication with no complaints. Patient asked to be allowed back into his room immediately after taking medication. Other patients in the pod tried to speak with me regarding the patient not eating for 9 days. Patients were advised due to HIPPA, no medical information can be discussed with them. Pod officer verified there was no record of patient not eating for 9 days. Charge nurse was notified regarding concerns."

> "While in pod 3-2 C, the medication pass had begun approximately 2015. C-101 was started with medication first. After providing medication to C-109, I heard banging and I looked up to room C-212 and noticed one of the inmates hitting the window stating, "He's down" and making hand gestures pointing inside the room. I ran up the stairs and noticed the patient, Fountain, Victor, sitting on the floor vomiting. I notified Officer Bangura to call a code. I then took the radio after the 10-52 was called and added "Code Blue." Officer MJO Allen came to assist along with Officer MJO Rogers, Officer Dew. I advised for 911 to be called. The patient was still breathing, however vomiting. The patient was placed on his side until the back board arrived and patient was transported out of the room C-212. The patient was placed on stretcher and taken out to the vestibule area and given further treatment with oxygen, AED and CPR compressions."

Inmate Fountain was found to be in medical distress at approximately 10:29 p.m. on February 23, 2019. HRRJ Internal Affairs described the incident and subsequent response as follows:

> "On Saturday, February 23, 2019 at approximately 8:29 p.m., while conducting pill pass in Housing Unit-3/Pod-2 with Registered Medical Assistant Tekeema Spain, Officer John Bangura reported finding Inmate Victor Fountain JCA #43794 lying on the floor of cell C-212, where he appeared to be unresponsive. At the direction of RMA Spain, Officer Bangura initiated a code 10-52 (medical emergency) and responding staff prepared Inmate Fountain for transport to medical via the medical transport gurney. While in transit to medical, Inmate Fountain became non-responsive and at the direction of Nurse Kent, the medical emergency upgraded to a 10-52, code blue (medical emergency, victim not breathing). Resuscitation efforts immediately commenced in the HU-3 first floor vestibule, near the unit control booth. At approximately 8:50 p.m., emergency responders from the Portsmouth EMS and Fire Department arrived on scene and continued resuscitation efforts. At approximately 8:58 p.m., Portsmouth EMS ceased resuscitation efforts and Paramedic Kenny Wilkins pronounced Inmate Fountain deceased."

The emergency response worksheet revealed that CPR was performed and the AED was activated. Dr. Michael Hays, Assistant Chief Medical Examiner, performed an autopsy and classified Mr. Fountain's Manner of Death as Natural, and Cause of death as Complications of Ileal Volvulus; History of Small Bowel Resection with Postoperative Adhesive Bands Contributing.

Dr. Hays detailed the case summary as follows, "This 62 year-old man was an inmate at Hampton Roads Regional Jail who reportedly collapsed following recent gastrointestinal complaints. Medics responded and pronounced dead at scene. Autopsy examination revealed a normally formed adult male with no evidence of inflicted injury. Death resulted from a small bowel volvulus related to postoperative adhesions; review of the medical record was notable for a history of small bowel resection, which was reported by family members as related to a prior hernia."

Portsmouth Police Department Detective William Baker investigated this in-custody death, which was attributed to natural causes.

It was determined that security inspections/well-being checks were not completed as required during February 22-23, 2019. The checks were documented in the database as being properly completed by Officers Christopher Gibbs and Charles Anderson.

The HRRJ Internal Affairs investigation revealed the following issues related to Officer Christopher Gibbs, (D-Team) – Day Shift HU-3/2 Pod Manager:

> "Prior to Inmate Fountain's death, during the day shift from Friday, February 22, 2019 – Saturday, February 23, 2019, Officer Christopher Gibbs completed twelve (12) out of forty-eight (48) required security inspections/well-being checks. Although Officer Gibbs documented security inspections/well-being checks in the database properly, he failed to conduct thirty-six (36) physical rounds in accordance with facility policy."
>
> "For the noon and evening meals served on 2/22/2019 and 2/23/2019, Officer Gibbs documented Fountain as refusing all four meals; However, it was determined that Fountain did not exit his cell during the meal times and Officer Gibbs failed to conduct wellness checks before completing the meals."

The HRRJ Internal Affairs investigations revealed the following issues related to Officer Charles Anderson, (B-Team) – Night Shift HU-3/2 Pod Manager:

> "Prior to Inmate Fountain's death, during the evening shift from Friday, February 22, 2019 – Saturday, February 23, 2019, Officer Charles Anderson physically completed ten (10) out of the twenty-seven (27) required security inspections/well-being checks. Although Officer Anderson documented security inspections/well-being checks in the database properly, he failed to conduct seventeen (17) physical rounds in accordance with facility policy."

Based upon the internal review, disciplinary action was taken against both officers for violation of policy regarding security inspections/well-being checks.

There were also problems identified regarding the failure of Inmate Fountain being provided immediate medical attention on February 23, 2019.

