Special Report
State of Iowa

Citizens' Aide/Ombudsman
Report of Task Force into Critical Incidents within the Iowa Prison System

TO: Honorable Thomas J. Vilsack
Governor

Report # 04 - 02
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Introduction

Governor Tom Vilsack, concerned about the deaths of two Iowa inmates at the Anamosa State Penitentiary (ASP), asked the Citizens' Aide/Ombudsman (Ombudsman) to review the incidents and provide an assessment of each incident. The Governor also asked the Ombudsman to propose a set of recommendations for improving inmate and staff safety within ASP.

The Ombudsman met with the Director of the Iowa Department of Corrections (DOC) who pledged his agency's cooperation. As a result of that meeting and review of investigations by the Division of Criminal Investigations (DCI), Department of Corrections' inmate files, and autopsy reports, the Ombudsman proposed a Task Force to conduct the review.

The Ombudsman suggested working with the Iowa Protection and Advocacy and the Iowa State Medical Examiners Office due to their expertise in areas discussed in this report.

This Task Force is comprised of the following agencies and designated staff:

Iowa Citizens' Aide/Ombudsman Office

William P. Angrick II, Ombudsman
Ruth Cooperrider, Deputy Ombudsman/Legal Counsel
Judith Milosevich, Assistant Ombudsman for Corrections
Kyle White, Assistant Ombudsman

Iowa Department of Corrections

Gary D. Maynard, Director
Harbans Deol D.O., Ph.D, Medical Director
Fred Scaletta, Public/Media Relations Officer
Michael Savala, Legal Counsel

Iowa Medical Examiner's Office

Julia Goodin M.D., State Medical Examiner
John Kraemer, Director Forensic Operations

Iowa Protection & Advocacy, Inc.

Sylvia Piper, Director
David Parr, Advocacy Coordinator
Nancy Simon, Disability Rights Advocate/Investigator

At its inception, the goal of this Task Force was to establish the facts of each incident, analyze compliance with policy and procedure, and if necessary, recommend change. After the Ombudsman selected the core members of the Task Force, the 2003 death of another inmate at the Iowa State Penitentiary (ISP) prompted an additional request by Governor Vilsack to include the events surrounding his death in the Task Force's review. Independently, the Ombudsman included in his review an offender who displayed several self-mutilative acts while incarcerated at the Iowa Correctional Institution for Women (ICIW).

In the initial review, the Ombudsman discovered one common thread: mental illness. All four individuals [redacted][1] and each was placed in to a heightened observation status during their incarceration. One committed suicide, one injured himself with staff intervention probably leading to his death, one was able to severely mutilate herself, and one died from unknown causes.

Redactions in Report

Iowa Code section 2C.9 allows the Ombudsman to have access to information relevant to an investigation. The Ombudsman, however, is prohibited from disclosing information that is confidential by law. The Ombudsman consulted with the appropriate agency officials or their attorneys regarding what information can be disclosed in the report, based on applicable statutes and rules. As a result of consultation, the Ombudsman has agreed to redact those parts of the report the officials or their attorneys believe to be confidential by law. The legal authority for each redaction is provided in the endnotes on pages 67 - 70 of the report.

The Mentally Ill Offender

The issue of the mentally ill in prison gained the attention of many groups within the last few years. In 2003, the Human Rights Watch (HRW)[1] published a report entitled *Ill-Equipped: U.S. Prisons And Offenders With Mental Illness*. This report is the result of interviews with correctional officials, mental health experts, offenders and lawyers across the country.

The Council on State Governments (CSG)[2] developed the Criminal Justice/Mental Health Consensus Project to assist local, state, and federal policymakers and criminal justice and mental health professionals in identifying and providing access to effective treatment to people who become involved or are at risk of becoming involved in the criminal justice system. They released their report in June 2002.

In April 2002, the President of the United States announced the creation of the New Freedom Commission on Mental Health. The goal of the commission was to study the mental health service delivery system and make recommendations to enable those with serious mental illness to live, work, learn, and participate fully in their communities. While this commission did not address the issue of the mentally ill in the criminal justice system, improved efforts in the community will help divert people from prisons and jails.

On June 5, 2003, Ohio U.S. Senator Mike Dewine introduced a bill (S. 1194), the "Mentally Ill Offender Treatment and Crime Reduction Act of 2003." Six other senators, including Iowa U.S. Senator Chuck Grassley, co-sponsored the bill. If passed, the bill will create a new grant program authorized at one hundred million dollars for each of the next two years, to foster collaborative efforts between criminal justice and mental health partners at the state and local levels. The grant funds could be used for a diverse array of programs, including court-based initiatives, training for mental health and criminal justice system personnel, and programs that facilitate the successful transition of offenders with mental illness back into their communities. The Senate passed this bill and it is currently in a House subcommittee.

The administrators of prisons and jails across the country are struggling to find ways to deal with the mentally ill population. According to the U.S. Department of Justice, over sixteen percent of adults incarcerated in United States jails and prisons have a mental

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[1] According to its website, the Human Rights Watch is an independent, nongovernmental organization, supported by contributions from private individuals and foundations worldwide. The internet site states HRW, among other things; 1) Stand with victims and activists to prevent discrimination, to uphold political freedom, to protect people from inhumane conduct in wartime, and to bring offenders to justice; 2) Investigate and expose human rights violations and hold abusers accountable; 3) Challenge governments and those who hold power to end abusive practices and respect international human rights law. <**http://www.hrw.org/about/**> (July 6, 2004)

[2] Founded in 1933, CSG serves the executive, judicial and legislative branches of state government through leadership education, research and information services. Founded on the premise that the states are the best sources of insight and innovation, CSG provides a network for identifying and sharing ideas with state leaders. CSG; 1) Builds leadership skills to improve decision-making; 2) Advocates multi-state problem solving and partnerships; 3) Interprets changing national and international conditions to prepare states for the future; and 4) Promotes the sovereignty of the states and their role in the American federal system. <**http://www.csg.org/CSG/About+CSG/faq/default.htm**> (July 6, 2004)

illness. Experts with the HRW estimate that two hundred thousand to four hundred thousand people with mental illnesses are confined within the United States prisons and jails. This criminalization of the mentally ill is the result of many factors; however, the two most common contributing factors are the inadequacies of the community-based mental health treatment facilities and the punitive criminal justice policies.

The federal Office of Juvenile Justice and Delinquency Prevention estimates that approximately twenty percent of youth in the juvenile justice system have serious mental health problems with a significant number having dual mental health and substance abuse disorders.[3]

As mental health institutions closed during the last quarter of the 20th century in efforts to de-institutionalize, adequate community-based services intended to replace these hospitals did not materialize. Some individuals who were mentally ill, particularly the homeless, unable to manage their basic needs, would commit crimes and find themselves within a correctional setting. Due to this increased number in arrests and convictions, the criminal justice system emerged as a surrogate mental health provider.

The report by the HRW provides the following observations as a broad overview of the problem:

> Fifty years ago, public mental health care was based almost exclusively on institutional care and over half a million mentally ill Americans lived in public mental health hospitals. Beginning in the early 1960s, states began to downsize and close their public mental health hospitals....Many factors precipitated the process. The first generation of effective anti-psychotic medications were developed, which made successful treatment outside of hospitals a real possibility. Litigation increased due to process safeguards in mental hospital involuntary commitment and release procedures, which meant fewer people could be committed or kept in the hospitals against their will. Today, fewer than eighty thousand people live in mental health hospitals...[4]
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> Proponents of deinstitutionalization envisioned former mental health hospital patients receiving treatment through community mental health programs and living as independently in the community as their mental conditions permitted. This process was catalyzed by passage of federal legislation providing seed funding for the establishment of comprehensive mental health centers in the community. Unfortunately, community mental services have not been able to play the role the architects of deinstitutionalization envisioned. The federal government did not provide ongoing funding for community services and while states cut their budgets

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[3] See "Findings" under Section 2 of Senate File 1194.

[4] Human Rights Watch, *Ill-Equipped: U.S. Prisons and Offenders with Mental Illness*, New York, NY, USA 2003, p. 19.

> for mental hospitals, they did not make commensurate increases in their budgets for community-based mental health services.[5]

The HRW report notes:

> Mental disorders include a broad range of impairments of thought, mood, and behavior. The degree of impairment can vary dramatically from individual to individual. Also, some individuals with mental illness have periods of relative stability during which symptoms are minimal, interspersed with incidents of psychiatric crisis. Other individuals are acutely ill and dramatically symptomatic for prolonged periods.[6]

While serious mental illness[7] is prevalent in both male and female prisoner populations, the statistics for female prisoners are particularly stark. A national study in 1999 by the Bureau of Justice Statistics based on a survey of prisoners, found that "[t]wenty nine percent of the white females, 20 percent of the black females and 22 percent of Hispanic females in State prisons were identified as mentally ill. Nearly four in ten white female inmates aged twenty-four or younger were mentally ill."[8]

Fred Cohen is an expert on correctional law and correctional mental health care law. When he was a federal court monitor in Ohio, he interviewed front-line personnel, those who have daily face to face contact with inmates. These staff, whether treatment or security, agreed the number of "seriously mentally disordered inmates in prison has increased dramatically in the last few years." Their explanations for this trend are: "[f]irst, overcrowding increases tension in prison and causes more mental illness than previously existed" and "[s]econd, the increasingly narrow criteria for civil commitment of the mentally ill and the general policy of deinstitutionalization have resulted in higher rates of conviction and imprisonment of persons who earlier would have entered the mental health system."[9]

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[5] Ibid., p. 20.

[6] Ibid., p. 30.

[7] HRW defines "serious mental illness" as: A diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified in the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association (DSM-IV-TR) and that results in substantial interference with or limitations on one or more major life activities. Ibid., p 31.

The DSM-IV-TR further describes the difficulty in defining a mental disorder but clearly states that a "syndrome or pattern" of a diagnosis "must be considered a manifestation of a behavioral, psychological, or biological dysfunction in the individual." Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, Text Revision DSM-IV-TR, American Psychiatric Association, 2000, p. xxxi.

[8] HRW, p. 38

[9] Fred Cohen, *The Mentally Disordered Inmate and the Law*, Civic Research Institute, New Jersey, 1998.

> "Security and program staff have come to believe that decent mental health care contributes to the security of the facility and enhances the work environment as it eases the suffering of the mentally ill."[10]

In an article by Terry A Kupers, M.D., M.S.P., he states, "[w]e know that serious mental illness tends to follow a waxing and waning course over a lifetime."[11]

In the same issue of the Correctional Mental Health Report, but a separate article, Fred Cohen notes, "Dr. Kupers…stated when placed in maximum-security units, normal prisoners often exhibit symptoms such as massive anxiety, acute confusion, paranoia, concentration and memory problems, and aggressive or self-destructive behaviors. Someone prone to psychotic episodes is likely to develop these symptoms, which will often throw that person into a psychotic breakdown."

"Given the almost non-existent mental health care in U.S. prisons two decades ago, all prison systems have improved the quality of their mental heath care. However, current practices are still woefully short of the need for mental health care."[12]

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[10] Ibid., p. 1-13

[11] Terry A. Kupers, M.D., M.S.P., *Malingering in Correctional Settings,* 5 Correctional Mental Health Report, p. 81, p. 82 (2004)

[12] HRW, p. 46.

Overview of Assessment and Treatment of Offenders in Iowa Prison System

Assessment of Offenders Entering the System

When offenders are sentenced to the custody of the Director of the Iowa Department of Corrections (DOC), they are first taken to the Iowa Medical and Classification Center (IMCC) at Oakdale. Section 904.201 of the Code of Iowa designates IMCC: "...as a forensic psychiatric hospital for persons displaying evidence of mental illness or psychosocial disorders and requiring diagnostic services or treatment in a security setting; as a security unit for persons requiring confinement in a security setting; and as a classification unit for the reception, orientation, and classification of inmates before placement in the most appropriate correctional institution according the necessary security and custody arrangement and the assessed service needs of the inmates."

Each inmate undergoes a battery of tests to determine their Intelligence Quotient (I.Q.) level as well as their present mental and physical health needs. Once an offender's needs are determined, including their custody score, IMCC staff decides the appropriate correctional facility to place the offender.

If a Pre-Sentence Investigation (PSI) is available, information from that source is included in the initial custody/classification level of the offender and helps determine the DOC institutional placement. PSI's are now completed on the Iowa Corrections Offender Network (ICON)[13] system and can be electronically accessed by correctional staff. In the past, copies were mailed by the judicial district where the report was completed.

All offenders receive a three-tier mental health screening at the time of the admission and consists of the following.

Independent Review: Correctional staff will ask the offender to independently complete portions of a questionnaire. The purpose of this questionnaire is to ascertain whether an offender has ever been diagnosed with a mental or emotional disorder; been admitted to a hospital or program because of mental or emotional problems; received recent mental health treatment; been prescribed medication; and used alcohol, "street" drugs or prescription drugs excessively in recent months.

Staff Interview: A correctional intake officer completes the next portion of the questionnaire. The intake officer will ask if any medications arrived with offender; if the offender admits to any attempts of self-harm; and whether the offender is presently

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[13] ICON is a computerized system that provides the following information regarding an offender: Past arrests, nature of current crime, prior correctional supervision, known physical or mental health issues, family history, employment history, and education information. It also includes scores of custody and classification, treatment needs, disciplinary reports, and notes about counselor contacts with the offender.

contemplating harm to self or to others. The officer should also objectively assess whether there is evidence of impaired function that could possibly be associated with alcohol and/or drugs, whether the offender is demonstrating any behavior that would suggest mental health problems and whether the offender is able to read and understand the form. Nursing staff next interviews the offender for additional information to determine whether the offender requires additional intervention by a correctional psychologist.

Health Services Review: Correctional health services performs physical, dental and vision examinations on each new admission including screens for tuberculosis (TB), Human Immunodeficiency Virus (HIV) and other diagnostic tests. Health service staff enters the test results into the offender's electronic medical record. At the time an inmate transfers to the next institution, the health record will accompany them. If staff learns the offender received treatment at any time prior to their present commitment, they will ask the offender to sign a release of information and request those records.

Each offender is assigned a correctional counselor at the time of his or her admission. The counselor interviews the offender and reviews any available documentation or computerized records. If the offender was on a supervised release program prior to trial and sentencing, ICON notes should reflect his/her cooperation with the program, any identified needs, and participation in programs or assessments during the pre-trial period.

The correction's education department administers "The Adult Basic Education" test primarily to determine reading level but also to give a sense of educational level. The Comprehensive Adult Student Assessment System is also administered. This tests how offenders apply academic knowledge in the work place and towards life skills. For offenders who appear to be low functioning, a Wexler Adult Intelligence Scale – 3 may be administered.

The Minnesota Multiphasic Personality Inventory (MMPI) is more commonly administered, at the counselor's request, to offenders with a known history of mental health problems. The counselor may also request the MMPI based solely upon interviews.

The counselor prepares a reception report which includes:

- Synopsis of current offense(s)
- Review of offender's criminal & social history
- Summary of offender's adjustment to the IMCC reception program
- Highlight of potential problem areas
- Staff recommendations for suggested programming, custody rating, and institutional assignment.

The reception report includes the PSI and IMCC psychological assessment when available. The Classification Committee reviews information provided by the counselor and determines the appropriate security level, treatment programs, and housing assignments for each offender.

Placement and Treatment Programs

The Clinical Care Unit (CCU) at ISP was designed and built as the result of the decision in a federal court case, *Goff v. Harper* 60 F.3d 518, 520 (8th Cir. 1995). Inmates challenged the extended, segregated cell confinements, the general environment in the cell blocks, small cell sizes, and lack of mental health care, exercise and educational opportunities. In 1997, U.S District Court Judge Donald O'Brien ordered officials to develop a plan to remedy these problems; the plan included creating a higher security level "special needs" program at ISP. This is a program for men only.

Upon referral by staff, a mental health team assesses an offender's mental health needs. This team determines whether the offender is appropriate for CCU. The offender must have a major diagnosis of Psychotic Disorder, Bi-Polar, Major Depression or other major psychiatric diagnosis. CCU met its capacity of 200 inmates/patients in late 2003. There have been two suicides at this facility since it opened. Other correctional institutions in the state have special needs units for male offenders.[14]

DOC is constructing a new unit at IMCC; however, its defined mission is undecided. DOC is trying to determine how best to utilize this 170-bed facility. The DOC Medical Director stated the potential uses for the new unit may include, but not limited to:

- A health services unit
- Long-term health care unit for offenders
- Post-surgical recovery unit
- Offenders requiring specialized care at the University of Iowa Hospitals and Clinics. Examples include dialysis and chemotherapy.

Offenders may be moved to this unit if they cannot safely be removed from the Suicide and Self Injurious Protection (SSIP) status within 48-72 hours.

The IMCC also needs to make some alterations in the patient program, a 24-bed unit for court ordered-evaluations and offenders whose mental illness requires intervention that is not available at their current facility. Currently, DOC houses accused and convicted male and female patients within this same unit.

For the seriously mentally ill female offender in Iowa, there are few choices within the institutional structure. Special needs female offenders can be housed at either the Mount Pleasant Correctional Facility (MPCF) or Unit Six at ICIW, depending upon their behavior

[14] Special needs can incorporate other attributes such as immaturity, social inadequacy, intellectually limited, youthful, or unable to cope with general population for other reasons. The acute special needs are those whose behavior may present a threat to themselves or others.

Opened in April 1999, the women's unit is located in the mental health building on the Mount Pleasant campus. This 96 bed special needs unit works with offenders who are mentally disabled, socially inadequate, borderline intellectual functioning, medically limited and physically challenged. The unit also provides programs to help the offender transition back into the community.

ICIW has an eight-bed unit, Unit Six, for special needs offenders. It is designed for the acute special needs offender and those with serious mental health diagnoses, particularly those experiencing serious problems. The correctional manager for Unit Six stated this unit houses women diagnosed with bi-polar, schizophrenia, and/or depression. This unit can also be used for offenders having an emotional crisis or for "time out" purposes. Once the offender believes the crisis has passed, they can request a transfer back to their originating unit.

Summary of Offenders and Incidents

Within Iowa's correctional facilities, there are documented incidents of mutilation, serious self-injury, attempted suicides, and deaths. Included in this section are the incidents surrounding particular offenders' injuries or deaths which serve as the foundation of this report.

Warren Mundy

At the time of his death on April 13, 2003, Warren Mundy was thirty-three years of age. Sentenced to serve twenty-five years for prohibited acts/contraband, the DOC classified him to ASP, a maximum secure facility. According to DOC records, he displayed [redacted][2][3]

According to his ASP counselor's personal notes, [redacted]

[redacted]

Prior to his final incarceration, Mundy was held at the [redacted] on two separate occasions. [redacted][4]

[redacted]

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[15] [redacted]

[redacted][5]

Between the dates of March 7, 2002 and August 12, 2002, [redacted][6]

[redacted]

A July 18, 2002 jail nursing note states [redacted][7]

[redacted][8]

ICON entries also reveal Mundy voluntarily cancelled more than one [redacted] appointment. Because of Mundy's comments, like the March 28, 2002 conversation documented above, staff made frequent ICON entries instructing Mundy to keep his [redacted] appointments and obtain his previously ordered medication, [redacted]. ICON notes indicate he did neither.

When he was committed on August 12, 2002 for his last offense, Mundy reported [redacted] but could not recall any specific diagnosis. A September 5, 2002 appointment [redacted] notes the following:

[redacted]

[redacted]

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[16] [redacted]

[17] [redacted]

[redacted]

In the months between his commitment and death, Mundy alternated placements between general population and protective custody. On Saturday, April 12, 2003, he began punching his cell wall and reporting problems with an offender housed in an adjacent cell. A behavior log indicates his hands were black and blue in color and swollen.

After the Shift Captain spoke with Mundy, he decided to transfer Mundy from Living Unit A (LUA) to the infirmary. LUA is an area used for administrative segregation purposes; compared to general population, it provides a more secure atmosphere with increased observations. Staff incident notes describe him as tearful. The Shift Captain recorded Mundy admitted to previous attempts at hanging himself.

The Shift Captain further ordered that staff place Mundy in a mental health observation status with observations occurring [redacted]. This observation requires correctional staff to visualize and document an offender's location within the cell and posture [redacted].[10] Staff provided him with an anti-suicide smock and blanket[18] which he later, at different times, wrapped around his neck. He complied when staff asked him to surrender these items.

At 2:00 a.m. on April 13, 2003, correctional staff observed Mundy pacing in his cell and banging on his cell door. An incident report states Mundy told staff he was having delusional thoughts. Observation notes indicate he may not have slept at all. Sometime after 10:00 a.m. this same day, an officer observed Mundy repeatedly running and hitting his head into the wall. He refused to stop after repeated requests by the infirmary officer. Incident reports state the nurse was also present with the infirmary officer and attempted to "calm" Mundy.

Infirmary staff notified the Shift Captain, who ordered additional security staff to the area, including a staff member to videotape the cell entry. Correctional staff donned protective suits due to the accumulated and splattered blood on the cell walls, cell floor, and on Mundy's body. They entered his cell approximately at 10:30 a.m.

Incident notes indicate Mundy continued to resist the application of restraints. Correctional staff involved in the restraint process told the Ombudsman that Mundy continued to "hit his head on the floor," and would "rear up growling like an animal" and officers' use of the [redacted][19] [11] appeared to agitate him further. The following

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[18] The suicide blanket and smock are made of a heavy, quilted fabric blanket; the thickness of which makes it more difficult for a high-risk offender to tie into knots.

[19] [redacted]

excerpts taken from correctional staffs' incident reports describe the difficulty they encountered in restraining Mundy.

> He was on his belly and would not get cuffed. Mundy was kicking and yelling and hitting his head.
>
> The ofc's were not able to get any cuffs on him because the Blood on his body made it hard to control him.
>
> Mundy was struggling trying to get away and due to the large amount of blood on the inmates body and floor staff had a hard time holding on his arms and legs. Staff rolled the inmate on his belly while trying to maintain control of our footing as the floor was very slick with blood.

Reports further describe Mundy as having "super strength." They describe the difficulty in cuffing his ankles together and bringing his arms together behind his back to apply the wrist cuffs. An interoffice memo to the warden, prepared by the deputy warden and associate warden for security, describe staff as "tiring rapidly and the inmate was still not restrained." The Shift Captain ordered a "code red" to summon additional staff.

Because of this delay in restraining him, Mundy remained in a prone position (face down on stomach) for approximately twenty minutes before he ceased struggling. At 10:55, one officer noted shallow breathing. A nurse confirmed [redacted][12] Officers' incident reports state staff called for an ambulance. Control Center notes the ambulance arriving at 11:03 and leaving at 11:30. The nurse's notes indicate a nurse continued CPR en route to Jones Regional Medical Center. An emergency room physician later officially pronounced Mundy's death.

On April 23, 2003, the Polk County Medical Examiner concluded in his autopsy report: ".....It is my opinion that Warren James Mundy.....died as the result of a cardiac arrest while being restrained.....During the ensuing struggle to restrain him, the decedent became unconscious..." Mundy's toxicology report showed ethyl alcohol in his plasma and urine.

Michael Madigan

At the time of his death on May 3, 2003, Michael Madigan was a forty-five year old male confined at ISP and required to serve 8.5 years of a 10-year sentence for robbery in the second degree. [redacted][13] His file reflects numerous incidents of self-injurious behavior (eye gouging, possible ingestion of bleach, non-specific injury to his chest) and an unsuccessful attempt at hanging himself. [redacted]

[redacted][14]

On February 27, 2003, Madigan reported he was unable to sleep and was hearing noises from the vents. On March 21, 2003, correctional staff placed him in a strip cell status with a suicide blanket. Health notes stated [redacted][15]

Reports indicate Madigan was last observed moving on May 3, 2003 around 5:50 a.m. He got out of his bed and used the toilet.

The Ombudsman observed, during the viewing of the security time lapsed videotape (not fluid movement with segments of time absent), that Madigan apparently removed his underwear and covered himself with his suicide blanket. The tape briefly shows an exposed buttock without underclothing. Around 6:00 a.m., the videotape reveals something white near Madigan's head. At 6:01 a.m. Madigan's left leg moved partially off the bed into view. His right leg remained on the bed but later it became exposed as it straightened. At 6:02 a.m., no further movement observed.

At 7:51 a.m., the officer working the main control center requested officers perform a cell check on Madigan. Three officers entered the cell and one officer may have removed the underwear from Madigan's mouth. This act is not visible on the tape, but the underwear appeared on the floor and then it was moved aside. The three officers left and four returned a few moments later with a nurse. An officer and nurse initiated CPR with another nurse joining them. Ten minutes later an officer brought in the Auto External Defibrillator. They resumed CPR with the ambulance crew arriving at approximately 8:20 a.m. The Emergency Medical Staff (EMS) attempted intubation (placing a breathing tube into a person's throat) but Madigan's airway remained blocked with hair and toilet paper. EMS removed these objects and successfully intubated him. EMS transported Madigan to the Fort Madison Hospital approximately at 8:40 a.m. with an emergency room physician officially pronouncing his death at 8:54 a.m.

The Lee County Medical Examiner performed the autopsy and determined the cause of death to be "asphyxia due to obstruction of upper airways with foreign body material (toilet paper and underwear). The manner of death is suicide."

Shayne Eggen

Shayne Eggen is a forty-year-old female sentenced to concurrent ten-year terms for arson in the first degree, going armed with intent and assault with a weapon. Her tentative discharge date is April 1, 2005. She is presently incarcerated at IMCC, but during her sentences has spent time at ICIW with temporary releases to the hospital. [redacted]

[redacted][16] Eggen has been civilly committed since 2000 and received care at the [redacted] prior to this correctional commitment. [redacted][17]

Eggen's history is [redacted][18] possibly beginning as early as age thirteen. At that time, due to disruptive behavior, [redacted][19] Due to her out of home placement, she went through several institutional and group home placements.

During her incarcerations, both in jail and prison, she gouged out both eyes, chewed off a portion of her finger that also resulted in the loss of three teeth, and burrowed an opening in her cheek which resulted in a severe infection. She alternates between Administrative Segregation and SSIP status. The Ombudsman included Eggen in this report due to her [redacted][20] and self-injurious behavior. Prior to the creation of the Task Force, Eggen had seriously injured her left eye resulting in complete blindness. After the Task Force's inception, it became aware of other self-injurious incidences as described below.

On December 21, 2002, while in the administrative segregation unit, a correctional officer watching security monitors noticed Eggen touching her left eye. She removed the right eye during a Winneshiek County Jail stay. A correctional officer verbally intervened but these attempts were unsuccessful and Eggen continued to pull out her eye. Correctional staff followed the chain of command sequence and assembled a team to enter her cell. Time lapse between first noticing her behavior and actual cell entry was twenty-three minutes. Even though this entry appeared delayed, the correctional officer assessing Eggen's condition and speaking with her stated the eye removal was immediate. The correctional officer described the incident as Eggen "all of a sudden shoved her finger up to the knuckle into her eye socket."

DOC documents record Eggen continually manipulating the eye by pulling it out and pushing it back into the socket. Incident reports further describe Eggen as combative, refusing all requests and orders to stop, and refusing the restraint process. [redacted][21]

On June 2, 2003, describing another incident, a nurse encounter note states:

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[20] [redacted]

[redacted][22]

Administrative staff transferred her to IMCC but she returned to Mitchellville within 10 days. On October 20, 2003, she tied a robe belt around her neck requiring guards to cut it with an emergency knife. Nursing notes indicate [redacted][23]

An October 22, 2003 2:15 p.m. nursing document indicates [redacted][24] The Ombudsman spoke with this nurse, who further stated the area was red and approximately the size of a dime and did not have any apparent swelling.

An October 22, 2003 5:33 p.m. nursing documentation states that [redacted][25]

While the CERT assembled, security staff observed Eggen applying vaginal secretions and fecal material into her cheek wound. After staff restrained her, a physical assessment revealed that Eggen was also biting the inside of her cheek.

The Ombudsman reviewed the removal videotape and noted the right side of Eggen's face was extremely swollen, so much so that her right eye was swollen shut. One October 22, 2003 incident report, completed by an ICIW counselor, specifically stated it took medical staff 90 minutes to respond to her first request for nursing staff to assess Eggen's condition.

The CERT placed Eggen in four point restraints around 5:55 p.m. Correctional officers in Unit Six closely monitored her condition and increased swelling of her right facial area. [redacted][26]

After her release from Broadlawns the next day, correctional staff transported her to the University of Iowa Hospitals and Clinics for [redacted]

[redacted][21][redacted][27]

DOC initially reported to the Ombudsman that Eggen was scratching at her face. The videotape of her restraint communicated a different story. The Ombudsman observed Eggen's face to be extremely swollen with this inflammation extending to her right eye. Her speech appeared slightly slurred.

In speaking with medical staff, this incident began as a red mark on Eggen's face. The second shift nurse recalls being paged, either by Unit Six staff or by health services, to the unit in response to a scratch on Eggen's face. He completed his outside rounds before returning to health services to review Eggen's medication orders. The Shift Captain hesitated in initiating 4-point restraints, absent a medical order, since he "only noted a red mark" on Eggen's right cheek. A Unit Six counselor expressed great concern in the delay of correctional and medical staff in responding to her request for immediate action to prevent Eggen from causing further self-injury.
A Unit Six correctional officer, also a CERT member, stated to the Ombudsman that correctional staff were always "doing something" in preparing for the cell entry. Staff was speaking with Eggen and assembling a team. He reviewed the extraction film and expressed surprise that her face appeared so swollen. He states he didn't recall her face being that large and also recalls the swelling didn't take place until the last hour of their intervention. During the debriefing on this incident and according to the ICIW Deputy Warden, the Unit Six counselor expressed displeasure with medical staff and placed the full blame of Eggen's injuries on this department.

Other issues identified were differences of opinion on whether medical staff needed to be present prior to CERT members entering an offender's cell and whether gathering the CERT was even needed in all cases. Two medical staff stated they felt a few staff members could enter Eggen's cell and this would decrease delay time in gathering the CERT. A nurse opined that he along with two other male security staff could safely restrain Eggen. The other medical person who questioned the efficiency of always gathering the CERT admitted they would not enter a cell to assist in the restraint of an offender.

[redacted][28] Having much experience with Eggen, they described her enhanced strength during stressful times and her history of serious assaults against others. They further stated they waited for health services to arrive before entering her cell on one incident and thought nursing staff must be present.

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[21] [redacted]

The Ombudsman raised these differing opinions with the ICIW Warden and Deputy Warden and asked specifically what their policy was. [redacted].[29] The Ombudsman suggested the Warden and Deputy Warden address this issue with staff.

Eggen's has not always directed the destructive behavior at herself. She assaulted staff in April 2003 and assaulted another special needs offender in June 2003. When asked why she did it, she responded that she didn't know because she liked the other person. She frequently comments to those who talk with her that if people really cared, they would not let her do this to herself.

An IMCC psychiatrist favors [redacted].[30]

According to the DOC medical director, Eggen continues to display behavior requiring staff to use [redacted] and [redacted][22] to prevent attempts of self-harm.[31]

When discussing debriefing with ICIW's Warden and Deputy Warden, they stated the CERT immediately debriefs after every encounter. The Ombudsman suggested they tape the debriefing and offer debriefing opportunities to other staff as well.

Leslie Brinson

At time of his death on August 17, 2002, twenty-year-old Leslie Brinson was serving three-10 year sentences for theft in the first degree. He was confined at ASP and had served a little over a year when he died.

[redacted][32]

[redacted]

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[22] [redacted]

[redacted]

On April 4, 2001, an IMCC nurse completed the reception health history. [redacted] However, the nurse did mark areas for [redacted] This document further listed his parents and siblings [redacted][33] [redacted][34]

Brinson spent the majority of his incarceration in a special needs administrative segregation status or disciplinary detention status. Twice he advanced to a Level status 2,[25] however was not able to maintain this for more than two to three weeks at a time.

On August 15, 2002, Brinson did not respond to staff orders and stand for count. After several verbal attempts by officers to arouse Brinson, officers decided to enter his cell to perform a welfare check. [redacted][35] According to DOC incident files, officers entered the cell and one officer removed a blanket that covered Brinson. Staff notes describe Brinson as coming off the bed and "flailing" his arms with closed fists. Officers restrained him using [redacted][36]

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[23] [redacted]

[24] [redacted]

[25] Levels exist within housing units. By demonstrating good behavior, an offender can work upwards in the level system and earn certain privileges. Those privileges can include increased property allowances, commissary spending, phone access, exercise, treatment and work opportunities.

After officers applied restraints, they first transferred Brinson to the corner management cell (CMC) and later transferred him to the infirmary due to [redacted] [37] While in CMC, incident reports indicate staff turned on the exhaust fan and provided him with a washcloth [redacted] [38] A nurse assessed his physical condition and reported no injuries [redacted] [39] Officers also videotaped Brinson's transfer from CMC to the infirmary. This videotape shows Brinson ambulating with a steady gait, not displaying any combative behavior, or verbalizing any complaints.

According to DOC records, while in the infirmary, staff placed Brinson on fifteen-minute observations. On August 16, 2002, [redacted] [40]

According to the observation log, Brinson's final activity, documented by correctional staff, was taking medication on August 16, 2002 at 8:03 pm. The remainder of the observation log documents Brinson as resting quietly or sleeping.

A memorandum from a correctional supervisor reports correctional staff briefed him on August 17, 2002 at 5:20 a.m., at the beginning of his shift that Brinson was in an unusual position. An ASP nurse said from her observation outside Brinson's cell, she believed he was breathing. Her notes indicate this occurred in the early morning hours; however her documentation is not clear when this observation took place.

Another nursing note indicates [redacted] [41] [redacted] [42] even though officers observed his body as stiffened[26] and cold to the touch. When EMT'S placed Brinson on the stretcher, his body remained in the same stiffened position. The ambulance arrived at 8:55 a.m. and transported his body to the Jones County Hospital where the Jones County Medical Examiner officially pronounced him dead.