The HRRJ Internal Affairs investigation revealed the following issues related to Sergeant Derrick Brown, (D-Team) – Day Shift HU-3 Unit Manager:

> "During an interview, Sergeant Brown stated while conducting unannounced supervisory rounds in HU-3/2 on 2/23/2019, an inmate housed on the C-side of the pod reported that Inmate Fountain was not feeling well. At approximately 3:00 p.m., Sgt. Brown reported to Fountain's cell and conducted an initial assessment. Sgt. Brown stated that he observed Fountain lying on the bottom bunk, in the fetal position, and clutching his abdomen as if he was in pain. According to Sgt. Brown, Fountain stated that doctors diagnosed him with stage-4 cancer, that he had abdomen pains, and could not keep food down. Sgt. Brown allegedly gave assurance that he would report his condition to medical. He then directed Fountain to be very specific and descriptive of his ailments during the medical assessment."
>
> "At approximately 4:00 p.m., after completing other duties, Sgt. Brown stated that he contacted duty charge nurse, C. Ledford (RN), and informed her that Fountain had stage-4 cancer and was not feeling well. Sgt. Brown alleged that Nurse Ledford appeared to have difficulties accessing Fountain's medical records, and she appeared to be busy at the time. Allegedly, Ledford stated that she would call back within a few minutes after she accessed Fountain's records, but Sgt. Brown stated that he would not be in the office, and offered to call her back instead."
>
> "At approximately 6:00 p.m., Sgt. Brown stated that he followed-up by calling Nurse Ledford for an update on Fountain's status. Sgt. Brown alleged that he could not recall the details of the conversation but insisted that his intentions were to receive the approval from the charge nurse to escort Fountain to medical for assessment. Sgt. Brown alleged that Nurse Ledford again appeared busy; so instead, he

suggested escorting Fountain to medical the following morning during their next duty shift (2/24/2019). According to Sgt. Brown, Nurse Ledford agreed and they subsequently terminated the phone call."

> "It was noted that during the interview, Sgt. Brown admitted that Fountain's condition appeared to warrant immediate medical attention, Brown maintained that he never received approval from the charge nurse to escort Fountain to medical for further assessment. Sgt. Brown further stated that he had no authority to override medical."

It was determined that Sergeant D. Brown failed to have Mr. Fountain assessed by medical staff when he was in obvious distress.

The HRRJ Internal Affairs investigation revealed the following issues related to RN Christina Ledford, Wellpath – Day Shift Charge Nurse:

> "During an interview, Nurse Ledford confirmed that Sgt. Brown called at approximately 4:00 p.m. on 2/23/2019 and notified her about Inmate Fountain's condition. However, according to Nurse Ledford, Sgt. Brown only stated that Fountain was not feeling well, and did not report any acute concerns. Nurse Ledford alleged that she never denied Fountain access to medical but instead allowed Sgt. Brown to use discretion based on his on-site assessment."

> "Nurse Ledford confirmed that Sgt. Brown followed-up at approximately 6:00 p.m. by asking the status of Fountain's medical records. Nurse Ledford explained to Sgt. Brown that based on Fountain's diagnosis, she understood why he was not feeling well. Nurse Ledford alleged that she made it clear to Sgt. Brown that he could use discretion and escort Inmate Fountain to medical should he deem necessary. Allegedly, Sgt. Brown offered to escort Fountain to medical the following morning during their next duty day and Nurse Ledford agreed; they subsequently terminated the phone call."

It was determined that Registered Nurse C. Ledford failed to provide medical treatment for Inmate Fountain after being advised by jail staff that he needed a medical assessment.

It was also determined through internal review that Wellpath Registered Medical Assistant Tekeema Spain, and Wellpath Certified Medical Technician Tayla McCoy, were found to have failed to properly document Mr. Fountain's medical records. This writer's investigation observed that information was reported during after-action statements, which had not been documented in medical records. There were also late entries noted.

Inmate William Harrell, Mr. Fountain's cellmate, stated that Fountain had not eaten for days prior to his death. Harrell stated that when Fountain's condition deteriorated, he overheard several inmates complaining to Officer Gibbs and requesting to see a supervisor. Inmate Harrell confirmed that Sergeant Brown conducted a wellness check on Fountain at approximately 3:00 p.m. on February 23rd, but never returned to escort Fountain to medical as promised.

Other inmates housed in HU-3/2 submitted statements. The consensus among them was that Inmate Fountain did not eat for consecutive days and that he appeared to be in medical distress. The inmates alleged that they verbally reported Mr. Fountain's condition to security and medical staff, but they took no action.

Inmate Fountain was observed on captured video on Thursday, February 21st at 5:07 p.m., accepting an evening meal tray and sitting in the C-side dayroom eating and interacting with other inmates. From that video, he did not appear to be in medical distress. There was no written correspondence to either security or medical staff to support the allegations that the inmates reported Inmate Fountain's condition. The one exception was the progress notes written by RMA Tekeema Spain reported previously in this report.