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[26] Rigor mortis can be used to help estimate time of death. The onset of rigor mortis may range from 10 minutes to several hours, depending on factors including temperature (rapid cooling of a body can inhibit rigor mortis, but it occurs upon thawing). Maximum stiffness is reached around 12-24 hours post mortem. Facial muscles are affected first, with the rigor then spreading to other parts of the body. The joints are stiff for 1-3 days, but after this time general tissue decay and leaking of lysosomal intracellular digestive enzymes will cause the muscles to relax. **Anne Marie Helmenstine, Ph.D., "What Causes Rigor Mortis, *Your Guide to HYPERLINK "http://chemistry.about.com/" Chemistry*, <http://chemistry.about.com/cs/biochemistry/a/aa061903a.htm>** (June 25, 2003)

At the request of the Jones County Medical Examiner, a pathologist employed by St. Lukes Hospital in Cedar Rapids, Iowa performed the autopsy. This pathologist found the lungs were heavy and concluded that Brinson died from pulmonary edema[27]. During the Ombudsman's telephone conversations with the pathologist, he was unable to provide the event that triggered the pulmonary edema. He first suspected Brinson died of an elevated [redacted] level. His suspicions were ruled out when Mayo Medical Laboratories (Mayo) in Rochester, Minnesota, reported "no drugs identified" in blood samples collected during the autopsy. The hospital pathologist did not question the negative results even though he included "[redacted]" on the order sheet provided to Mayo and was aware [redacted][43]

The Task Force requested additional blood and urine analysis and through the State Medical Examiner's office, coordinated with AEGIS Sciences Corporation (AEGIS), a federally certified forensic toxicology laboratory, to perform these tests. AEGIS reported high levels of Doxepin[28] and its metabolite in the blood labeled as belonging to Brinson. A urine sample yielded negative results for Doxepin. Since AEGIS does not test for [redacted], they sent a separate blood tube and a portion of the urine to a separate certified forensic laboratory, National Medical Services. NMS detected normal levels of [redacted] in the blood and urine samples labeled as belonging to Brinson.

After completing several tests of Brinson's blood and urine, there remains no conclusive evidence what actually triggered the pulmonary edema causing his death. Due to the inconsistencies of his blood and urine testing (discussed in more detail under "Autopsy" in this report) the Task Force is prepared to consider all test results and not rule out the possibility that Brinson received a large acute dose of Doxepin. [redacted][44]

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[27] Pulmonary edema involves fluid accumulation and swelling in the lungs. Pulmonary edema is usually caused by heart failure that results in increased pressure in the pulmonary (lung) veins. However, problems within the lungs themselves can also result in fluid accumulation. Pulmonary edema can be a complication of a heart attack, leaking or narrowed heart valves (mitral or aortic valves), or any disease of the heart that either results in weakening and/or stiffening of the heart muscle (cardiomyopathy). The failing heart transmits its increased pressure to the lung veins. As pressure in the lung veins rises, fluid is pushed into the air spaces (alveoli). This fluid then becomes a barrier to normal oxygen exchange, resulting in shortness of breath. Pulmonary edema can also be caused by direct lung injury from toxins including heat and poisonous gas, severe infection, or an excess of body fluid as seen in kidney failure. A.D.A.M.Inc, July 28,2002, <http://www.nlm.nih.gov/medlineplus/ency/article/000140.htm> (June 11, 2004)

Pulmonary edema can also occur in cases of drug overdoses, particularly narcotic overdoses, and in cases of drowning. Bernard Knight, *Death From Narcotic and Hallucinogenic Drugs*, Forensic Pathology, Oxford University Press, New York (1991), pp. 367-369, 520-522.

[28] According to the 2004 *Physician's Desk Reference*, Doxepin is a tricyclic antidepressant. "Signs and symptoms of toxicity develop rapidly and critical manifestations of overdose included: cardiac dysrhythmias, severe hypotension, convulsions, and CNS depression, including coma." Outward physical signs of overdose "may include: confusion, disturbed concentration, transient visual hallucinations, dilated pupils, agitation, hyperactive reflexes, stupor, drowsiness, muscle rigidity, vomiting, hypothermia and hyperpyrexia" p. 2637

After conferring with a forensic toxicologist and providing him with information relating to weight, height, source of blood sample, and the levels of Doxepin found in Brinson's blood -1940 nanograms per milliliter (reference levels 150-250 ng/ml) - he estimated that Brinson needed to consume 2.3 grams (2300 milligrams) of Doxepin to reach the level found in a blood specimen marked as belonging to Brinson.

Since the highest available dose of Doxepin is equivalent to 150 milligrams, it can be estimated an individual would need to ingest at least 15 capsules to account for the level found in Brinson's blood. According to ASP nursing supervisor, this institution utilized Doxepin in 50 milligram and 100 milligram doses. The forensic toxicologist further surmised the consumption was an acute dose (a one time rapid dose) since testing revealed a negative Doxepin level in Brinson's urine specimen. This possibly means the drug was not in his system long enough to filter through his kidneys and into his bladder.

Assuming Brinson ingested Doxepin, there is no explanation as to how Brinson might have obtained the drug. Staff moved him twice in the days just prior to his death and by DOC policy; [redacted][45] Little personal property accompanied him on each move. After interviewing DOC medical staff, ASP utilizes security staff in distributing medications, both controlled and non-controlled substances, to offenders located in administrative segregation status (LUA, D-3) and disciplinary detention (DD).

After further inquiry, the Ombudsman determined a DOC physician prescribed Doxepin to four other offenders held at ASP during Brinson's incarceration. During Brinson's time in LUA, D3 and DD, ASP held up to two other offenders prescribed Doxepin in areas that utilized security staff dispensation. This information further revealed the proximity of Brinson to the offenders prescribed Doxepin was not close. The other offenders were housed either in a different building or on a different floor within the same segregated area as Brinson. Because of the distance between Brinson and other offenders prescribed Doxepin, the Ombudsman is inclined to rule out potential drug sharing activity between offenders.

As stated earlier, [redacted][46] According to an internet medication resource, "the plasma concentrations of [redacted] gradually rise, reaching a peak at about six days after the injection, and falling thereafter, with an apparent half-life of about three weeks."[29] [redacted] on August 15th and 16th, one and two days prior to his death. His medication record also indicates he received a [redacted][47] on August 17, 2002, at 8:00 p.m., approximately nine hours after a physician pronounced his death. The

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[29] [redacted]

Ombudsman's informed the ASP nursing supervisor of this error and he stated he should have corrected the record upon his review.

The outcome of the Task Force's multiple testing performed on Brinson's blood and urine samples resulted in one positive serum test for [redacted] and Doxepin, with three other tests for these same drugs resulting in zero levels found. Two urine tests were positive for [redacted] - the initial urine testing by NMS and confirmation testing performed by Medtox. Due to the gradual peak and half-life of [redacted],[48] all testing for this medication in his blood and urine should have measured some level within specimens marked as belonging to Brinson.

Response to Critical Incidents

Medical Intervention

Appropriate medical intervention depends in part on effective emergency policies and procedures, proper diagnosis of the offender's condition, appropriate treatment and medication, knowledge of the offender's treatment and medication status, and attentive observations of the offender's behaviors and statements.

Emergencies

The American Corrections Association (ACA) Accreditation Standards for Emergency Care (Standard 4-4351) states, "[i]n the event the usual health services are not available, particularly in emergency situations, the institution should have developed a backup to serve the program. The plan might include an alternate hospital emergency service or physician 'on call' service."[30]

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[30] *Standards for Adult Correctional Institutions*, 4th Edition, American Correctional Association, January 2003, p. 100.

Standard 4-4389 mandates a written policy, procedure and practice to provide that:

> Correctional and other personnel are trained to respond to health-related situation within a four-minute response time. The training program is established by the responsible health authority in cooperation with the facility administrator and includes the following:
>
> - recognition of signs and symptoms, and knowledge of action required in potential emergency situations
> - administration of first aid and CPR
> - method of obtaining assistance
> - signs and symptoms of mental illness, retardation, and chemical dependency
> - procedures for patient transfers to appropriate medical facilities or health care providers[31]

Standard 4-4351 also requires (for certification) a written plan for 24-hour emergency medical, dental, and mental health services availability. The plan includes the following:

- on-site emergency first aide and crisis intervention
- emergency evacuation of the offender from the facility
- use of an emergency medical vehicle
- use of one or more designated hospital emergency rooms or other appropriate health facilities emergency on-call or available 24 hours per day, physician, dentist, and mental health professional services when the emergency health facility is not located in a nearby community
- security procedures providing for the immediate transfer of offenders, when appropriate

> *Comment:* In the event that primary health services are not available, and particularly in emergency situations, back-up facilities or providers should be predetermined. The plan may include the use of an alternative hospital emergency service or a physician on-call service.[32]

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[31] Ibid., p. 117
[32] Ibid., p. 100

ASP policy INS-MH-1 Mental Health Services addresses the procedures for referrals. "Inmates in need of mental health care come to the attention of staff in many ways. Reasons to suspect the need for mental health care may include reports of unusual behavior within the institution, sudden changes in personality, referrals from the medical staff, reports from the community indicating unusual behavior, or recommendations for psychiatric attention submitted by judges, parole officers, etc. Medical staff will use the mental health clinical referral information for (HSF 82.615) and forward to the Psychologists."

The policy provides direction for screening emergency referrals.

1. A sudden or rapid change of mental state or behavior that endangers the inmate or others may indicate the need for emergency mental health services.

2. Any information regarding unusual behavior will be referred to the Counselor who should then consult with the team psychologist.

3. The counselor and team Psychologist will decide if the situation calls for psychiatric services or if it can be dealt with by the Psychologist on a more informal basis.

4. Those needing psychiatric services may be considered for :
   a. Referral to the Consulting Psychiatrist
   b. Routine referral to IMCC
   c. An emergency referral to IMCC

5. In cases where an inmate is already receiving psychiatric attention from the Consulting Psychiatrist, it may be appropriate to contact the Consultant by telephone to obtain recommendations. This should be done by the team Psychologist. In the absence of both Psychologists,[33] it would be done from the Counselor after consulting with the Treatment Team leader.

6. If immediate psychiatric attention is needed, the team Psychologist should consult with the Treatment Team leader and then telephone IMCC to request assistance or recommendations.

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[33] ASP policy requires that ASP have two psychologists on staff.

7. If immediate transfer is required, the Psychologist should contact the Records Administrator or the Associate Warden – Security to make arrangements for appropriate transportation and escort and to make suggestions for dealing with the inmate until he is admitted to IMCC.

[redacted] when reviewed during the reception phase, Mundy exhibited some of the critical signs he was at risk of self-injury or harm the day before his death. He admitted he tried to hang himself with his blanket before he was placed in SSIP status. He was crying, described as incoherent at times, and talking to himself. Security staff called [redacted] at home and reported Mundy's behavior; [redacted] said he would see Mundy "the following day."[49]

Observation

In cases such as Mundy's, it would have been valuable to have a psychologist or psychiatrist immediately observe him. At the time of this incident, no psychologist was on call or available within the institution. The process as defined by the policy does not provide for nighttime or weekend coverage.

The Task Force believes DOC needs to provide 24/7 access to emergency mental health care. This could be accomplished by hiring an additional psychiatrist and/or working with the Iowa Department of Human Services (DHS), to share psychological/psychiatric services from the mental health institutions. (The Task Force did not contact DHS to determine the feasibility of this option.) In order to facilitate actual observation, the Task Force believes DOC should purchase portable telemedicine terminals. This arrangement could provide for emergency intervention during other than normal business hours. If this is not practicable, the DOC should develop a back up plan for the evaluation of offenders at risk during other than normal business hours.

As a part of the United States Bureau of Prisons Policy on Suicide Prevention (P.S. 5324.03), one section provides for inmate companions.

> Companions shall be selected based upon their ability to perform the specific task but also for their reputation within the institution....
>
> Each companion shall receive at least four hours of training before assuming a suicide watch and shall also receive at least 4 hours of training semiannually. Each training session shall review policy requirement and instruct the inmates on their duties and responsibilities during a suicide watch, including:
>
> - The location of suicide watch areas
> - Summoning of staff during all shifts

- The locations of staff offices
- Recognizing behavioral signs of stress or agitation
- Recording observations in the suicide watch log

A companion policy is in place at the following DOC institutions: IMCC, ICIW and the Fort Dodge Correctional Facility. This policy provides another set of eyes to assist in observing offenders during a suicide watch. Unlike officers, the inmates have no other duties.

The Ombudsman visited ASP and toured the infirmary area that, at different times, housed Brinson and Mundy. The Ombudsman became concerned with the nursing assessment of Brinson's condition. A nurse assessed Brinson on August 16, 2002 at 11:00 p.m. and noted [redacted][50] The Ombudsman inspected Brinson's infirmary room. Incident reports indicate the ASP nurse performed a visual assessment from outside the cell.[51] The Ombudsman estimated the distance of the nurse from Brinson's body was thirty to forty feet. The observation window used to assess Brinson's physical condition was approximately fourteen inches in length and six inches in height with a slight tint to the glass.

The ASP nursing supervisor and DOC medical director also had concerns with the nurse's assessment of Brinson and reiterated the importance of "hands on physical assessments" instead of distant observations.

Diagnosis

In order to properly diagnose and treat offenders, it is important to obtain and consider all relevant medical information.

In the case of Mundy, there are some differences of opinions in his diagnostic history. At the time of his return to prison in 2002, Mundy reported to DOC staff [redacted], but he was unable to recall the specific diagnosis. He told nursing staff during reception he was on [redacted][52][53]

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[34] [redacted]

[redacted]

[redacted]

Mundy's DOC counselor later referred him to the [redacted] in January 2003. The counselor reviewed his written notes and informed the Ombudsman he referred Mundy to [redacted] because Mundy was [redacted] Mundy further elaborated that he felt other inmates were talking about him, that other inmates did not like him, and that they considered him a snitch. After the January 2003 appointment, [redacted]

[redacted][34]

DOC HSP 615 Mental Health Services Procedure states "[r]eception psychological screening facilitates the initial identification of inmates with mental health impairment. Subsequent to reception screening, institutional professional staff may determine that an inmate should be

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[35] [redacted]

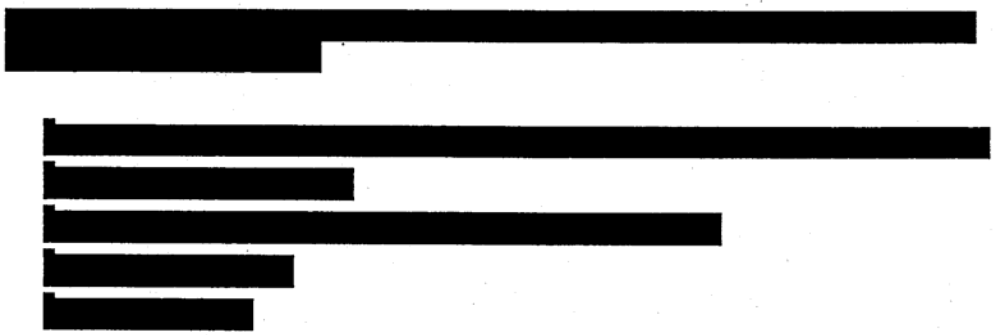
[36] Ibid., p. 686

[37] Ibid.

[38] [redacted]

identified as having a mental disorder. This determination would be confirmed by a psychiatrist or psychologist and....

> [a] DOC employed psychiatrist or a psychologist may determine that a finding of mental disorder no longer applies for a particular inmate. Under these circumstances, a psychiatrist or psychologist must document the basis for this determination in the inmate's record.



According to the DSM-IV-TR, schizophrenia and other psychotic disorders "are grouped together to facilitate the differential diagnosis of disorders that include *psychotic symptoms* as a prominent aspect of their presentation."[39]

"In Schizophrenia, Schizophreniform Disorder, Schizoaffective Disorder, and Brief Psychotic Disorder, *psychotic* refers to delusions, any prominent hallucinations, disorganized speech, or disorganized or catatonic behavior. In Psychotic Disorder Due to a General Medical Condition and in Substance-Induced Psychotic Disorder, *psychotic* refers to delusions or only those hallucinations that are not accompanied by insight. In Delusional Disorder and Shared Psychotic Disorder, *psychotic* is equivalent to delusional."[40] (*Emphasis added*) The key components of "Psychotic Disorder Not Otherwise Specified" are:

- Postpartum psychosis that does not meet criteria for Mood Disorder With Psychotic Features, Brief Psychotic Disorder, Psychotic Disorder Due to a General Medical Condition, or Substance-Induced Psychotic Disorder.

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[39] DSM-IV-TR 2000 Revised Edition, p. 297

[40] Ibid., p. 297-298

- Psychotic symptoms that have lasted for less than one month but that have not yet remitted, so that criteria for Brief Psychotic Disorder are not met.

- Persistent auditory hallucinations in the absence of any other features.

- Persistent nonbizzarre delusions with periods of overlapping mood episodes that have been present for a substantial portion of the delusional disturbance.

- Situations in which the clinician has concluded that a Psychotic Disorder is present, but is unable to determine whether it is primary, due to a general medical condition, or substance induced.[41]

The DSM-IV-TR further clarifies mood episodes as "psychotic symptoms that occur exclusively during a full Major Depressive, Manic, Mixed Episode and Hypomanic Episode."[42] [redacted]

Medications

[redacted]

[41] Ibid., p. 343

[42] Ibid., p. 345

[redacted]

[redacted][55] according to the Physician's Desk Reference:

> Zyprexa is not a controlled substance. In studies prospectively designed to assess abuse and dependence potential, Zyprexa was shown to have acute depressive CNS effects but little or no potential of abuse or physical dependence in rats administered oral doses up to 15 times the maximum recommended human daily dose and rhesus monkeys administered oral doses up to 8 times the maximum recommended human daily dose.
>
> Zyprexa has not been systematically studied in humans for its potential for abuse, tolerance or physical dependence. While the clinical trials did not reveal any tendency for any drug-seeking behavior, these observations were not systematic, and it is not possible to predict on the basis of this limited experience the extent to which a CNS-active drug will be misused, diverted, or/or abused once marketed. Consequently, patients should be evaluated carefully for a history of drug abuse, and such patients should be observed closely for signs of misuse or abuse of Zyprexa. The signs of abuse include development of tolerance, increase in dose, drug-seeking behavior.[45]
>
> Frequent adverse effects for the central nervous system include abnormal dreams, emotional lability, euphoria, libido decreased, paresthesia, and schizophrenic reaction.[46]

[redacted][56]

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[43] [redacted]

[44] Ibid.