HRRJ provided feeding rosters for the period from February 15-23, 2019. A notation was made in records that the February 14th roster for the entire pod was missing. Also noted was the February 22nd roster for C-Side (Fountain's side) was missing. According to the available check-off lists, Inmate Fountain received three meals a day through February 21st.

As previously reported, Officer Gibbs documented that Inmate Fountain refused the noon and evening meals (4 total) on February 22nd and 23rd. This was not factual, as it was determined that the inmate did not exit his cell during those meal times, and that the officer failed to conduct wellness checks before completing the meals.

Based upon the available evidence, his last meal was at 5:07 p.m. on February 21, 2019. He missed all meals on February 22nd and 23rd.

Captured video footage revealed the following:

Thursday - February 21, 2019

5:07 p.m.: Fountain observed receiving a dinner meal, sitting at a day room table, and interacting with other inmates before returning to his cell for the evening at approximately 5:46 p.m.

8:22 p.m.: During cell call, Fountain observed signaling to the pod manager to secure his cell door.

8:36 p.m.: Fountain exited cell, interacted with other inmates, stood at the top of the stairwell for a brief moment, and eventually proceeded to the bottom tier of the day room. He used the toilet located in the day room and sat at a day room table where he appeared to watch television.

9:22 p.m.: Fountain received medication during evening pill pass.

9:24 p.m.: Fountain returned to his cell for the rest of the evening.

Friday - February 22, 2019

3:46 a.m.: Fountain was escorted to medical experiencing abdomen pain.

5:26 a.m.: Fountain returned from medical, refused breakfast meal and entered his cell, where he remained for the rest of the day.

Saturday – February 23, 2019

9:58 a.m.: Fountain exited his cell for morning pill pass (medication administered).

10:27 a.m.: Fountain re-entered cell, where he remained for the rest of the day.

8:29 a.m.: 10-52 medical emergency code called.

8:58 p.m. Fountain was pronounced deceased.

In accordance with NCCHC standards, a clinical mortality review was conducted. The findings of that review remain in the possession of the medical provider and are unknown.

The facility reported the following administrative corrective actions:

1. Appropriate corrective/disciplinary action was taken for personnel found to be in violation of departmental policies and procedures as well as the Minimum Standards of the Virginia Board of Corrections.

2. The Hampton Roads Regional Jail is still in the process of implementing the automated well-being/security round system in the facility. Access points for the system have been placed throughout the facility and are active. The actual system has been purchased and we are currently working to have it deployed. As stated in the past, the system will inform jail officers and supervisors when well-being checks have been completed as well as when future rounds need to be completed.

3. The Hampton Roads Regional Jail has worked to increase the certification of medical personnel in the facility. Over the past year, we have replaced a number of LPN staff positions will RN positions. RNs are assigned to all three housing units of the facility.

4. Modification to Hampton Roads Regional Jail's Policy and Procedure #17.2 (Emergency Medical Services). All sworn staff have the authority to contact medical concerning an inmate's illness or missed medication without having to obtain permission from supervisory staff first. Furthermore, authorizes staff to take in inmate to medical without seeking permission of supervisory staff first.

Contract medical services are provided to Hampton Roads Regional Jail by Well Path Medical Providers, formally named Correction Care Solutions. The medical provider provides one full-time doctor, two nurse practitioners, mental health staff, and a dentist four days a week. The contract provides for 62.5 full-time employees, which includes registered nurses and licensed practical nurses. Jail policy requires a registered nurse to always be on duty, and at night and on weekends, at least seven licensed practical nurses are always on duty.

The physician is on call 24 hours daily. When medical attention is needed, the initial evaluations and routine care are provided by the nursing staff. If the problem is more severe, the patient care is advanced to nurse practitioners or the physician, depending upon the severity of the condition. Based upon the training of the nurses, it is at their discretion at what point the doctor should be consulted. A sliding scale is used for treatment of diabetic inmates that is approved by the doctor and medical director. A blood glucose level of more than 420 requires that the doctor be notified immediately. In situations deemed an emergency, EMS is contacted and the inmate patients are transported to Bon Secours Maryview Medical Center in Portsmouth.

This jail receives inmates with serious medical problems from the surrounding cities of Chesapeake, Hampton, Newport News, Norfolk, and Portsmouth. The facility is staffed with medical personnel who can more effectively treat inmates with serious medical and mental health issues than the local member jurisdictions.

Hampton Roads Regional Jail Policy and Procedures Number 17-1, Health Care Services, Paragraph I and Paragraph III (d.-1-3 & e.-1-2) state as follows:

> Paragraph I, Policy – Page 2: Through its Medical Services Contractor (MSC), the Hampton Roads Regional Jail shall provide that accurate inmate medical records are maintained.
>
> d. (1): The Medical Services Provider shall establish policies and procedures for handling and responding to each inmate request for medical treatment.
>
> d. (2): Medical requests initiated by inmates orally, electronic kiosk or in writing must be processed daily, upon receipt.
>
> d. (3): Inmates making a medical request must be acted upon by a Licensed Registered Nurse or a Licensed Practical Nurse or Licensed Correctional Health Care Assistant, who will make the necessary referrals to the on-site Primary Care Physician and/or Medical Director.
>
> e. (1): The Medical Services Provider shall establish policies and procedures for the care and handling of inmate medical treatment requests as appropriate at all times.
>
> e. (2): After-hour medical treatment requests initiated by inmates must be processed daily. Treatment shall be scheduled or administered depending on the urgency of the medical condition.

Case No: 19-0006, date of death, 4/19/2019

The Jail Review Committee PRELIMINARILY FINDS that on February 16, 2018, Inmate Tyrone Lee Bailey was convicted in the Chesapeake Circuit Court of driving after being declared an Habitual Offender (2nd Offense) and sentenced to 12 months in jail. Initially, he was incarcerated in the Chesapeake Correctional Center, but was transferred to the Hampton Roads Regional Jail on April 23, 2018.

On August 17, 2018, Inmate Bailey was transported to the Chesapeake Circuit Court, where he was tried and convicted of Perjury, and sentenced to an additional one-year sentence. Although he had an extensive criminal record, there was no information to indicate a previous incarceration in this facility.

Inmate Bailey was processed into the Hampton Roads Regional Jail on April 23, 2018. His medical records from the Chesapeake Correctional Center and Sentara Norfolk General Hospital were also transferred which noted a diagnosis of Stage IV Adenocarcinoma of the Right Upper Lobe of Lung with Metastatic Disease in the Subcarinal and Midiastinal Lymphadenopathy and Right Adrenal Gland.

Prescribed medications were as follows: Hydrochlorothiazide 12.5 mg. tablet, Norvasc (Amlodipine) 5 mg. tablet, Ipratropium – Albuterol 0.5 mg. (Nebulization Solution), Qvar (Aerosol Oral Inhaler), ProAir HFA (Aerosol Inhaler).

Inmate Bailey was also being treated offsite at the Virginia Oncology Associates in Chesapeake. On May 31, 2018, he completed six cycles of chemo radiation therapy.

Mr. Bailey answered "No" to all mental health screening questions. His Orientation was classified as "Alert," and his Thought Process as "Logical." Affect, Speech, Mood, and Activity/Behavior were "Appropriate." He answered "Yes" to only one question on the suicide potential screening questionnaire. The question was as follows: "Worried about major problems other than legal situation?" He specified "terminal illness."

Dr. Dale Moreno continued the prescribed medication and added Tylenol 325 mg. tablets for pain. Medical orders from the Chesapeake Correctional Center were continued and the doctor ordered the inmate be assigned to medical housing for continued monitoring.

Inmate Bailey was classified as a medium-security inmate and assigned to medical housing, HU-1/1, D-201 for continued monitoring in accordance with previsions set by the previous facility.

Medical records reflect Inmate Bailey submitted two health care requests (sick calls). He complained of stomach pain on January 18 and again on February 14, 2019. Medical staff treated him on both occasions. In addition to offsite treatment at the Virginia Oncology Associates, records reveal that Inmate Bailey was monitored closely in the medical unit at the jail. Dr. Moreno routinely reviewed and adjusted his prescribed medications.

The Internal Affairs investigation noted that Inmate Bailey often refused various prescribed medications. A review of medical records confirmed frequent refusals throughout his incarceration.

Inmate Bailey compiled nine behavior log entries; four entries addressed minor behavior related incidents. There were no documented incidents resulting in restriction status. Two of the entries reported that he refused medication on March 20 and April 4, 2019.

Officer J. Gravely recorded two of the incidents as follows:

1. 4/12/2019: I called medical to see when Inmate Bailey was going to his chemo treatment and the officer said she didn't know and would have to get the nurse to call back because she was busy.

2. 4/17/2019: Called medical for Inmate Bailey to see when he goes for his chemo treatment and Nurse Towne said he is going but she can't tell me when.

On Friday, April 19, 2019, at approximately 8:34 a.m., transportation Officers Carl Frankiewicz and Melvette Alston transported Inmate Tyrone Bailey to the Virginia Oncology Associates in Chesapeake for a chemotherapy appointment. Captured video footage from earlier that morning revealed Inmate Bailey did not appear to be in medical distress. He exited his cell at 7:38 a.m., and was seen standing in the vestibule area pumping his aerosol inhaler. He left the pod one minute later with Officer Frankiewicz enroute to the appointment.

At approximately 11:45 a.m., during the last dosage of chemotherapy treatment, Inmate Bailey reportedly complained of stomach pains, began convulsing, and subsequently became unresponsive. The Virginia Oncology Associates medical staff immediately initiated and continued resuscitation efforts until the Chesapeake EMS arrived on scene at approximately 11:58 a.m. to provide advanced life support.