[45] *Physicians Desk Reference*, p. 1861

[46] Ibid.

Through years of handling correctional complaints and gathering information, the Ombudsman observed it is not unusual for mental health staff working in corrections to believe an inmate is "med seeking" or "malingering."

> Malingering, the fabrication or exaggeration of psychiatric symptoms for secondary gain, certainly occurs in prison. There is a strong desire to escape from culpability or win placement in a more tolerable setting. The clinician must be aware of this possibility so that scarce mental health resources will not be squandered on prisoners who are not suffering from any significant psychiatric disorder. On the other hand, over-utilization of such attributions as "malingering" or "no diagnosis on Axis I" by frustrated clinicians masks the presence of serious mental illness. The unfortunate result is under-diagnosis, which can lead to unfair punishment of prisoners whose unacceptable behaviors are actually driven by their mental illness. Of course, the ultimate tragedy is when over-concern about malingering leads mental health staff to miss what would otherwise be clear signs of an impending suicide....[47]

> But when the staff decides that a prisoner is "malingering," his or her subsequent complaints about psychiatric problems and suicidal inclinations are not taken seriously.[48]

> After grappling with this problems for years, and meeting many well-meaning and quite competent correctional psychologists and psychiatrists who diagnose malingering and no mental illness in prisoners who clearly exhibit indisputable serious mental illness, I have concluded that an unfortunate combination of stigma, mental health staff trying too hard to fit in with the culture of security, relatively insufficient mental health resources, and burn-out are the underpinnings of the widespread under-diagnosing.[49]

Contributing factors may include cost of medication, lack of resources, insufficient information, staff burnout, or lack of sufficient staff to provide satisfactory treatment. If the offender is not exhibiting symptoms at the time of the interview, they may be seen as malingering. They are not considered "mad," but simply "bad."

> The problem is magnified in corrections today to think about badness and madness in terms of *either/or* dichotomies rather than *both/and* complexities. Are the prisoner's unacceptable acts the result of mental illness or merely reflections of his badness or antisocial personality? If the prisoner is BAD, he deserves punishment. If he is MAD,

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[47] Kupers, p. 81.

[48] Ibid., p. 82

[49] Ibid., p. 95

for example, truly suicidal or hearing voices commanding him to carry out illegal acts, he needs more intensive treatment, and there is some degree of mitigation for his bad acts.[50]

In 1991, the Ombudsman began an investigation into the use of chemical agents on offender Craig Gardner during a forced cell move. In 1994, the Ombudsman issued Critical Report 94-1 (delay due to legal battle over release of videotape copy to the Ombudsman's office). As that investigation progressed, the Ombudsman learned a previous medical director removed Gardner from his psychotropic medication he had used for six years. This same medical director dismissed other physicians' diagnosis of bi-polar since he believed "no psychiatric disorder is permanent; the belief these disorders are permanent is a simplistic approach not supported by data." This same medical director further believed Gardner was simply trying to deny responsibility for his actions with his claim and removed him from his psychotropic medication, Haldol. The current medical director does not subscribe to the same philosophy.

Documentation

As stated previously, a DOC [redacted] Leslie Brinson [redacted]. After his death, officers entered his cell and one officer found a tablet on the floor. The Shift Captain or responding officer did not document if, and or how, he preserved this tablet. After speaking with the ASP Nursing Supervisor, he informed the Ombudsman's office a death file existed in the Warden's office. The DOC Medical Director, through a chain of custody, brought the pill to a Task Force meeting. Members of the Task Force identified the pill inscription and after providing this information to a local pharmacist, he identified the pill as [redacted].

[redacted][57]

After touring ASP's medical department and specifically questioning pill dispensing practices, the Ombudsman became concerned with the minimal charting requirements of officers who dispense medications to the segregated areas. The ASP Nursing Supervisor stated the third shift nurse prepares the medication box for the assigned pill officer's use. After placing the blister pack and/or single dose medication in the medication box, this nurse initials the medication sheet giving the appearance the medication was already dispensed.

According to the ASP Nursing Supervisor, "[t]he 3rd shift nurse reviews all the medication administration records of offenders in segregation. Officers take offenders' medication to the unit in a locked carrying case which has been prepared by nursing staff. Nursing staff completes

[50] Ibid., p. 82.

a "Segregation Medication Administration" form to verify the medication card is labeled with the offender's correct name, offender number, correct medication, dose, route, and administration time. The nurse documents this on the medication administration profile and makes appropriate changes the following evening when she reviews it.

Under rule 657-9.7(2)(a) of the Iowa Administrative Code (IAC), a nurse may verify the accuracy of medications placed in a "medication bin." The administrative code section also requires that "policies and procedures shall also provide for documentation identifying the individual who provides verification of medications stocked in dispensing components." In review of the ASP medication records, the third shift nurse initialed the medication followed by a signature.

The ASP Nursing Supervisor further stated, "Correctional Officers trained in medication administration are utilized for dispensing medication in segregation units and in those instances when the offender can not report to a regular scheduled pill-line. This is a safe, cost effective procedure when Health Services staffing does not allow for medical staff to manage that responsibility."

He further stated if an offender refuses a medication, nursing staff generally correct the medication sheet to reflect the refusal. In the case of Brinson, the Ombudsman discovered the medication sheet reflects this offender receiving a dose of [redacted][58] on August 17, 2002, approximately nine hours after a physician pronounced him dead. The ASP Nursing Supervisor admitted he should have corrected this error during his review of Brinson's medical file.

During a visit, the Ombudsman observed an unlabeled capsule in the medication box. When questioned about this capsule, the "pill officer" confirmed he dropped it on the floor and removed another capsule from the unit dose blister pack. However, the officer's medication flowsheet did not reflect this activity. The pill officer felt the nurse would "figure out what happened."

The Ombudsman suggested changes regarding the documentation of dispensed medications. The ASP Nursing Supervisor quickly implemented a new medication form that allows officers to check areas for offender acceptance or refusal of a medication. A comment area is available to track other drug dispensing activities such as an officer dropping a pill. The medication sheet also requires officers to include their signature and badge number for identification purposes when dispensing medication.

Suicide and Self-Injury Prevention

Iowa DOC HSP-82.604 Suicide and Self-Injury Prevention Policy (SSIPP) describes the procedure for the management of offenders who demonstrate self-destructive behavior. "An SSIPP is usually initiated by psychology staff. In their absence, an SSIPP would be initiated

jointly by on-site nursing staff and designated institution management staff. In the absence of psychology, nursing and psychiatric staff, the institution manager or his/her designee may implement an SSIPP. This emergency application of SSIPP cannot exceed 72 hours. At the earliest opportunity (next business day), psychology, nursing or psychiatry staff must assess any administratively initiated SSIP and assume, as well as document, appropriate responsibility."

Shayne Eggen gouged out her left eye on December 21, 2002. She gouged out the right eye two years prior. From the time security staff first noted she was picking at her eye and its ultimate removal, twenty-three minutes elapsed before staff entered her cell. Since this incident, in an attempt to bite of the tip of a finger, she lost 3-4 teeth. In a separate incident, she knotted a robe belt around her neck requiring security staff to cut it.

During the October 22, 2003 incident, security staff saw Eggen digging at her cheek. Nursing observed her picking at her right cheek several days before. Staff notes describe Eggen as vigorously digging at the spot and trying to poke her finger through her right cheek. A counselor's incident report stated it took 90 minutes from the time she called attention to Eggen's behavior before medical staff responded; another twenty-two minutes lapsed before security staff went in and restrained her.

The counselor, aware of Eggen's history, notified [redacted][51] [59] During the Ombudsman's interview with the [redacted], she stated unless she took this action, correctional staff would not restrain Eggen. This [redacted] further said after she completed her charting in Eggen's medical file, she informed the ICIW Warden of the incident and then left the facility. As she was leaving, she learned from the control room that staff had not restrained Eggen, and then left the building. When questioned why she didn't stay, she responded she did what she could by ordering restraints and surmised the Warden could take over if needed. The [redacted] alluded to overtime when discussing her reasons for leaving.

In speaking with the ICIW Warden and Deputy Warden, they denied knowledge of Eggen's injury to her cheek until [redacted][60] exited through the administrative building around 5:00 p.m. and informed the Warden of what occurred. The Warden denied she or the Deputy Warden supervise every security incident—that is the duty of correctional staff and the CERT team. The Warden told the Ombudsman that, given Eggen's past self-injurious behavior, she probably should have inquired more about the incident before leaving the institution. However, she said she was told Eggen was "scratching" her face and she was not informed of the severity of the scratch. After she reviewed the cell extraction tape, she became very concerned regarding Eggen's injuries and questioned why she did not receive a more detailed report.

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[51] DOC policy SE-IV-30 defines four point restraints as "restraint of both the wrists and ankles requiring authorization by the Warden/Superintendent or designee when determined [redacted].

De-Escalation

Attempts at verbal de-escalation should be the first step in many non-emergency uses of force situations. The main objective of this technique is to reduce the level of aggression or violent behavior with the goal of preventing the individual from causing harm to themselves or others.

De-escalation is often useful in dealing with mentally ill, agitated, frustrated, angry or intoxicated people. The main objective in using de-escalation is to "reduce the level of arousal so that discussion becomes possible."[52]

De-escalation has three important facets and consists of non-verbal cues, non-verbal behavior and verbal communications.

- Non-verbal cues accounts for 65 percent of an individual's message and consists of body language.This aspect of communication is as important as what a person says.
- Verbal communication accounts for 35 percent of an individual's message and includes pitch and loudness of a person's voice as well as the speed of their speech.
- The remaining important facet of communication is what a person actually says.[53]

If a person speaks in a low tone of voice, but simultaneously clenches their fists, they are sending a mixed message. The goal is to calm the person and stop the behavior.

Other suggestions include:

- Remain calm. Maintain eye contact.
- Maintain a neutral facial expression.
- Keep a relaxed and alert posture. Stand up straight, generally at an angle to the individual. Do not cross your arms in front of you or rest your hands on your cuffs, mace, or other potential weapons.
- Listen. Do not argue or interrupt. Wait for a pause before calmly saying something like "I understand you are upset."
- In some cases, distracting the individual is effective.
- Re-focus the individual on something positive and/or neutral such as the time and weather.
- Clear up misunderstanding and respond to valid complaints.
- Trust your instincts. If these suggestions are not working, consider moving to the next level[54] (cell extraction, use of force).

The Task Force believes DOC should incorporate these techniques or something similar into their Use of Force and the Cell Extraction policies.

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[52] Ray DuGray, *Verbal De-escalation Techniques, EMS Defensive Tactics*, Texas Department of Health, Bureau of Emergency Management, August 27, 2003 <> (July 2,2004)

[53] Ibid., at <> (July 2, 2004)

[54] Ibid.

There was no institutional policy in place during the incidents previously discussed regarding de-escalation techniques. After the development of the Task Force, ICIW developed the practice of using a hostage negotiator for de-escalation purposes but they have not promulgated this practice into policy. The Task Force discussed the use of de-escalation prior to cell entry and recommends incorporation of this practice into the Use of Force and cell extraction policies.

DOC is in the process of developing an Emergency Cell Extraction policy. They provided the Ombudsman with two drafts and the opportunity to comment. The Ombudsman forwarded a copy of the policy to the Iowa Protection and Advocacy, Inc for their comments as well.

This policy appears to incorporate the basic issues the Task Force believes are important, such as de-escalation and cautions against prone restraint. DOC will provide all wardens with the opportunity to review the policy and comment as well as provide the Task Force with another opportunity to review the policy for additional comments. Once the reviews are completed, the policy will be forwarded to the DOC director for approval.

Videotaping

Videotaping use of force incidents and cell extractions is extremely important. When done properly, it provides documentation and verification of staff's actions. [redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]61

In Eggen's case, the Ombudsman believes the delayed cell entry is partially attributable to the steps practiced by correctional officers when performing a planned cell move. In both instances, the CERT team recorded their reason for the cell entry including their names and assigned roles. [redacted]

[redacted][62]

The Task Force understands the importance of recording this information but during incidents of self-injury and self-mutilation, time is critical. Faster emergency response could mean less injury to the offender. The ICIW Warden and Deputy Warden also opined that during certain cell entries, introductions and assignments could be taped during the debriefing period to fulfill the introduction requirement.

As mentioned previously in use of force, when officers intervene to stop fights between offenders, even though injury is possible, officers do not delay intervention by recording their role in the process.

The Task Force also identified problems in operating and storage of audiovisual equipment. During the filming of Mundy's cell entry, the officer responsible for the filming, did not record certain segments due to a faulty connection and/or the need to replace depleted batteries. For example, the use of the [redacted] is documented in written reports but not visible on the audiovisual tape because of a camera malfunction.[63]

DOC policy SE-IV-30 requires:

- Audiovisual recording equipment should be stored in a readily accessible location where use of force situations are prevalent. The [redacted][64] recommended as suitable locations.

- Sufficient staff members on each shift will be trained to use this equipment to provide 24-hours coverage.

- A regular maintenance/inspection process will be established to ensure the equipment is functional. Repair and/or replacement of broken equipment will receive priority consideration.[65]

Michael Madigan attempted suicide on more than one occasion. His DOC file reflects numerous incidents of self-mutilation. At the time of his death, the file notes he was compliant with medication. The file also indicates he was difficult to approach in days just prior to his death. He blocked the door with his mattress. Staff placed him in an SSIP status with video monitoring capability. Officer incident reports state Madigan's underwear was in his mouth and one responding officer removed them from Madigan's mouth.

The Ombudsman toured the CCU at ISP and examined the cell previously assigned to Madigan. Below is a list of what they found:

- The cell is located approximately eight to ten feet from the officers control area (pod).
- This cell is enclosed by clear plexiglass with steel beams.
- Madigan and his cell were easily visible by the officer located within the pod.
- This pod has three video screens and is capable of having one screen designated to this cell at all times.
- Some officers designate a video screen for this cell when occupied by an offender.
- Video recording from the pod camera is not time lapse.
- No ISP policy or expected practice exists that requires pod officers to designate one video screen to the observation cell at all times.
- The day officer who notified other officers of Madigan's situation works in the main control center for the entire institution.
- Part of this officer's responsibility is monitoring every camera within ISP.
- The officer was rotating through her routine monitoring of all cameras when she noticed Madigan lying down.
- After completing entire camera rotation and again going through the process, the officer noticed Madigan had not moved from his original position.
- This officer notified other staff to check on Madigan's condition.
- Main control records daily events.
- This recording is in time-lapse form when viewed.

Because of the time lapse recording, the Task Force makes the following observations:

- It is difficult to determine when Madigan obtained the toilet paper.
- It is difficult to ascertain exactly when Madigan removed his underwear and placed them in his mouth.
- It is difficult to ascertain whether Madigan underwent spastic and seizure type activity due to an airway obstruction.
- It is difficult to determine what the pod officer actually saw on the pod video screen.

The Task Force will not make assumptions in this case but consider it more likely than not, if the pod officer was monitoring Madigan's cell, either visually or by camera, the officer would have noted spastic type movement by Madigan after he obstructed his airway. Because this movement consists of quick jerks, it could possibly have warned the correctional officer of an existing problem. The American Heart Association generally advises seconds count when responding to cardiac and respiratory arrests.

Use of Force

In prison settings, uses of force are necessary in several instances. An offender may refuse to come to the cell door to be cuffed, but not necessarily acting out, destroying property or threatening staff, self, or other offenders. Those situations allow time to plan.

However, when an inmate is presenting an immediate threat to the safety and security of the institution, staff must be prepared to instantly use force and restore order.

The U.S. Bureau of Prisons policy describes their Immediate Use of Force as:

> Staff may immediately use force and/or apply restraint when the behavior described in section 552.20 constitutes an immediate, serious threat to the inmate, staff, other, property, or to institution security and good order.
>
> In an immediate use of force situation, staff may respond with or without the presence or direction of a supervisor.
>
> (1)Circumstances. Based on experience, calculated rather than immediate use of force is feasible in the majority of incident correction practitioners encounter. Staff must use common sense and good correctional judgment in each situation to determine where there is time for the calculated use of force.
>
> The safety of persons involved is the major concern. Obviously immediate (an unplanned) use of force by staff is required if an inmate is trying to self-inflict life-threatening injuries, or is attacking a staff member or another inmate. If those circumstances are not present, staff should ordinarily employ the principles of calculated use of force.[55]

The ACA Standard (4-4206) requires:

> Written policy, procedure, and practice restrict the use of physical force to instances of justifiable self-defense, protection of other, protection of property, prevention of escapes, and to maintain or regain control, and then only as a last resort and in accordance with appropriate statutory authority. In no event is physical force justifiable as punishment. A written report is prepared following all uses of force and is submitted to administrative staff for review.

ACA Training Standard (4-4090) for use of force requires:

> All security and custody personnel are trained in approved methods of self-defense and the use of force as a last resort to control inmates.
>
> *Comment:* All security and custody personnel should be trained in the techniques of using physical force to control and/or move inmates with minimal harm and discomfort to both staff and inmates.

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[55] Craig Hemmens, J.D., PH.D, Eugene Atherton, *Use of Force Current Practice and Policy,* American Correctional Association, 1999, p. 202.

The DOC Use of Force policy SE-IV-30 provides guidelines within which force may be used. [redacted][66]

In the Gardner case, this use of force began with the offender writing bizarre statements. Staff believed he needed to be transferred to an infirmary sideroom for observation. Gardner dismantled his bed, flooded his cell and the surrounding sideroom area. Due to his destructive behavior, officials decided to transfer Gardner to a disciplinary unit. When he refused to come to the door to be cuffed, staff emptied a 520 gram canister of Mace into the cell through the food slot. Not only was Gardner overly exposed to the Mace, many officers also became contaminated from the excessive use.