At approximately 12:38 p.m., Chesapeake EMS transported Inmate Bailey to the Chesapeake Regional Medical Center Emergency Room where resuscitation efforts continued. At 1:27 p.m., emergency room medical staff ceased resuscitation efforts and Dr. Sean Murrand pronounced Inmate Bailey deceased.

Captured video footage from the evening before his death revealed that Inmate Bailey did not appear to be in medical distress. He moved about freely, interacted with other inmates in the pod, and consumed his evening meal. He pushed another inmate (Minyard) in the dayroom at 8:19 p.m., and dropped his laundry bag into the dayroom slider at 9:59 p.m. He stood in the pill pass line at 10:04 p.m. and received his medication. He retrieved something (unknown) from another inmate at 10:39 p.m. and went into his cell one minute later.

Dr. Elizabeth Kinnison, Assistant Chief Medical Examiner, performed an autopsy and classified Inmate Bailey's Manner of Death as Natural with Cause of Death as Cardiac Arrhythmia during Treatment for Metastatic Lung Cancer with Atherosclerotic and Hypertensive Cardiovascular Disease Contributing. The doctor reported that the autopsy found evidence of both treated Metastatic Lung Cancer and Atherosclerotic and ypertensive

Cardiovascular Disease. A non-toxic amount of Diphenhydramine (over-the-counter antihistamine) was detected in the blood.

Detective J. Mills of the Chesapeake Police Department investigated this incident and classified the case as a death from natural causes.

Additional information from prior to April 19, 2019 detailed that on March 29, 2019, Officer Moechoe transported Inmate Bailey to the Virginia Oncology Associates for a medical appointment at which time Dr. Naga, attending physician, approached the officer. According to the officer's incident report, the doctor questioned why Mr. Bailey had missed his last appointment on March 13 2019. The officer informed Dr. Naga that the inmate had advanced knowledge of that appointment and for security reasons; the appointment had to be changed.

Dr. Naga informed Officer Moechoe that Inmate Bailey had missed at least twelve appointments in the past year, which "is slowing down his treatment." The officer submitted an incident report to the HRRJ supervisor, who in turn contacted Ms. Vanderpool, the Wellpath scheduler. Ms. Vanderpool stated the doctor's information was "untrue and appointments had not been canceled." The doctor's office was asked to have someone call Ms. Vanderpool to discuss the missed appointments.

Pursuant to the incident report, Captain T. Barnes spoke with Ms. Vanderpool and reported the following: "I spoke to Ms. Vanderpool concerning this incident and she explained that Inmate Bailey has not missed his appointments. Some of his appointments have been rescheduled due to the heavy medical load on transportation at times. The doctor's office did confirm that all rescheduled appointments were made. The doctor's office has been scheduling the appointments without speaking with Wellpath scheduler (Ms. Vanderpool)."

HRRJ Internal Affairs investigator interviewed the Director of Nursing at Virginia Oncology Associates. That interview was reported as follows:

"During an interview with Laura, VOA director of nursing, Inmate Bailey's condition required another round of chemo radiation treatment consisting of five cycles, not to exceed twenty-one days. On September 6, 2018, Dr. Naga scheduled the round of chemo radiation treatments. Nurse Laura submitted a regimen and lab summary confirming all treatment dates and subsequent delays as follows:

1. Cycle-1: 9/06/2018 – Chemo administered as scheduled;
2. Cycle-2: 9/27/2018 – Administered on 11/09/2018, treatment delayed 43-days.
3. Cycle-3: 10/18/2018 – Administered on 12/21/2018, treatment delayed 21-days.
4. Cycle-4: 11/15/2018 – Administered on 03/29/2019, treatment delayed 77-days.
5. Cycle-5: 12/06/2018 – Administered on 04/19/2019"During the Cycle-5 treatment on April 19, 2019, Mr. Bailey reportedly complained of stomach pains, began convulsing, and subsequently became unresponsive. During an interview, Nurse Laura stated that she did not want to speculate on whether or not Inmate Bailey had an adverse reaction to the chemo treatment."

The Internal Affairs investigative report concluded, "Based upon the internal review, it appears that Mr. Bailey had an adverse reaction to the chemotherapy off-site while at Virginia Oncology Associates.

This investigator sent an email requesting the reason for the three delays in treatment detailed above. The Internal Affairs Lieutenant responded, "To expand on the treatment delays, there were a number of reasons that treatment was delayed. These delays included – inclement weather, where the treatment facility was closed due to a hurricane warning, the inmate having prior knowledge of the appointment schedule (which is a safety and security issue), and the scheduler limiting the number of outside appointments for a day."

Hampton Roads Regional Jail Policy and Procedures Number 17.1, I – Policy (page 1) - Paragraph 2-4 states: The purpose of the regional jail's medical services contract is to establish and maintain: "An off-site Preferred Provider Network of hospitals, physicians, and other ancillary medical providers to provide medically necessary services to inmates which cannot be provided at the regional jail."