Below is a partial list of recommendations the Ombudsman made in the 1994 critical report.

- Officers routinely receive training in recognition of the onset of symptoms of mental health episodes.
- The use of force training must follow the guidelines established by the courts and DOC policy.
- Prohibit those officers authorized to use nonlethal devices from such use unless they have received training since 1991.

While the use of force issue was slightly different compared to the issues in this report, the Ombudsman recognized in 1994 a need for policy updating and additional staff training. Officers needed annual training in the use of force and in recognizing symptoms of mental illness. These needs still exist.

There seems to be a difference in philosophy when officers respond to use of force incidents. [redacted][67] During interviews of ASP correctional staff, the Ombudsman posed this use of force issue to them. Staff concurred it was the amount of blood in Mundy's cell that concerned them. Officers stated they do not see much blood, if any, during fights.

When Eggen assaulted another offender, officers intervened immediately. When she gouged her eye and then later severely injured her cheek, there was a minimum of twenty minutes before staff actually entered her cell.

Previously in this report, quoting an ACA standard, it states that correctional staff and health staff should respond to a health-related situation within four minutes. The Ombudsman's office interviewed the Shift Captain on duty during Eggen's cheek injury incident. [redacted][68]

In the four cases reviewed by the Task Force, cell entry is accomplished only after significant delays. Three of the delays were caused by donning protective clothing or videotaping the CERT team prior to a cell entry. The Ombudsman believes for situations requiring the use of protective gear, correctional staff should regularly practice its application. The Ombudsman further believes regular practice will familiarize staff with the gear, increase their efficiency in its application, and possibly decrease cell entry time.

Restraint

The Polk County Medical Examiner determined Mundy's cause of death was "asphyxiation during restraint." Once staff entered his cell and wrestled him to the floor, they maintained Mundy in a prone position. While correctional staff physically forced (their knees to Mundy's back) him to remain on his stomach, he continued to struggle and resist being restrained.

The National Law Enforcement Technology Center describes the basic physiology of a struggle.[56]

- A person is restrained in a face-down position, and breathing may become labored.
- Weight is applied to the person's back—the more weight, the more severe the degree of compression.
- The individual experiences increased difficulty in breathing.
- The natural reaction to oxygen deficiency occurs—the person struggles more violently.
- The officer applies more compression to subdue the individual.

Several articles describe positional asphyxia as restraining the individual in a prone position (lying on stomach). An article authored by California Protection and Advocacy, Inc., relied on the impressions of Werner U. Spitz M.D.[57]

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[56] U.S. Department of Justice, June 1995, pp. 1-2.

[57] Dr. Spitz is a forensic pathologist, board certified in Pathologic Anatomy and Forensic Pathology and an expert in excited delirium and positional asphyxia. This from The Lethal Hazard of Prone Restraint, Positional Asphyxiation, Protection & Advocacy, Inc., April 2002, Publication #7018.01, p. 3.

Dr. Spitz concluded that the prone restraint position was a significant contributing factor in the demise of the individuals restrained. Literature shows that sudden death during prone restraint, particularly for those in a state of agitated delirium[58], is not an uncommon phenomenon but one infrequently reported in medical literature. The mechanism of death is a sudden fatal cardiac arrhythmia or respiratory arrest due to a combination of factors causing decreased oxygen delivery at a time of increased oxygen demand.

This article further lists factors that increase a person's risk for positional asphyxia. They include:

- Position during restraint, particularly the prone position.
- Agitated delirium or excited delirium syndrome
- Obesity
- Prolonged struggle or physical exertion
- Drug and/or alcohol intoxication, in particular cocaine and methamphetamine intoxication or cocaine-induced psychosis
- Mania
- Respiratory syndromes, including asthma and bronchitis
- Exposure to pepper spray
- Pre-existing heart disease, including an enlarged heart and other cardiovascular disorders[59]

[redacted][69] The Task Force believes DOC Training Academy should provide annual training in the recognition of the onset of symptoms of mental illness, the use of force without prone restraint, protective clothing, and videotaping to all staff. Staff who works daily with the mentally ill offenders need the most immediate, frequent, and extensive training.

Scene Preservation

Policy AD-I-11 Imminent Offender Death/Offender Death (B) (5) "[i]n cases involving the DCI, the Warden/Superintendent shall ensure the scene and all related areas are secured and preserved pending release by the DCI." On the videotape, the Ombudsman observed an officer flushing the toilet upon exiting Brinson's cell after officers commented how cold and stiff Brinson's body appeared. The flushing appeared odd since officers exited the cell in single file. When this officer paused to flush the toilet, other officers backed into him.

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[58] Agitated delirium (also known as excited delirium or acute excited state) is a condition of extreme mental and motor excitement characterized by aggressive activity with confused and unconnected thoughts, hallucinations, paranoid delusions and incoherent or meaningless speech. Victims display extraordinary strength and endurance while struggling, apparently without fatigue. Ibid., p. 7.

[59] The Lethal Hazard of Prone Restraint, pp. 5-7.

There is nothing in the incident reports reflecting why the officer flushed the toilet. When the Ombudsman asked the officer months later why he did this, he did not remember flushing it or if any matter was present in the toilet water.

In light of the difficulty in determining what medications Brinson potentially consumed, the contents of the toilet become increasingly important. The inmate death policy should be expanded to include scene preservation and all officers should be trained accordingly. No evidence should be altered or removed except by the investigator(s). ASP has a policy on Collection and Preservation of Evidence (SEC-SI-3). This policy however, only addresses handling potential criminal evidence.

An article in the CORRECTIONS MANAGERS' Report, Volume VIII, NO. 3 October/November 2002, titled In-Custody Death Investigation, authored by Ken Wallentine, suggests separate investigations - generally at least two and in some cases three conducted independently, each with its own objectives.

1. First and foremost, the law enforcement agency with appropriate jurisdiction must thoroughly investigate each in-custody death to determine if the case involves criminal responsibility. Deaths which appear to be incontrovertibly natural might later be ruled homicides following the autopsy, which is virtually mandatory in some jurisdictions for an in-custody death.

2. The second mandatory is conducted as preparation for the inevitable civil suit. This investigation should involve corrections managers, legal counsel and risk management staff.

3. A third investigation may be conducted by the facility's management to consider whether breaches of policies and procedures have occurred.

He further states, "[r]isk managers and corrections managers should not rely on the criminal investigation to answer all of the necessary questions and obtain critical information for liability defense. Criminal investigators are usually highly skilled and experienced in putting together a case for prosecution. They concentrate on establishing criminal culpability and gathering the evidence available to support a conviction. The criminal investigation will not turn all of the stones that should be helpful in defending the civil lawsuit."

Wallentine developed a checklist of "essential investigative actions applicable for the majority of in-custody deaths...."

Initial Scene Response:

- First priority is to preserve life, then isolate the suspect, and protect the scene;
- Treat like any homicide scene;
- Do not be too quick to conclude suicide; and
- Preserve reporting information.

Entering the scene:

- Record time of entry;
- Preserve a single path of entry;
- As soon as practicable, lock down inmates and insist on silence;
- Leave hanging bodies in place, except as necessary for life-saving; do not cut knots;
- Turn water off; stop toilet from flushing;
- Note scene alterations by emergency medical providers;
- Document condition of lights, doors, restraint, water, toilets, etc; and
- Obtain a dying declaration.

Contamination Issues

[redacted]

[redacted]

70

One officer who was issued a beeper was unable to respond to health services during the Mundy cell extraction. His assignment that day was the visiting room and physical search area. April 13, 2003 was a Sunday, a typically busy day with many visitors. Each offender who has a visit must be searched before and after the visit. Another officer was assigned to assist.

When the officers arrived at health services to enter Mundy's cell, they donned their protective coveralls. The coveralls did not properly fit all the officers and some said they had trouble when inserting their shoes into the feet portion of the suit. Some commented to the Ombudsman that the sleeves were too short and their arms were exposed. Only one officer had any experience donning and doffing this protective clothing because he worked in the unit regularly. He said he often used the coveralls when he cleaned the cells. They were unanimous about the failure of the coveralls to maintain their integrity.

The helmets with face shields added to the problem by either steaming up or popping up exposing their faces. Some officers did not have facial protection because there were not enough helmets to go around. The floor was extremely slippery with blood and the officers who first responded tired as they struggled with Mundy. The Shift Captain sent in officers to relieve the initial responders. Nurses later arrived and attempted to resuscitate Mundy. The

nurses donned latex gloves but had no other barrier equipment or clothing as they performed CPR or otherwise assessed his condition.

The Shift Captain ordered one officer to assist even though he did not have a suit on. That officer held Mundy's head while the officers tried to restrain him. In his interview with the DCI agent, the officer said there was blood all over his arms. He was told to leave the area (he does not know by whom) and went to the sink to decontaminate himself with biohazard soap. He then donned a suit and went in to relieve a first responder.

The Ombudsman returned to ASP and interviewed some of the officers involved in the forced cell extraction. Additional information was needed from the officers' perspective regarding the sufficiency of equipment and follow up. Of the seven staff interviewed, none had less than five years of experience.

The officers told the Ombudsman the following:

- There was no debriefing after the incident.
- They described it as placing Mundy into the ambulance and returning to their assignments.
- One officer accompanied Mundy's body to the hospital, and stayed for several hours in his blood-contaminated clothing until a second shift officer relieved him.
- [redacted][71]
- They did not receive other health information pertaining to Mundy for several months.
- Several had their first blood-borne pathogens training 6 months prior to the Ombudsman's interview.
- Some officers worried that Mundy had the Human Immunodeficiency Virus (HIV).
- For three weeks after their blood exposure, they shared normal daily family activities. Their children drank from their glasses and they were intimate with their wives.
- A majority of officers were upset to learn later, instead of immediately after the blood exposure, [redacted][72]
- Staff kept their blood stained protective suits on while transferring Mundy's body to the ambulance.

The ACA Standards (ACI 4-4225-1) suggest a debriefing be conducted after each critical incident.

> The debriefing process includes coordination and feedback about the incident with designated staff of the facility as soon as possible after the incident. A debriefing includes, but is not limited to:
>
> - A review of staff and offender action during the incident
> - A review of the incident's impact on staff and offenders
> - A review of corrective actions taken and still needed

- Plans for improvement to avoid another incident

COMMENT: A "critical incident" is any event or situation that threatens staff or offenders in their community (criminal justice setting). While debriefings should occur as soon as possible, some information may not be available until later. All staff impacted by a critical incident should be included in the debriefings and referred to appropriate services to mitigate the stress associated with these events. All critical incidents should be reviewed by the administration, security, and health services. A two-week follow-up debriefing should occur to review the validity and appropriateness of all policies, plans, and information used during the critical incident and immediately after.

All officers interviewed wanted some type of tool to prevent Mundy from further injuring himself. [redacted][73] They expressed a desire for more training or equipment that would have allowed them to get control of Mundy sooner. Staff interviewed by the Ombudsman believed Mundy committed suicide and the cause of death was due to a significant blood loss. Officers admitted they had not seen the Polk County Medical Examiner's autopsy results.

The officers further believed debriefing after a critical incident is important. After Mundy was placed into the ambulance, they went back to their posts. They wanted to discuss what happened, but no one initiated a debriefing or discussion. Most officers stated they received little or no blood borne pathogen training prior to Mundy's cell extraction.[60] Because of this lack of training, the officers stated they did not understand the potential for exposure to their families or the precautionary measures they should have taken. Officers said they believe institution officials are supposed to have documents available for staff to report possible exposures, but nothing was provided after this incident.

Some of the officers were "angry" the Shift Captain did not instruct officers to shower and change into clean uniforms. The officer who accompanied the body was in his uniform for several hours. He further stated:

- He noticed after returning to the facility that his watchband scratched his arm during the struggle with Mundy.
- Because ASP did not properly instruct officers to secure the suits sleeves, the scratched area was exposed to Mundy's blood.
- He did not realize the soles of his shoes were cracked until after he ended his shift and returned home.
- Once at home, and after removing his uniform and shoes, he became aware his socks had blood on them.

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[60] A previous administrative law judge, and now warden of another institution, disagreed with this statement. This warden stated blood borne pathogen training was offered annually and considered required reading. An ASP shift captain stated he ensured his second shift correctional officers completed and signed their required reading that included blood borne pathogens.

- He discarded the shoes and socks and washed his own uniform.

Officers are issued their uniforms (3 short sleeved shirts, 3 long-sleeved shirts, 3 pairs of pants and work shoes/boots). The previous DOC policy ADM-EM-9 deemed it the responsibility of the officer/supervisor to contact the Shift Supervisor to request an exchange of clothing. Clothing damaged during the performance of their duties may be exchanged. If the Storeroom is not open, the staff member will be escorted to the Staff Clothing room by a Correctional Supervisor to exchange the clothing on a one-for-one basis. The recently revised policy adds "[i]n the event of a blood and body fluid exposure to uniforms, a Correctional Supervisor will ensure that replacement clothing is made available in a timely manner as a part of the decontamination process."

HSP 92.207 requires, "[g]arments penetrated by blood or other potentially infectious material shall be removed immediately or as soon as possible and all personal protective equipment shall be removed prior to leaving the work area. These will be placed in an appropriately designated area or container for storage, washing, decontamination or disposal." The three officers who transferred Mundy's body out to the ambulance still wore their personal protective coveralls visibly marked with bloodstains. The route of transfer involved taking the gurney out through the entrance to health services, back into the institution near the cafeteria, up the stairs and through the main sally-port, through the waiting room, out a side door, and down a ramp to the waiting ambulance. Wearing the contaminated clothing into the public area had the potential to contaminate many other people.

An unknown individual(s) filed a complaint with the Iowa Occupational Safety and Health Bureau (IOSHB). An IOSHB inspector examined ASP on August 28, 2003. As the result of their inspection, IOSHB cited ASP for several violations. IOSHB initially fined ASP $28,000 but later, after a settlement agreement, the IOSHB reduced the fines to $13,900.00. DOC paid the fines in full with all violations abated based upon a follow-up inspection by IOSHB. (Refer to Appendix B for specific violations and fines.)

The ASP officers told the Ombudsman the following:

- Both medical staff and administrative staff provided conflicting information regarding correctional officers' exposure to Mundy's blood.
- [redacted]
- The officers were then told Mundy bled out and there was not enough blood to test.
- Later, a Shift Captain said there was enough blood, but one of the blood tubes broke.
- [redacted][74]
- The Medical Director attributed the delay in obtaining test results towards minimal return communication from the County Medical Examiner.

DOC Health Services Policy 92.207 Exposure Control for Bloodborne Pathogens/Bioterrorism advises "[all DOC employees are considered at possible risk for occupational exposure. Within 10 working days of initial work assignment and after receiving required training, all staff will have Hepatitis B vaccination offered/provided at employer expense...."

This policy instructs staff to use universal precautions "...to prevent contact with infected body fluids." Universal Precautions "include the use of an appropriate barrier (gloves, mask, goggles, face shields, etc.)..., standard sterilization and disinfection measures as well as effective waste disposal procedures."

Training on the potential for exposure, Universal Precautions, exposure control and post exposure evaluation and follow up is required by this policy to be provided at the time of initial job assignment and at least annually thereafter." The policy requires the training comply with the Code of Federal Regulations 1910.1030.

According to Policy 96.911 Blood and Body Fluid/Tissue Exposure, "[p]ersons (inmates and staff) possibly exposed to blood borne pathogens need prompt consultation with Health Services staff to determine if an involved party was previously known to be infectious for hepatitis B and/or C, or HIV. A Post Exposure Report ...will be initiated by Health Services staff. An educational packet concerning blood borne pathogen exposure will be given to the employee." ASP Nursing Director sent the Ombudsman a copy of this packet. There was no such packet available for staff involved in the Mundy event.

Iowa currently screens offenders for TB and HIV, but not for HCV. According to a 1996 survey, 2.3% of all state and federal prisoners were known to be HIV-positive and the overall rate of confirmed AIDS cases in U.S. prisons was six times higher than in the general population (0.54% vs. 0.09%)[61] The exposure risk for HCV is far greater than for HIV+/Aids.

The Center for Disease and Control (CDC) publication on Hepatitis B or HBV, states sexual intercourse is the predominant mode of transmission among adults and adolescents.[62] The overall prevalence of HBV infections for correctional staff was 12.6%, a rate not significantly different from the general population after adjusting for race and age. Percutaneous and mucous membrane exposures to blood were relatively infrequent, and the most frequently reported exposure was blood on skin, which is not associated with HBV infection."[63]

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[61] U.S. Department of Justice, Office of Justice Programs, National Institute of Justice. 1996-1997 Update: HIV/AIDS, STDs, and TB in correctional facilities, Washington, D.C., July 1999.

[62] Center for Disease and Control, Morbidity and Mortality Weekly Report, January 24, 2003, Vol. 52, No. RR-1, p. 5.

[63] Ibid., p. 6.

The CDC further states that 16-41% of prison inmates have serologic evidence of HCV infection, and 12%-35% have chronic HCV infections.[64] Other sources reveal infection rates between 29 % and 54%.[65] "HCV is not transmitted efficiently through occupational exposure. The risk of acquiring HCV infection from a contaminated needle stick is less than 2%, and transmission rarely has been documented from mucous membrane or nonintact skin exposures."[66]

On the website Prevent Hepatitis, it states "[i]n one state prison that routinely tested all prisoners for hepatitis C virus (HCV), 39% of prisoners were seropositive."[67] There is no clear picture of HCV infection in the prison and jails across the country as few states routinely test all offenders. A sample testing of new admissions to the DOC conducted approximately two years ago revealed 25-26% of Iowa inmates were infected with Hepatitis C.

According to Iowa Department of Public Health's Coordinator for the Hepatitis Program, the CDC estimates 1.8% of the general population has Hepatitis C. This estimate does not include the homeless or those incarcerated. CDC cautions this is a very conservative estimate.

DOC is required by Iowa Administrative Code and DOC's own Health Services Policy 85.906 (Diseases Reportable to the Iowa Department of Public Health) to report certain infectious diseases to the Iowa Department of Public Health (DPH). According DPH, DOC is supposed to report. The laboratories are supposed to report, as is the medical examiner. DOC did not have the information at the time of Mundy's death so there was no reporting responsibility.

The Iowa Legislature appropriated $250,000 to begin testing all new prison admissions for Hepatitis C starting July 1, 2004. Inmates already incarcerated may request the test.

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[64] Ibid., p. 7.

[65] Mark Wilson, "America's Prisons Turn a Blind Eye to HCV," *Prison Legal News*, Vol. 14, No. 8, August 2003 p.1.

[66] CDC, Morbidity and Mortality Weekly Report, p. 7.

[67] <http://www.preventhepatitis.com/correct_in_prisons.htm> (June 17, 2004)

Review of Deaths

Institutional Reviews

DOC Policy SE-IV-22 (revision date August 2003) mandates institutional officials report critical incidents to the DOC Central Office located in Des Moines, Iowa. Reporting requirements are classified into priority statuses ranging from priority one to priority three.

SE-IV-22 lists an offender's death as a priority one status and must be reported immediately to Central Office followed by a written report submitted as soon as possible. Priority two includes, among other things, self-mutilation and mandates this priority status be reported within twenty-four hours to Central Office via telephone. The institution is to issue a written report as soon as possible but no later than twenty-four hours after the incident. Priority three includes priorities not classified as a one or two and do not require telephone notification to Central Office but are to be reported through written notification.

Concerning the deaths of Leslie Brinson and Warren Mundy's, ASP complied with telephone notification followed by written incident reports. The ISP complied with the notification process for Michael Madigan. The ICIW also complied with reporting requirements involving Shayne Eggen.

DOC policy AD-I-11 establishes an Offender Death Review Committee. This committee is chaired by the DOC Medical Director. Additional participating staff includes the Warden/Superintendent, Treatment Manager, and the Health Services Coordinator.

This policy mandates that "within six weeks of an offender's death, all relevant policies, procedures, forms, and all available documentation[68] including autopsy results and death certificate are collected and reviewed by the Committee. The Committee will determine the adequacy of written policy and procedure and assess whether compliance with policy and procedure" occurred in each case.

The Committee Chairperson is to complete a written report within three weeks after the Offender Death Review Committee has completed its review of the facts and circumstances surrounding an offender's death. The report summarizes the results of the review, and where relevant, provides recommendations for enhancing the Department's commitment to address offender deaths in a fully professional and

[68] During the Ombudsman's review of Mundy's case, his counselor referenced "personal notes" in an incident report. The Ombudsman requested and received a copy of these notes and in reviewing other death review notes, it is unclear whether the Offender Death Review Committee utilized, or even collected, the counselor's notes.

caring manner. This policy requires that the completed report be forwarded to the DOC Medical Director.[69]

The Medical Director compiles a report that includes history of incarcerations and charges, summary of medical history, which includes main diagnosis and medications used during the incarceration, and a description of the incident surrounding the offender's death. The Medical Director then discusses findings of the autopsy and pertinent notifications.

He wrote in Brinson's death review that administratively, "all aspects surrounding the deaths were complete." However, he did not comment on the negative [redacted] result in the autopsy's toxicology report even though he mentioned, [redacted].[75] He recommended in Mundy's death review that all staff involved in the incident be monitored for infectious disease prophylaxis[70] protocol.

Debriefing can be used to review actions taken during any incident in any setting. In the cases mentioned, debriefing performed for staff members involved in Mundy's incident was primarily for health purposes. Due to the significant exposure to blood, staff was concerned with exposure to infectious diseases. In Eggen's case, institution officials provided debriefing to correctional staff traumatized by Eggen's removal of her left eye. The ICIW Warden added their CERT team debriefs after each incident that required its involvement.

Division of Criminal Investigation

Iowa Administrative rule 661-1.2(6) defines the Division of Criminal Investigations (DCI) as "a law enforcement unit that conducts criminal investigations, enforces Iowa's beer and liquor law, pari-mutual laws, lottery laws, maintains the state's central repository for all criminal history records, and operates the state criminalistics laboratory."

DOC policy AD-I-11 requires the Warden to notify DCI of any death that is not the result of natural causes. The Warden and DCI determine if an investigation is warranted. This policy further requires staff to obtain fingerprints for DCI and the Warden will secure and preserve the scene and any related areas until released by DCI.

DCI investigates by following Procedural Directive C.200 (effective date January 01, 1986). As written, the purpose of this directive is to:

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[69] Actual language of this policy. DOC administration will change the language to state the Committee Chairperson will complete a report and forward it to the DOC Director.

[70] A measure taken for the prevention of a disease. <http://www.medterms.com/script/main/art.asp?articlekey=12063>. (June 15. 2004)

> Coordinate the activities of the Department of Corrections employees and Division of Criminal Investigation agents assigned to conduct investigations within state institutions. Guidelines are established to enhance effective, efficient, and harmonious working relationships between departments which will, in turn, insure a thorough criminal investigation. These guidelines will be used when cases specifically mentioned herein are incurred or other investigations are requested within state correctional institutions.

This directive applies to homicides, escapes, hostage situations, other crimes not previously mentioned, and non-criminal investigations.[71]

For homicides within institutions, a DCI investigator performs the following:

1. Instructs institutional authorities to preserve the crime scene.
2. Contact the Zone Special-Agent-In-Charge or weekend duty officer for the crime scene unit which will respond.
3. Contact the Special-Agent-In-Charge or the weekend duty officer upon arriving at the scene for additional help, if needed.
4. After arriving at the institution, make contact with the warden or his designated assistant and also the county attorney and/or assistant attorney general to brief them on the situation.
5. Coordinate the investigative activities using the procedures outlined in the manual relating to death investigations and proper investigative techniques.
6. Assist the crime scene response team in processing the scene, scheduling of an autopsy, and other matters which arise with the use of the crime scene response team.
7. Prepare a full investigative report on the matter.

DCI personnel then forward the investigative report to the appropriate office that has jurisdiction to prosecute the case.

DCI investigated Leslie Brinson's, Warren Mundy's, and Michael Madigan's deaths. Reports generally included information from the following sources: incident reports, witness interviews (staff and other offenders), incarceration history, description of the incident, emergency medical response reports, offender medical files, autopsy findings, and DOC central office and institutional policies.

Specifically in the Brinson case, the DCI agent questioned ASP Deputy Warden about the autopsy results. The Deputy Warden informed him the hospital pathologist stated, "There were no marks or bruises on the body, but more tests would be needed to determine what caused the lungs to be filled with fluid." The DCI agent responded, "That unless further testing showed something other that a natural death we did not need to be involved." There is no indication within the DCI Investigative Report that

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[71] According to Directive C.200, non-criminal investigations include investigations of an internal and non-criminal nature at the request of a warden.

the agent questioned the negative [redacted] result, even though he obtained and used as evidence 1) the DOC medical director's death review stating [redacted],[76] and 2) the nursing medication record showing the dispensing of this medication.

The DCI agent also lists under "Section 3 – Evidence Index" a "VHS tape (copy of video tapings by ASP staff during cell extractions/transfer to infirmary.) It is unclear specifically what "tapes" the agent obtained. He also did not mention reviewing the tapes or noticing the ASP officer flushing the toilet after they began existing Brinson's cell. There is no indication the agent inquired about the "pill" one officer discovered in Brinson's cell and documented that he found. The Ombudsman believes this is an important issue since DCI is responsible under their directive to instruct authorities to preserve the crime scene.

In Madigan's review, the DCI agent observed the crime scene and noted, as the Ombudsman did, that Madigan's cell "could be monitored from the Control Center, with a few blind areas because of the window frames and the solid walls towards the corners of the cell. The cell was also monitored by the aid of a camera located within the cell several feet above the height of the entrance door into the cell and towards the northwest corner of the cell."

When gathering evidence in the Madigan case, the agent noted "a pair of white 'Fruit of the Loom' underwear, size 42-44. This item also had what appeared to be dried, brownish-red stains on it. This item was located on the floor at the base of the metal sink/toilet fixture." The Ombudsman observed on the videotape, during the staff resuscitation efforts of Madigan, the underwear appeared at Madigan's head and then appeared on the floor.

The DCI agent assigned to Mundy noted the gaps in the videotaping of the incident. He personally tested the equipment and was able to recreate the disconnecting idiosyncrasy of this camera. He also provided the institution with information on the dangers of positional asphyxiation.

State Medical Examiner

Iowa Code section 691.6 details the duties of the State Medical Examiner (ME) as:

> 1. To provide assistance, consultation, and training to county medical examiners and law enforcement officials.
>
> 2. To keep complete records of all relevant information concerning deaths or crimes requiring investigation by the state medical examiner.
>
> 3. To adopt rules pursuant to chapter 17A, and subject to the approval of the director of public health, with the advice and approval of the state medical examiner advisory council.

4. To collect and retain autopsy fees as established by rule. Autopsy fees collected and retained under this subsection are appropriated for purposes of the state medical examiner's office. Notwithstanding section 8.33, any fees collected by the state medical examiner that remain unexpended at the end of the fiscal year shall not revert to the general fund of the state or any other fund but shall be available for use for the following fiscal year for the same purpose.

5. To conduct an inquiry, investigation, or hearing and administer oaths and receive testimony under oath relative to the matter of inquiry, investigation, or hearing, and to subpoena witnesses and require the production of records, papers, and documents pertinent to the death investigation. However, the medical examiner shall not conduct any activity pursuant to this subsection, relating to a homicide or other criminally suspicious death, without coordinating such activity with the county medical examiner, and without obtaining approval of the investigating law enforcement agency, the county attorney, or any other prosecutorial or law enforcement agency of the jurisdiction to conduct such activity.

6. To adopt rules pursuant to chapter 17A relating to the duties, responsibilities, and operations of the office of the state medical examiner and to specify the duties, responsibilities, and operations of the county medical examiner in relationship to the office of the state medical examiner.

Rule 641-127.9 of the IAC authorizes the State ME to provide notice to physicians who fail to comply with the rules governing county medical examiners. If the State ME determines that noncompliance actually occurred, they may forward their findings to the county board of supervisors who appointed the county medical examiner.

Under chapters 641 IAC 90 and 641 IAC 91, the State Medical Examiner participates in the Iowa Child Death Review Team and the Iowa Domestic Abuse Death Review Team. Chapter 641 IAC 92 governs the Iowa Fatality Review Committee which reviews how agencies responded to specific cases of child abuse. This committee is "ad-hoc" and appointed by the Director for the Iowa Department of Public Health on a case-by-case basis. Rule 641-92.3 requires that "a medical examiner" sit on this committee but does not mandate the Iowa State Medical Examiner fill this position. The Iowa State Medical Examiner has served as a representative on this committee.

Autopsy

Current Policy and Practice

Iowa Code section 331.802 states deaths affecting the public interest, the county medical examiner shall perform a preliminary investigation into the cause and manner of the death and submit a written report to the state medical examiner and county attorney. It further states that a death affecting public interest includes death of a person confined in a prison, jail, or correctional institution.

Under rule 641-127.3, it is recommended, but not mandated, an autopsy be performed on cases involving deaths in prisons, jails, correctional institutions or under police custody, where a natural disease process that accounts for the death is unknown.

Under rule 641-127(4)(b), an autopsy shall be performed by a pathologist trained or with experience in forensic pathology, licensed to practice medicine and surgery or osteopathic medicine and surgery in he state of Iowa and board-certified by the American Board of Pathology, or under the direct supervision of a physician with the above qualifications.

The administrative code further mandates that a medical examiner will forward a completed record to the state medical examiner's office, county attorney where the death occurred, and to the county attorney where the injury occurred and contributed to the death of the person. The above requirements are to be completed within 90 days of the person's death.

Inconsistencies

There is no statute or administrative rule mandating how a pathologist must perform an autopsy and what testing, including confirmations of results, should be performed. The qualifications of a physician can also vary, as described in rule 127.3(4)(b). In review of the three offenders' autopsies, two county medical examiner pathologists, and one independent pathologist routinely ordered drug screen testing and each used their lab of choice for testing purposes. The pathologists did not confirm certain tests until the Ombudsman questioned the inconsistent results of two autopsies.

The Task Force was specifically concerned with the lab testing in the Brinson case. It should be mentioned that most labs assume a specimen is properly identified and labeled. Due to the inconsistencies of results the Task Force received, a question remains whether Brinson's blood tubes were correctly identified as belonging to him. The issue of dated samples may also play a role in the inconsistent results.

The Ombudsman commenced lab-testing inquiries by speaking with a Mayo toxicology lab supervisor. The Ombudsman learned [redacted] is not a drug included within the routine drug screen test. Even though the hospital pathologist order sheet indicated "[redacted]", the Mayo lab supervisor stated Brinson's blood probably was not tested for [redacted]. The Mayo's lab result sheet further indicated the lab conducted a routine drug screen test.

The hospital pathologist specifically ordered a [redacted] level on Brinson's blood. The lab results from Mayo referenced no drugs found under a "routine drug screen." There was no indication they tested Brinson's blood for [redacted]. However, when the pathologist's lab transcribed Mayo's finding onto their own lab form, it gives the appearance Mayo performed a serum [redacted] and drug screen testing with the final report showing no drugs found.

When the lab results came back negative for [redacted], the pathologist did not test other blood samples or order confirmation testing. He based part of his conclusions on the negative drug results provided by Mayo.

After reviewing Brinson's autopsy, the Ombudsman questioned the accuracy of Mayo's testing since [redacted], if actually dispensed as nursing records [redacted],[77] should have appeared with proper testing. The State ME coordinated confirmation testing at the request of the Ombudsman. The hospital pathologist forwarded blood and urine specimens to the State ME while retaining other blood and urine samples for possible future testing.

According to chain of custody records, on July 31, 2003, the hospital lab sent urine, along with blood samples to the State ME. The blood samples consisted of a green top tube and an aliquot (portion of blood) from a gray top tube.[72] The State ME recorded they received a gray transfer tube and green top tube within a styrofoam container on August 1, 2003. They placed this container in an AEGIS shipping bag and forwarded the specimens to AEGIS Science Corporation, Nashville, Tennessee on August 21, 2003. The delay in forwarding the specimens to AEGIS were due to the Task Force conferring on what tests to request.

AEGIS then assigned case numbers to the individual specimens and forwarded the green top tube and portion of Brinson's urine to National Medical Services Inc.(NMS), located in Willow Grove, Pennsylvania. The chain of custody reports indicate NMS received the green top tube and urine sample on September 8, 2003. AEGIS specifically tested for serum ethanol/volatiles, trazodone, and tricyclic antidepressants.[73] They tested the urine for a number of drugs ranging from opiates, cocaine, to amphetamines and barbiturates. They specifically tested the urine for trazodone and tricyclic antidepressants. AEGIS found 1940 nanograms/milliliter of doxepin and 1290 nanograms/milliliter of desmethyldoxepin (doxepin metabolite) in Brinson's blood. His urine sample was negative for this drug.

Because AEGIS does not test for [redacted], NMS performed the serum and urine testing for this drug. NMS found eleven nanograms/milliliter of [redacted] in Brinson's blood and twenty nanograms/milliliter of [redacted] in his urine.

Due to the differing results between Mayo and those of AEGIS and NMS, some Task Force members expressed concerns and questioned the accuracy of all the lab testing performed on Brinson's urine and blood. The Task Force decided to order confirmation testing performed by a lab that could test for both Doxepin and [redacted]. NMS declined to perform confirmation testing after concluding the amount of blood remaining was too small to run both tests. Medtox Laboratories, Inc. stated they could test all samples for both drugs.

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[72] The hospital pathologist still has this gray top tube.

[73] The hospital pathologist provided a green top tube and a portion of blood from a gray top tube. NMS tested from the green top tube and AEGIS tested from the gray top tube.

According to chain of custody sheets, Medtox tested for serum [redacted] from the same tube and sample in which NMS performed their testing. Medtox performed Doxepin testing from the same tube and sample in which AEGIS performed their testing. Under Medtox, Brinson's blood was negative for both Doxepin and [redacted]. The urine testing performed by Medtox yielded a negative result for Doxepin, but measured 27.6 nanograms/milliliter of [redacted].

Because of the inconsistent results, the Task Force met again to discuss the lab results. The group decided to retest Brinson's blood and stressed that lab testing should be conducted by a certified forensic lab that could test for both Doxepin and [redacted]. The Ombudsman emphasized the importance of testing from the same test tube as well. The Task Force noted when the first positive results for Doxepin and [redacted] occurred, the results yielded from two separate samples; however, both tubes were labeled as belonging to Brinson.

NMS' lab tests towards the latter part of December 2003 yielded both negative results in blood and urine for Doxepin. Since ASP documents indicate [redacted] the Task Force requested that NMS test this same sample for [redacted][78] with the expectation [redacted] should be present. This test occurred around February 5, 2004 and yielded a negative result for [redacted].