Hampton Roads Regional Jail Policy and Procedures Number 17.1, I – Policy (page 11) - Paragraph 2 (c) states: The Medical Care Provider shall establish policies and procedures for referring inmates off-site for necessary

medical treatment for a Preferred Medical Provider. The medical provider employees a scheduler for outside appointments who establishes the appointments and arranges for jail transportation officers to provide security and transportation to the inmates attending those appointments. Ms. Vanderpool, the Wellpath scheduler, placed a limit of five appointments per day due to workload of the transportation officers.

The Board's investigator interviewed Superintendent David Hackworth (Ret.), who advised that he had no idea the scheduler had placed a limit on the number of outside appointments. This came to his attention during his review of this case, and he stated that he immediately directed the medical provider to change the practice to "no limits" on the number off-site visits.

The Superintendent stated that outside medical appointments were considered practice for the regional jail, and there was no written policy other than the information previously stated in this report.

The final administrative report stated, "Based upon the internal review, the facility has ensured that there is no limit on the daily number of outside appointments and that should an appointment be cancelled for any reason it is rescheduled in, no later than, 5 to 7 days."

The final report stated that a mortality review was conducted in accordance with NCCHC standards. The review did not include any information beyond what was reported in this report.

Contract medical services are provided to Hampton Roads Regional Jail by Well Path Medical Providers, formally named Correction Care Solutions. The medical provider provides one full-time doctor, two nurse practitioners, mental health staff, and a dentist four days a week. The contract provides for 62.5 full-time employees, which includes registered nurses and licensed practical nurses. Jail policy requires a registered nurse to always be on duty, and at night and on weekends, at least seven licensed practical nurses are always on duty.

The physician is on call 24 hours daily. When medical attention is needed, the initial evaluations and routine care are provided by the nursing staff. If the problem is more severe, the patient care is advanced to nurse practitioners or the physician, depending upon the severity of the condition. Based upon the training of the nurses, it is at their discretion at what point the doctor should be consulted. A sliding scale is used for treatment of diabetic inmates that is approved by the doctor and medical director. A blood glucose level of more than 420 requires that the doctor be notified immediately. In situations deemed an emergency, EMS is contacted and the inmate patients are transported to Bon Secours Maryview Medical Center in Portsmouth.

This jail receives inmates with serious medical problems from the surrounding cities of Chesapeake, Hampton, Newport News, Norfolk, and Portsmouth. The facility is staffed with medical personnel who can more effectively treat inmates with serious medical and mental health issues than the local member jurisdictions.

The purpose of the regional jail's medical services contract is to establish and maintain: An off-site Preferred Provider Network of hospitals, physicians, and other ancillary medical providers to provide medically necessary services to inmates which cannot be provided at the regional jail.

Hampton Roads Regional Jail Policy and Procedures Number 17.1, I – Policy (page 11) - Paragraph 2 (c) states: The Medical Care Provider shall establish policies and procedures for referring inmates off-site for necessary medical treatment for a Preferred Medical Provider.

The evidence reveals that the medical provider was responsible for and expected to make transportation arrangements. The scheduler adopted the practice of restricting the number of off-site appointments per day due to use of limited transportation officer concerns.

Hampton Roads Regional Jail administration contracted with the medical provider to make transportation arrangements for off-site appointments. Information developed during this review made it apparent that administrative staff was not aware of the delays caused by the scheduling practice the medical provider established limiting the number of daily outside appointments. It is also obvious that the Virginia Oncology Associates staff were discussing appointments with the inmate/patient without communicating with the scheduler. The other reasons for delays were detailed in the administrative investigation as inclement weather causing the medical provider to be closed, and the inmate having prior knowledge of an appointment which is a safety and security issue.

The Internal Affairs Lieutenant responded to this investigator's email inquiry as follows: "We have ensured through our practice that there are no limits to the number of appointments that can be scheduled for each day. Additionally, the medical provider implemented a system ensuring that all cancelled medical appointments are rescheduled within 5-7 days. Please understand that this is the practice of the facility now."

The change made in scheduling practice should prevent future delays in outside medical appointments for patients.

PRELIMINARY VIOLATION FINDINGS:

Based on the facts adduced herein, the Jail Review Committee makes the PRELIMINARY FINDING that these facts demonstrate acts or omissions by the Hampton Roads Regional Jail or any employee or agent thereof that may have directly or indirectly contributed to the death of these inmates. The Jail Review Committee therefore, will RECOMMEND that the Board of Local and Regional Jails FIND as FOLLOWS:

Case #18-0066, date of death 12/31/18: Based on the facts revealed in the investigation and audit, as outlined above, the Jail Review Committee RECOMENDS that the Board of Local and Regional Jails FIND that the Hampton Roads Regional Jail FAILED to meet the minimum acceptable level of compliance with the minimum standards required for the supervision of inmates as outlined in 6VAC-15-40-1045.