A forensic toxicologist provided the following explanation for the different results achieved throughout this process. Regarding the inconsistency of Doxepin and [redacted] via confirmation by Medtox, on December 12, 2003 he wrote:

Blood specimen 4309819 was analyzed as a micro-specimen and found to be negative for doxepin and metabolite. The finding of a None Detected can be attributed to various possibilities. The micro-specimen approach may be flawed due to binding of the small amount of drug within the very small specimen to the large surface area of the plastic transfer tube. The drug may have undergone decomposition during repeated
handling of the specimen since it is a relatively old case. These conclusions are supported by the fact that MedTox was also unable to reconfirm, (per request by Aegis Analytical Laboratories) the presence of haloperidol via a micro-assay technique in blood specimen 4309820.

Regarding the inconsistency for Doxepin and Desmethyldoxepin results via AEGIS and NMS, on January 14, 2004 he wrote:

The specifically requested test was Doxepin and metabolite (desmethyldoxepin) performed on the minimum specimen volume accepted by a National Medical Services, which is 1 ml. The results of this test were no drugs detected.

These results are not consistent with the results originally reported as positive for Doxepin and desmethyldoxepin in the specimen received on August 22, 2003 in the

plastic serum transfer tube and assigned the laboratory number 430819. Review of the records associated with the various specimens and numerous tests performed on these specimens reveals a number of issues that may be relevant in attempting to understand the seemingly inconsistent Doxepin results. The most recently received results were obtained from a green-top blood tube assigned the laboratory identification number 4309820 on August 22, 2003. These two tubes had undergone very different pathways in their handling and storage. The chain of custody documents from St. Lukes's Hospital laboratory appear to indicate that the original urine specimen received at Aegis August 22, 2003 was aliquoted for shipment to the State Medical Examiner's office on July 31, 2003 and that the green-top tube #1 was NOT shipped to the Medical Examiner's office (but received December 22, 2003 at Aegis) was handled at this same date and time. While there is no indication of why the specimen was removed from frozen storage and then returned, it indicates an additional freeze/thaw cycle was introduced in handling the December 22, 2003 blood specimen and it suggests (no chain of custody available) that the green-top tube received on August 22, 2003 may also been processed for shipment to the Medical Examiner's Office at this date. Since the chain of custody documents available for review do not account for the interval between July 31, 2003 and August 21, 2003 it is difficult to characterize sample integrity and suitability for analysis.

The results from the August 22, 2003 blood received in the serum transfer tube, aliquot
number 4309819 could differ from those obtained from the December 22, 2003 blood received in the green-top blood tube, aliquot number 4310838 for a variety of reasons. The positive results for Doxepin were generated from specimen 4309819 that was originally indicated as being a blood sample from a gray-top tube. Since it was received in a serum transfer tube, it was either a different specimen or it was transferred into a plastic tube without documented date and time. The properties of absorption of the plastic specimen tube used to contain specimen 4309819 and found positive for tricyclic antidepressants is unknown and could have affected the observed results obtained from this aliquot. Numerous differences in handling of these two samples are noted in the chain of custody documents and, as previously stated, all the records are not available for review. As these specimens are all old, and specimen 4310838 was approximately four months older than 4309819 at the time of testing, stability can be an important factor to consider in the observed results. The greatly different collection and transport containers also offer a source of significant variability in the test results. In conclusion, it appears that there are numerous unknowns involved in the different specimens and analyses associated with this case that confound interpretation of the tricyclic antidepressant results. An adequate volume of a fresh homogenous blood specimen clearly linked to the deceased would avoid interpretive problems.

Due to the lapse in time between Brinson's death and the Task Force inquiry, the St. Lukes lab supervisor could not recall the reason for the removal of the samples from the freezer to the refrigerator and later placing samples back into the freezer without

any documentation of other activity. This example alone may support a need for centralizing autopsies and lab testing for individuals confined within our correctional facilities.

The Task Force also requested additional testing after reviewing Mundy's autopsy and observing positive results for both propoxyphene (narcotic) and alcohol. The propoxyphene became an issue in this case since Mundy's medical file indicated DOC physicians [redacted][80] The State ME explained the urine test used that resulted in a positive propoxyphene level is a screening test. She explained the Thin Layer Chromatography exam can result in many false positives. Since Mundy's plasma was negative for propoxyphene using a more precise test, the State ME opined that propoxyphene was probably not present in his system.

The Task Force also questioned the presence of alcohol, 20mg/dl, in Mundy's whole blood. The State ME stated fermentation can occur at death and can result in a positive alcohol level in a deceased's bodily fluids. To rule out the potential of alcohol consumption versus postmortem fermentation (the fermentable sugars are converted to ethanol and carbon dioxide), she requested the Polk County ME perform vitreous testing.

According to the Deputy State ME, the vitreous, a thick, transparent substance that fills the center of the eye, is less subject to contamination. The autopsy revealed alcohol in the blood (20mg/dl) and urine (21mg/ml) but absent in the vitreous. Neither the Polk County Medical Examiner nor the State Medical Examiner's office ruled out the possibility Mundy consumed alcohol prior to his death.[74]

To provide additional support for centralized autopsies and testing, the Ombudsman discovered later both the DOC Medical Director and ASP Nursing Supervisor experienced difficulties in reaching the Polk County Medical Examiner to request additional testing. Due to the amount of blood in Mundy's cell and blood exposure to correctional staff, DOC medical staff wanted priority and speedy testing for infectious diseases. The ASP Nursing Supervisor stated Hepatitis C (HCV) is not generally included in infectious disease screening and eventually spoke with a county hospital lab technician who agreed to perform HCV testing on Mundy's blood. Within three weeks after Mundy's death, and after numerous calls, the ASP nursing supervisor obtained the infectious disease testing results and shared these results with correctional staff. The concerns expressed by the ASP nursing supervisor pointed to limited communication by the county medical examiner and the delay in receiving [redacted][81]

The Polk County ME concluded Mundy's manner of death was homicide. The Iowa State ME defines homicide as:

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[74] The possibility of Mundy consuming alcohol prior to his death becomes important since his DOC counselor documented Mundy stating he stopped drinking because alcohol made him "violent." See p. 11.

Death directly caused by the action of another person or a death that occurs during the commission of a felony. The death should stem from some kind of deliberate or purposeful action but intent to cause harm or death need not be present or proven for the medial examiner to rule a death as a homicide. Homicide, for the purpose of the medical examiner, does not always equal murder.

For example, a person who shoots someone to death in self-defense should be classified as a homicide even though there may or may not be a criminal liability attached to the act. Death at the hands of law enforcement should also be classified as homicides and allow the criminal justice system to determine what criminal penalty should or should not apply.

The Ombudsman researched this definition further and found the following information.

Homicide occurs when death results from a volitional act committed by another person to cause fear, harm or death. Intent to cause death is a common element but is not required for classification as homicide (see below). It is emphasized that the classification of homicide for death certification is a "neutral" term and neither implicates nor implies *criminal* intent, which remains a determination within the province of the legal processes.

...

The "but for" principle is commonly applicable. "But-for the injury (or hostile environment), would the person have died when he/she did?" This logic is often cited as a simple way to determine whether a death should be classified as natural or non-natural (homicide, suicide, accident). When an injury or poisoning is the cause of death, an answer of "yes" supports a natural death and an answer of "no" should prompt due consideration towards a non-natural cause of death. The certifier needs to recognize, however, that the intermingling of natural and non-natural factors presents a set of complex considerations in assigning a manner of death. Regardless of whether a non-natural factor (a) unequivocally precipitated death, (b) exacerbated and underlying natural pathological condition, (c) produced a "natural" condition that constitutes the immediate cause of death, or (d) contributed to the death of a person with natural disease typically survivable in a non-hostile environment, this principle remains: the manner of death is unnatural when injury hastened the death of one already vulnerable to significant or even life-threatening disease.

...

16. Deaths due to positional restraint induced by law enforcement personnel or to choke holds or other measures to subdue may be classified as **Homicide**, In such cases, there may not be intent to kill, but the death result from one or more intentional, volitional, potentially harmful acts directed at the decedent (without consent, of course). Further, there is some value to the homicide classification

toward reducing the public perception that a "cover-up" is being perpetrated by the death investigation agency.[75]

In summary the Task Force is concerned the format of an autopsy and bodily fluid testing differed among practitioners performing them. The development of centralized autopsies and testing for individuals confined within a correctional setting could bring uniformity and reduce variables.

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[75] Randy Hanzlich, MD, John C. Hunsaker III, MD, JD, Gregory Davis, MD, *The National Association of Medical Examiners' Guide for Manner of Death Classification*, February 2002, p. 6.

Recommendations

The Task Force believes increased training is the most important element.

With that in mind, the Task Force believes DOC should:

- Seek accreditation for the Iowa Department of Corrections training academy. The Task Force believes the ultimate goal should be certification of correctional officers in a manner similar to certification for police officers and jail personnel.

- Increase amount and types of training for correctional officers. Security officers who deal daily with mentally ill offenders need the most immediate and extensive training. The Task Force believes DOC needs to conduct annual training of all officers in identifying offenders in crisis. Training must include more information about de-escalation techniques. Ensure all staff receives annual training in the Use of Force continuum. Consider other restraints and devices to obtain control if de-escalation is not successful. Invite Iowa Protection and Advocacy, Inc and other knowledgeable groups or persons to review training curriculum.

- Include medical and security staff at the same training because each needs to understand the importance of the others' role.

- Include in the pre-service and in-service training all officers practicing videotaping other officers in mock cell entries. This should also be practiced on an annual basis with DOC providing examples of improper or delayed responses and inadequate video quality for officers to understand the importance of these exercises.

- Ensure all institutions provide appropriate protective gear. As part of the pre-service training and annual training, staff should be required to practice donning and doffing this clothing and gear and when it is appropriately used.

- Develop a training module on scene preservation and scene investigation to ensure critical evidence is not lost or compromised.

Mental Health Services

DOC should:

- Provide for emergency psychiatric and psychological intervention to be available at all times at all DOC institutions. One option is to hire sufficient psychiatrists to provide for 24-hour coverage. Another option may be to coordinate with the Iowa

Department of Human Services to share psychiatric and psychological services from the state mental health institutions.

- Purchase portable telemedicine terminals to facilitate observation of offenders by a psychiatrist or psychologist.

- When appropriate, utilize its statutory authority, in conjunction with the Department of Human Services, to transfer an offender to a mental health institution while retaining jurisdiction.

- Expand the companion inmate policy to all institutions.

Offender Deaths/Critical Incidents

DOC should:

- Explore legislation to create a Critical Incident Task Force modeled after Iowa Fatality Review Committee, to review offender deaths (other than by known natural causes) and critical self-injurious situations.

- Hire an inspector general at DOC to supervise, coordinate, and direct the efforts of all investigators at the institutions.

- Develop a centralized repository for reports of deaths of offenders in prisons, community-based corrections, and jails. Judicial districts and jails should be required to report the deaths of all offenders while under their supervision.

The State Medical Examiner should:

- Amend the Iowa Administrative Code, 641 – chapter 127, to require autopsies on all deaths in a prison, jail or other correctional facility, or under the custody of a law enforcement agency, except those where a natural disease process clearly caused the individual's death. [Current rule 641.1273(2)(c) recommends that a county medical examiner performs autopsies in the following cases: "Deaths in a prison, jail, or correctional institutions, or under police custody, where there is not a natural disease process which accounts for the death."]

- Amend Iowa Administrative Code, 641 – chapter 127, to require that all such in-custody deaths be sent to the State Medical Examiner's Office and the autopsies by performed by a forensic pathologist.

- Ensure County Medical Examiners and their Investigators are aware of the above changes in the Iowa Administrative Rules.

- Add specific guidelines to the County Medical Examiner Handbook that address in-custody death investigations. (Refer to Appendix C for these guidelines.)

- Ensure all toxicology and other laboratory testing be performed at a forensic laboratory.

[NOTE: The Task Force points out that sufficient funding is necessary to enable the State Medical Examiner to assume these additional responsibilities.]

Department of Corrections Response

In response to these incidents, the Iowa Department of Corrections provided the Task Force with the following information regarding the changes they have pro-actively made:

- Revised the mental health training for new employees and recommended a refresher course for all employees yearly.
- Training video for cell entry completed. Training recommended for all security staff at all prisons.
- Revised policy on Suicide/Self-Injury Prevention and restraints.
- Revising the DOC Mental Health Observation policy.
- Developed an inmate companion policy patterned after Bureau of Prison.
- Modified the Use of Force policy to prohibit use of prone restraint.
- DOC requests death investigations be done according to guidelines provided by the State Medical Examiners Office.
- Monitoring of equipment check at a regular interval (i.e. video, battery, crash carts, etc.).
- Training in gowning and cell entry in a timely fashion.
- Implemented timely and consistent Critical Incident Reporting Policy for both institutions and Judicial Districts.
- Revised policies to ensure review and approval of all new and modified policies by Regional Deputy Directors.
- Purchased three portable telemedicine machines to be utilized at the Clarinda Correctional Facility, Iowa Medical and Classification Center, and the Clinical Care Unit located at the Iowa State Penitentiary.
- Added an additional 16-bed unit at ICIW within Unit Six for female special needs structured living.
- Revising DOC policy AD-I-11 to require in cases of imminent death of an offender, the Warden will notify the DOC Director of any death that is not the result of natural causes where DCI will be called to investigate. The DOC Director will coordinate investigations with DCI.

- DOC Director will contact DCI about amending DCI Directive C.200, non-criminal investigations, for DCI to contact the DOC Director after arriving at a correctional facility to conduct an investigation. Current practice requires DCI to notify a warden.

Attached is the list of specific recommendations of Iowa Protection and Advocacy, Inc. The Task Force believes the spirit of most of these was incorporated into the Task Force Recommendations. They are listed in their entirety.

Iowa Protections and Advocacy Recommendations

- Continue active Task Force meetings to proactively focus on prevention, possibly quarterly meetings. Invite DHS, legislators and DCI possibly again.

- Suggested training resources: MANDT System, BRACEanalysis.com (Russell Smith) and JIREH Consulting and Training (800-656-3044 ext. 62)[76]

- Inmate Companion Policy: screening and training is crucial. We do not want to set up a vulnerable inmate to be manipulated and/or abused by these companions.

- Implement into the revised DOC Mental Health Observation policy irregular visual checks. This way the inmate will not be able to plan anything in-between checks as they will be random, such as in the Madigan case.

- Ensure heightened awareness when reintroducing items to the inmate when on "suicide watch."

- Possible use of a padded room, helmet and/or PRN med. in cases such as Mundy.

- Ensure appropriate medication follows the inmate. This could be crucial to their treatment.

- Ensure Emergency Services are available to perform post traumatic incident follow-up with both staff and inmates involved.

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[76] The Ombudsman performed additional research on these referenced systems. According to <www.mandtsystem.com>, "The Mandt System® teaches the use of a graded system of alternatives which uses the least amount of external management necessary in all situations. The entire philosophy of The Mandt System® is based on the principle that all people have the right to be treated with dignity and respect." JIREH provides training in crisis prevention, crisis intervention and de-escalation, "safe least restrictive control techniques", and restoration counseling. <www.jirehtraining.com>. According to <www.braceanalysis.com>, BRACE™ "is an acronym for Behavioral Relativity and Cognitive Economics. BRACE Analysis, Inc. is more concerned with education than therapy, focusing on helping others to better understand human nature in order to avoid many of life's pitfalls and to create adaptive change on purpose." (June 24, 2004)

- Stun gun: do not use in the spinal area and use judgment when the inmate is already in a state of delirium and obviously immune to pain @ that time.

- Mace: provide decontamination for all involved parties after use of mace.

- Ensure audio is clear during taping. This could be vital in an incident.

- If the MHI's do not accept a transfer, could the mental health staff from these institutions be utilized to enhance the mental health system in the prisons throughout Iowa.

- Recommend this task force backs the following legislative piece: Mentally Ill Offender and Crime Reduction Act of 2003.

- Suggest that Iowa consider a project such as the "Nathaniel Project."[77] This is an alternative treatment program as an option to incarceration.

- P&A recommended the use of a Self-Injury Risk Indicators Card and the DOC has implemented this recommendation by laminating 5000 cards that the Correctional Officers can carry in their wallets. P&A applauds this.

- Applaud the DOC for modifying the Use of Force policy to prohibit use of prone restraint.

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[77] According to the Ombudsman's research, "The Nathaniel Project is an alternative to incarceration program for people with serious mental illness who have committed felony offenses. This program is a two-year alternative to incarceration for people who have been indicted on a felony offenses, who are facing prison terms of generally three to six years, and have a serious mental illness. Most of the mental health courts that have developed in recent years were designed to provide services for misdemeanant offenders. The Nathaniel Project recognized the need to address needs of the felony offender with serious mental health issues.

No one is rejected from this program based on the severity of the offense or history of violence. Project staff closely evaluates each case and individuals who pose a real public safety risk are screened out. Once accepted Project staff advocate for the individual with the Judge, prosecutor, and defense counsel, educate them about client's psychiatric needs; and persuade the stakeholders releasing the client to the Project would result in a better outcome for the client and the community than sending the person to prison.

The goal for each client is to be connected with housing and mental health services that they will continue to participate in without court supervision." National GAINS Center for People with Co-Occurring Disorders in the Justice System (2002). *The Nathaniel Project: An Alternative to Incarceration Program for People with Serious Mental Illness Who Have Committed Felony Offenses,* Program Brief Series, Delmar, NY: The National GAINS Center.

1. Iowa Code sec. 904.602(2)(c) (medical or psychiatric information)

2. Iowa Code sec. 904.602(2)(g) (prior criminal history)

3. Iowa Code sec. 904.602(2)(c) (medical or psychiatric information)

4. Iowa Code sec. 904.602(2)(c) (medical or psychiatric information)

5. Iowa Code sec. 904.602(2)(c) (medical or psychiatric information)

6. Iowa Code sec. 904.602(2)(g) (prior criminal history)

7. Iowa Code sec. 904.602(2)(c) (medical or psychiatric information)

8. Iowa Code sec. 904.602(2)(g) (prior criminal history)

9. Iowa Code sec. 904.602(2)(c) (medical or psychiatric information)

10. Iowa Code sec. 904.602(10)(regulations, procedures and policies on internal administration)

11. Iowa Code sec. 904.602(10)(regulations, procedures and policies on internal administration)

12. Iowa Code sec. 904.602(2)(c) (medical or psychiatric information)

13. Iowa Code sec. 904.602(2)(g) (prior criminal history)

14. Iowa Code sec. 904.602(2)(c) (medical or psychiatric information)

15. Iowa Code sec. 904.602(2)(c) (medical or psychiatric information)

16. Iowa Code sec. 904.602(2)(g) (prior criminal history)

17. Iowa Code sec. 904.602(2)(c) (medical or psychiatric information)

18. Iowa Code sec. 904.602(2)(c) (medical or psychiatric information)

19. Iowa Code sec. 232.147 (juvenile court records)

20. Iowa Code sec. 904.602(2)(c) (medical or psychiatric information)

21. Iowa Code sec. 904.602(10)(regulations, procedures and policies on internal administration)

22. Iowa Code sec. 904.602(2)(c) (medical or psychiatric information)

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28. Iowa Code sec. 904.602(10)(regulations, procedures and policies on internal administration)
29. Iowa Code sec. 904.602(10)(regulations, procedures and policies on internal administration)
30. Iowa Code sec. 904.602(2)(c) (medical or psychiatric information)
31. Iowa Code sec. 904.602(10)(regulations, procedures and policies on internal administration)
32. Iowa Code sec. 904.602(2)(g)(prior criminal history)
33. Iowa Code sec. 904.602(2)(h)(family and personal history)
34. Iowa Code sec. 904.602(2)(c) (medical or psychiatric information)
35. Iowa Code sec. 904.602(10)(regulations, procedures and policies on internal administration)
36. Iowa Code sec. 904.602(10)(regulations, procedures and policies on internal administration)
37. Iowa Code sec. 904.602(2)(c) (medical or psychiatric information)
38. Iowa Code sec. 904.602(10)(regulations, procedures and policies on internal administration)
39. Iowa Code sec. 904.602(10)(regulations, procedures and policies on internal administration)
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50. Iowa Code sec. 904.602(2)(c) (medical or psychiatric information)

51. Iowa Code sec. 904.602(2)(j) (information from disciplinary reports and investigations)
52. Iowa Code sec. 904.602(2)(c) (medical or psychiatric information)
53. Iowa Code sec. 904.602(2)(g) (prior criminal history)
54. Iowa Code sec. 904.602(2)(c) (medical or psychiatric information)
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79. Iowa Code sec. 904.602(2)(c) (medical or psychiatric information)

80. Iowa Code sec. 904.602(2)(c) (medical or psychiatric information)

81. Iowa Code sec. 904.602(2)(c) (medical or psychiatric information)

Appendix A

Acronym Index

ACA – American Corrections Association

ASP – Anamosa State Penitentiary

ASPD – Anti-Social Personality Disorder

CCU – Clinical Care Unit

CERT – Correctional Emergency Response Team

CSG – Council on State Governments

DCI – Division of Criminal Investigation

DOC – Iowa Department of Corrections

HCV – Hepatitis C Virus

HRW- Human Rights Watch

ICON – Iowa Corrections Offender Network

ICIW – Iowa Correctional Institution for Women

IMCC – Iowa Medical and Classification Center

ISP – Iowa State Penitentiary

LUA – Living Unit A

ME – Medical Examiner

MHO – Mental Health Observation

MPCF – Mount Pleasant Correctional Facility

Ombudsman – Citizens' Aide/Ombudsman

SSIP – Suicide and Self-Injury Prevention

Appendix B

FAX TRANSMITTAL COVER

TO: Judy Milosovich

COMPANY: Ombudsman

TELEPHONE: -

FAX TELEPHONE: -

PAGES (including cover): -10-

FROM:

Mary L. Bryant
IOSH Administrator
Iowa Division of Labor
Des Moines, Iowa 50319-0209
515-281-3469
FAX: 515-281-7995

DATE: 12/08/03

MESSAGE--

Judy: Per our conversation this AM, attached is a copy of Citation 306678723 issued to Corrections (Anamosa) on 09/24/03. I am also attaching a copy of the settlement agreement reached between them and myself on 10/08.

Give me a call if you have further questions.

If you do not receive all pages, call 515-281-3469

Safety and Health Bureau

1000 East Grand
Des Moines, IA 50319
Phone: (515)281-3606 FAX: (515)281-7995

PENALTY SUMMARY

Company Name: Corrections Department of
Inspection Site: 406 N. High Street, Anamosa, IA 52205
Issuance Date: 09/24/2003
Case File/CSHO ID: 3621 / P1582

Summary of Penalties for Inspection Number 306678723

Citation 1, Serious	= $ ~~28,000.00~~	13,900.00
TOTAL PROPOSED PENALTIES	= $ 28,000.00	13,900.00

Mary L. Bryant
IOSH Administrator

DEVELOPMENT

LABOR SERVICES

Richard V. Running
Director

Byron K. Orton
Commissioner

Thomas J. Vilsack
Governor

Sally J. Pederson
Lt. Governor

October 9, 2003

John F. Ault, Warden
Department of Corrections
406 N. High Street
Anamosa, IA 52205

Dear Mr. Ault:

As a result of discussions between representatives of IOSHA and you or your representatives on October 8, 2003, the parties have reached a tentative agreement resolving disputed citations, penalties and abatement dates.

The document has been signed and dated by the IOSH representative and requires the signature of an authorized company official to make the agreement binding upon the company. **The agreement must be signed and returned, along with a check for any reduced penalty amounts, to this office on or before October 24, 2003.** No changes are to be made to the agreement without prior mutual agreement being reached between you and the IOSH representative.

It should be noted that the Original Citation and proposed penalty(ies), if any, will become a Final Order of the Employment Appeal Board unless the Settlement Agreement is signed or a notice of contest is filed within 15 working days of your receipt of the **original citation.**

If you have any questions regarding any of the matters discussed in this letter, please contact me at your earliest convenience.

Sincerely,

Mary L. Bryant
IOSH Administrator

Enclosures

cc: Mary L. Bryant, IOSH Administrator
Case File 3621 (306678723/P1582)
Owen Bickford, AFSCME Local 2994

WORKFORCE DEVELOPMENT DEPARTMENT

DIVISION OF LABOR SERVICES

IOWA OCCUPATIONAL SAFETY AND HEALTH ADMINISTRATION

In the Matter of: Corrections Department of
and its successors
406 N. High Street
Anamosa, IA 52205

IOSH NO: 306678723 / P1582

NOTICE TO EMPLOYEES

The law gives you or your representative the opportunity to object to any abatement date set for a violation if you believe the date to be unreasonable. Any contest to the abatement dates of the citations amended in paragraph four (4) of this Settlement Agreement must be mailed to the Department of Workforce Development Department, Division of Labor Services at 1000 East Grand, Des Moines, Iowa 50319 within 15 working days (excluding weekends, State and Federal Holidays) of the receipt by the employer of this Settlement Agreement. You or your representative also have the right to object to any of the abatement dates set for violations referred to in paragraph three (3) provided that the objection is mailed to the office shown above within the 15 working day period established by the original citation.

INFORMAL SETTLEMENT AGREEMENT

The undersigned employer and the undersigned representative of the Iowa Occupational Safety and Health Administration (IOSHA), in settlement of the above citation and penalties which were issued on September 24, 2003, hereby agree as follows:

1. The employer agrees to correct the violations as cited in the above citations or as amended below.

2. The employer agrees to pay the total penalty of $13,900.00.

3. The employer and IOSHA agree that the following citations and penalties, if any, are not being amended by this agreement:

NONE

4. IOSHA agrees that the following citations and penalties are being amended as shown (see attachments):

Citation No. 1
Item Nos. 1-7

5. The employer agrees to immediately post a copy of this Settlement Agreement in a prominent place at or near the location of the violation(s) referred to in paragraphs three (3) and four (4) above. This Settlement Agreement must remain posted until the violations cited have been corrected or for three (3) working days (excluding weekends, State and Federal Holidays), whichever is longer.

6. This Settlement Agreement was reached between the following parties on October 8, 2003.

Mary L. Bryant
IOSH Administrator
Workforce Development Department
Division of Labor Services
1000 East Grand
Des Moines, Iowa 50319
Telephone (515) 281-3606

John F. Ault
Warden
Department of Corrections
406 N. High Street
Anamosa, IA 52205

Owen Bickford
AFSCME, Local 2994

Citation and Notification of Penalty

Company Name: Corrections Department of
Inspection Site: 406 N. High Street, Anamosa, IA 52205

Citation 1 Item 1 Type of Violation: Serious

IAC 875 - Chapter 10
1910.1030(d)(3)(i): When there was occupational exposure, the employer did not provide appropriate personal protective equipment such as, but not limited to, gloves, gowns, laboratory coats, face shields, masks, eye protection, mouthpieces, resuscitation bags, pocket masks, or other ventilation devices suitable to the work conditions in which the equipment are used:

(a) Infirmary Side Room #4 - The personal protective equipment provided by the employer to protect employees from blood-borne pathogen hazards was not appropriate for the work conditions in which the protective equipment is used. This violation was noted on or about 8/19/03.

Date By Which Violation Must be Abated: Immediately Upon Receipt
Proposed Penalty: $ 5000.00

Citation 1 Item 2 Type of Violation: Serious Group with Item 1

IAC 875 - Chapter 10
1910.1030(d)(3)(iii): The employer did not ensure that appropriate personal protective equipment in the appropriate sizes was readily accessible at the worksite or issued to employees when there was occupational exposure:

(a) Infirmary Side Room #4 - An adequate amount of appropriate personal protective equipment was not readily accessible for employees performing duties that exposed them to blood-borne pathogen hazards. This violation was noted on or about 8/28/03.

Date By Which Violation Must be Abated: 12/04/2003
Proposed Penalty: ~~$ 5000.00~~ Delete

Citation and Notification of Penalty

Company Name: Corrections Department of
Inspection Site: 406 N. High Street, Anamosa, IA 52205

Citation 1 Item 3 Type of Violation: Serious

IAC 875 - Chapter 10
1910.1030(f)(3)(ii)(C): Results of the source individual's testing as a result of a post-exposure evaluation and follow-up of an exposure incident were not made available to the exposed employee, or the employee was not informed of applicable laws or regulations concerning disclosure of the identity or infectious status of the source individual:

(a) Infirmary - Exposed employees were not provided with documentation of the source individual's testing results and the applicable laws and regulations concerning disclosure of the source individual's identity and infectious status. This violation was noted on or about 8/28/03.

Date By Which Violation Must be Abated:	12/04/2003
Proposed Penalty:	$ 5000.00

Citation 1 Item 4 Type of Violation: Serious Group with Item 3

IAC 875 - Chapter 10
1910.1030(f)(3)(iii)(A): The post-exposure evaluation and follow-up of an exposure incident did not include the collection of the exposed employee's blood as soon as feasible or test for HBV and HIV serological status after consent was obtained:

(a) Infirmary - The employer did not ensure that the exposed employees' blood was collected and tested as soon as feasible. This violation was noted on or about 8/28/03.

Date By Which Violation Must be Abated:	12/04/2003
Proposed Penalty:	$ ~~5000.00~~ Delete

Citation and Notification of Penalty

Company Name: Corrections Department of
Inspection Site: 406 N. High Street, Anamosa, IA 52205

The alleged violations below have been grouped because they involve similar or related hazards that may increase the potential for injury or illness.

Citation 1 Item 5a Type of Violation: Serious

IAC 875 - Chapter 10
1910.1030(f)(4)(ii): The employer did not ensure that the health care professional evaluating an employee after an exposure incident was provided with all required information and documentation listed in 1910.1030(f)(4)(ii)(A) through (E):

(a) Infirmary - The employer did not ensure that the health care professional evaluating the employees after an exposure incident on April 13, 2003 was provided with all the information and documentation necessary and relevant for the appropriate treatment of the exposed employee. This violation was noted on or about 8/28/03.

Date By Which Violation Must be Abated: 12/04/2003
Proposed Penalty: $ ~~5000.00~~ 3000.00

Citation 1 Item 5b Type of Violation: Serious

IAC 875 - Chapter 10
1910.1030(f)(5): The employer did not obtain or provide the employee with a copy of the evaluating health care professional's written opinion within 15 days of the completion of the evaluation:

(a) Infirmary - The employer did not obtain and provide a copy of the evaluating health care professional's written opinion to the exposed employees within 15 days. This violation was noted on or about 8/28/03.

Date By Which Violation Must be Abated: 12/04/2003

Citation and Notification of Penalty

Company Name: Corrections Department of
Inspection Site: 406 N. High Street, Anamosa, IA 52205

The alleged violations below have been grouped because they involve similar or related hazards that may increase the potential for injury or illness.

Citation 1 Item 6a Type of Violation: Serious

IAC 875 Chapter 10
1910.1030(g)(2)(iv): Annual training for employees with occupational exposure was not provided within one year of their previous training:

(a) Infirmary - The employer did not ensure that blood-borne pathogen training was provided to all employee having occupational exposure was provided within one year of their previous training. This violation was noted on or about 8/28/03.

Date By Which Violation Must be Abated: 12/04/2003
Proposed Penalty: $ ~~1500.00~~ 900.00

Citation 1 Item 6b Type of Violation: Serious

IAC 875 Chapter 10
1910.1030(g)(2)(vii)(F): The bloodborne pathogens training program did not contain an explanation of the use or limitations of methods that would prevent or reduce exposure including appropriate engineering controls, work practices or personal protective equipment:

(a) Infirmary - The employer did not provided employees having occupational exposure to blood-borne pathogens with training specific to the proper use and limitations of the personal protective equipment supplied. This violation was noted on or about 8/28/03.

Date By Which Violation Must be Abated: 11/03/2003

Citation and Notification of Penalty

Company Name: Corrections Department of
Inspection Site: 406 N. High Street, Anamosa, IA 52205

Citation 1 Item 6c Type of Violation: Serious

IAC 875 Chapter 10
1910.1030(g)(2)(vii)(N): The bloodborne pathogens training program did not contain an opportunity for interactive questions or answers with the person conducting the training session:

(a) Infirmary - The blood-borne pathogen training provided by the employer did not provide employees with the opportunity for interactive questions and answers with the person providing the training. This violation was noted on or about 8/28/03.

Date By Which Violation Must be Abated: 12/04/2003

Appendix C

In-Custody Death Investigation Guidelines

Deaths, which occur while a person is being pursued, apprehended, or incarcerated by law enforcement or involve medical detainees are usually considered high profile cases. These deaths require prompt and objective investigations in order to prove or disprove public scrutiny, family member's concerns, and questions raised by the media. These cases have a high likelihood for civil and criminal litigation and they often have the potential for creating allegations of police or institutional misconduct.

Any in-custody death, which is other than natural, should be sent to and autopsied by the central office of the Iowa Office of the State Medical Examiner. Questions that usually arise in these types of deaths include:

-Was excessive force used during restraint of a combative person?
-Was a prisoner / patient beaten or otherwise abused?
-Were suicidal precautions adequate given the decedent's history?
-Was a prisoner / patient abused by other inmates?
-Were the physical complaints of an inmate/patient attended to?
-Was the quality of medical care adequate?
-Is there a way to prevent deaths like this in the future?

Many of these questions can be answered following the performance of a thorough death scene investigation, forensic autopsy with toxicology, and collaborating with other investigative agencies.

The duties of the Medical Examiner / Investigator in investigating in-custody deaths should always include:

-Visiting the scene (jail cell, prison yard, patient room) where the incident occurred, even if the decedent was removed and taken to a local hospital.

-Document the scene through photographs and scene sketches with dimensions.

-Obtain reports from police, the institution, rescue reports, time logs, statements from fellow inmates / patients, and any hospital / medical records of the decedent.

-Ascertain the decedent's location, position, actions, and the timing of actions leading up to the death.

-Leave any clothing and other personal effects on the body as they are considered evidence.

-Leave any ligatures in place, ***unless attempts are made to start life saving procedures***. Do not disturb any knots along the entire length of the ligature.

-Ascertain any antemortem (admission) specimens immediately for toxicological analysis.

-Examine the body and document rigor mortis, livor mortis, and any trauma to the body.

-In cases where drug-induced excited delirium is expected, a rectal temperature should be taken immediately. Also, note the room temperature.

-Place and transport the body in a sealed body bag.

Remember:

Avoid speculation and forming of premature conclusions.

In all in-custody death cases, there should be prompt responses to inquiries, even if only to tell those inquiring that the case is pending the outcome of an investigation.

An independent investigative agency (Iowa Division of Criminal Investigation) should be brought into the case to provide unbiased criminal investigative services.

When investigating in-custody deaths, always remember to take into consideration: underlying natural disease, hidden trauma that occurred prior to incarceration, induced trauma while in-custody, drug-induced excited delirium, psychosis, and deaths resulting from use of restraint procedures.