Case #19-0013, date of death 4/19/19 Based on the facts revealed in the investigation and audit, as outlined above, the Jail Review Committee RECOMENDS that the Board of Local and Regional Jails FIND that the Hampton Roads Regional Jail FAILED to meet the minimum acceptable level of compliance with the minimum standards required for access to Twenty-Four Hour Emergency Medical and Mental Health Care as outlined in 6VAC-15-40-360.

Case #19-0006, date of death 2/23/19: Based on the facts revealed in the investigation and audit, as outlined above, the Jail Review Committee RECOMENDS that the Board of Local and Regional Jails FIND that the Hampton Roads Regional Jail FAILED to meet the minimum acceptable level of compliance with the minimum standards required for access to Twenty-Four Hour Emergency Medical and Mental Health Care as outlined in 6VAC-15-40-360 and the supervision of inmates as outlined in 6VAC-15-40-1045.

In reviewing these cases, the Jail Review Committee FINDS that the Hampton Roads Regional Jail has shown a wonton disregard for the Board's minimum standards. The Jail Review Committee FINDS that the conditions at the Hampton Roads Regional Jail represent a significant public safety threat to inmates and correctional officers. The Committee further FINDS that all of these violations demonstrate an egregious lack of concern for the health and safety of all who enter the Hampton Roads Regional Jail. Furthermore, the Committee FINDS that Hampton Roads Regional Jail knowingly withheld information from this Committee and gave it manifestly inaccurate and misleading case summaries. Given all of these factors, this Committee will RECOMMEND that the Board of Local and Regional Jails FIND that there is no reasonable chance of bringing your facility into compliance with its minimum standards.

NOW THEREFORE, with respect to the above cases, the Committee ***Will RECOMMEND*** that the Board of Local and Regional Jails IMPOSE THE FOLLOWING PENALTIES:

Case No: 18-0066, date of death, 12/31/2018, Pursuant to 6VAC15-20-100, upon the findings made herein, the Jail Review Committee will RECOMMEND that Board of Local and Regional Jails DECERTIFY the Hampton Roads Regional Jail and, Pursuant to Virginia Code 53.1-69, and ORDER that the inmates held therein henceforth be TRANSFERRED to the custody of the jurisdiction of origin.

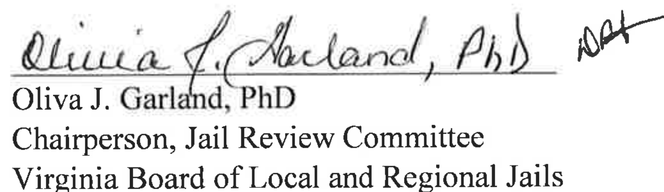
Case No: 19-0013, date of death, 4/19/2019, Pursuant to 6VAC15-20-100, upon the findings made herein, the Jail Review Committee will RECOMMEND that Board of Local and Regional Jails DECERTIFY the Hampton Roads Regional Jail and, Pursuant to Virginia Code 53.1-69, ORDER that the inmates held therein henceforth be TRANSFERRED to the custody of the jurisdiction of origin.

Case No: 19-0006, date of death, 4/19/2019, Pursuant to 6VAC15-20-100, upon the findings made herein, the Jail Review Committee will RECOMMEND that Board of Local and Regional Jails DECERTIFY the Hampton Roads Regional Jail and, Pursuant to Virginia Code 53.1-69, ORDER that the inmates held therein henceforth be TRANSFERRED to the custody of the jurisdiction of origin.

HEARING NOTICE:

Please note that your facility previously received a Notice of Preliminary Findings and Recommended Penalties in connection with **Case #18-0043, date of death 5/15/2018**. You then filed a Notice of Objections to the Preliminary Findings and Recommended Penalties and requested a hearing. At your request, that hearing had been delayed for two months. The Board has been unable thereafter to hold that hearing because of COVID-19 concerns and the restrictions imposed by Governor Northam that limited in-person meetings. That hearing can now take place given the precautions that will be implemented, the easing of restrictions, and the wide distribution of vaccines. Therefore, the hearing in **Case #18-0043, date of death 5/15/2018** is HEREBY scheduled for **May 19, 2021 at 10 am** when the Board of local and Regional Jails next meets in person. Furthermore, if your facility elects to file a Notice of Objections to the Preliminary Findings and Recommended Penalties with regard to **Case No: 18-0066, date of death, 12/31/2018**, **Case No: 19-0013, date of death, 4/19/2019,** and/or **Case No: 19-0006, date of death, 4/19/2019**, those matters will likewise be heard on **May 19, 2021 at 10 am.**

Entered on this the 14th day of April, 2021



Oliva J. Garland, PhD
Chairperson, Jail Review Committee
Virginia Board of Local and Regional Jails

General Procedural information:

Informal Presentation of Evidence:

The purpose of the Informal Presentation of Evidence is to give the facility a better understanding of the evidence obtained during the investigation, the minimum standards violated and the basis for the penalties. Upon written Notice filed within **10 days** of receipt of the Notice from the Jail Review Committee, a subordinate of the Jail Review Committee will work with the facility to schedule a time for the informal presentation of factual data or proof in connection with the case. The Informal Presentation of Evidence will not be on the record but may be recorded upon reasonable request of the facility. This informal presentation will most often be given by a Board investigator familiar with the case and may occur by telephone if both parties agree. The facility is encouraged to ask questions to gain a fuller understanding of the case. The facility will not be expected to present any evidence or argument at the Informal Presentation of Evidence.

Notice of Objections to the Preliminary Findings and Recommended Penalties:

The Notice of Objections to the Preliminary Findings and Recommended Penalties shall be filed with the Board within **21 days** of the Preliminary Findings and Recommended Penalties and include the following:

a) A general statement of the facts, legal authority, and conclusions of law objected to;
b) A general statement of facts, legal authority, and conclusions of law the Board should consider in determining whether there was a violation of the Board's minimum standards, laws, and/or regulations;
c) A general statement of facts, legal authority, and conclusions of law the Board should consider in the imposition of penalties, including any mitigating facts and measures the facility took to remedy violations revealed by the Board's investigation;
d) A list of witnesses the facility would like to have subpoenaed by the Board;
e) A copy of any documentation the facility intends to introduce at a hearing;
f) A statement of whether the facility intends to introduce evidence by proffer and whether it objects in whole or in part to a proffer of evidence by the Jail Review Committee Chairman; and
g) A statement of what if any penalties are appropriate.

The case is docketed.

A docket is the official schedule of hearings pending before the State Board of Local and Regional Jails. A case will be docketed once a facility files a Notice of Objections to the Preliminary Findings and Recommended Penalties. The facility will be notified of the date scheduled for a potential hearing which will normally occur at a meeting of the full Board. Dockets are available online.

The negotiation and consent period.

In cases where a facility filed a Notice of Objections to the Preliminary Findings and Recommended Penalties, there will be a Negotiation and Consent period that will last until 10 days prior to the formal hearing. This period provides the facility with the opportunity to try to resolve charges through discussions with the Executive Director. The facility can offer to admit to all or a portion of the alleged violation(s) and accept a negotiated penalty. To become final, the agreement must be

agreed to by a majority of the members of the Board. By accepting, the facility waives the right to a formal hearing and to an appeal.

Continuances.

A continuance is a request by one of the parties to a case to postpone a scheduled hearing to another time. As a rule, continuances are granted only for substantiated, unforeseeable circumstances. Delays in hiring an attorney are not grounds for a continuance.

The informal conference is held.

The goal of the informal conference is to prepare for the formal hearing. At the informal conference, each party must identify any undisclosed witnesses and materials it intends to use at the formal hearing; also during the informal conference, the parties will discuss stipulations, procedural and transcription issues, technology needs, translation services and make preliminary motions.

The formal hearing is held.

Hearings will usually be held at the office of the State Board of Local and Regional Jails located at 6900 Atmore Drive, Richmond, VA 23225 before the full Board. However, due to COVID-19 restrictions, the location is subject to change. The Board is under no obligation to conduct all or a portion of the formal hearing during a closed session. The Chairman of the Jail Review Committee will present the case to the Board. Proffers of evidence will be encouraged. In all such formal proceedings the parties shall be entitled to be accompanied by and represented by counsel, to submit oral and documentary evidence and rebuttal proofs, to conduct such cross-examination as may elicit a full and fair disclosure of the facts, and to have the proceedings completed and a decision made with dispatch. The parties may also stipulate as to the facts and present evidence and argument on whether the facts constitute a violation or the appropriateness of the recommended penalty. The facility and the Chairperson of the Jail Review Committee shall be given opportunity to submit in writing for the record proposed findings and conclusions and statements of reasons therefor. The burden of proof shall be upon the proponent or moving party.

The Chairman of the Board, or their designee, shall be the presiding officer at the proceedings may administer oaths and affirmations; receive probative evidence, exclude irrelevant, immaterial, insubstantial, privileged, or repetitive proofs, rebuttal, or cross-examination; rule upon offers of proof, and oversee a verbatim recording of the evidence; hold conferences for the settlement or simplification of issues by consent; dispose of procedural requests; and regulate and expedite the course of the hearing. Both parties shall have the opportunity to make closing statements and recommendations to the full Board.

A final decision is issued.

After the hearing, the Board will deliberate and will, upon a majority vote of the members constituting a quorum, issue a final decision which will then be reduced to writing and will mail and email the interested parties a written report detailing the final decision. All or a portion of this final decision may be subject to public disclosure under the Freedom of Information Act. All decisions shall be served upon the parties, become a part of the record, and briefly state the findings, conclusions, reasons, or basis therefor upon the evidence presented by the record and relevant to the basic law under which the agency is operating together with the appropriate order, sanction, relief, or denial thereof.

The decision may be appealed.

A facility can appeal the final decision of the Board of Local and Regional Jails. Such appeal shall be

conducted in accordance with Article 3 (§ 2.2-4018 et seq.) of the Administrative Process Act (§ 2.2-4000 et seq.).