Summary of Investigative Reports
OFFICE OF THE DEFENDER GENERAL
Defender General, Prisoners' Rights Office
6 Baldwin Street, 4th Floor
Montpelier, VT 05633-3301

August 12, 2015

SUMMARY OF FINAL INVESTIGATIVE REPORT
Defender General, Prisoners' Rights Office
6 Baldwin Street, 4th Floor
Montpelier, VT 05633-3301

Name Deceased Inmate: Annette Douglas
Date of Birth: 5/24/1971
Date of Incident: N/A
Date of Death: January 7, 2015
Cause of Death: Natural Causes / Diabetes untreated, other conditions / Patient non-compliance, treatment refused.
Place of Incident: N/A
Place of Death: Fletcher Allen Medical Center, Burlington, VT
Residence of Deceased (time of death): Chittenden Regional Correctional Center (CRCF), Medically Furloughed to Fletcher Allen.

NARRATIVE SUMMARY:

On January 9th, 2015 Annette Douglas, 43, passed away at Fletcher Allen on January 7, 2015. Douglas was placed on medical furlough, and taken to the hospital in an ambulance on the morning of Wednesday, January 7th.

Ms. Douglas suffered from numerous medical conditions, some of which if untreated would result, and did result, in her death. Ms. Douglas over a period of time refused medical treatment for those conditions and that precipitated her death on January 7, 2015.

PRO REVIEW:

The circumstances of Ms. Douglas' demise were investigated by PRO Investigator Anne Vachon, under the supervision of Senior PRO Investigator, Rubin Jennings, with consultation by the Defender General, Matthew Valerio.

Available medical records were reviewed by Joyce Caldwell, R.N., under contract with the ODG.

Various attempts were made by Investigators Jennings and Vachon to gain information from the decedent's surviving family in this case, but they declined to be part of the investigation.

CONCLUSION:

Ms. Douglas' death was caused by her failure and refusal to avail herself of medical treatment and care that was available to her. She expressed a desire to die, and she accomplished that by refusing treatment for her various medical conditions.

If there was one failure in this case, it was the lack of attention to Ms. Douglas' mental health issues, and the impact of those issues on her desire to refuse treatment and effectively end her life.

SUMMARY OF FINAL INVESTIGATIVE REPORT
Defender General, Prisoners' Rights Office
6 Baldwin Street, 4th Floor
Montpelier, VT 05633-3301

Name Deceased Inmate: James Nicholson
Date of Birth: 65 years old (DOB: Unknown)
Date of Incident: N/A
Date of Death: May 18, 2015
Cause of Death: Sudden cardiac death (presumed cardiac dysrhythmia) due to hypertensive and atherosclerotic cardiovascular disease. Diabetes mellitus was considered contributory. The contribution of blunt force injuries of the head sustained on April 2, 2015 to his sudden death on May 18, 2015 is unclear.
Manner of Death: Undetermined.
Place of Incident: N/A
Place of Death: Infirmary, CCA Prison Facility, Beattyville, KY
Residence of Deceased (time of death): CCA Prison Facility, Beattyville, KY

NARRATIVE SUMMARY:

James Nicholson—a 65 year old white man—was found dead in his bed at the infirmary at the Lee Adjustment Center on May 18th, 2015. Resuscitation was attempted but he was determined dead at 6:21 am, according to the Coroner report.

According to the patient's medical records he had diabetes and did not always comply with medication. He also suffered from high blood pressure. The medical examiner concluded that these were a few of the different conditions factoring into Nicholson's "sudden cardiac death". Mr. Nicholson was also involved in an incident on April 2nd, which resulted in "blunt force injuries" to the head. That incident could not be ruled out as contributing to the death of Mr. Nicholson, nor could it be ruled as contributing to his death. As a result, the KY Medical Examiner determined the manner of death to be "undetermined".

On May 18th Robbie Gray of CCA sent an incident report to Rick Byrne, VT DOC. The incident report was forwarded the Prisoners' Rights Office upon request on July 23rd.

The report states that an incident occurred at the Lee Adjustment Center on April 2nd, 2015 at around 3pm in the afternoon. An affray occurred between two inmates. No weapons were used, but it did result in one inmate being sent to the hospital.

The Shift Supervisor was in the South Dorm C & D wing lobby when an inmate came and told him an inmate in the B-wing bathroom was on the floor, bleeding. The S/S reported to the bathroom and found James Nicholson laying on the floor and bleeding from the back of the head. Medical was called, and when they arrived an ambulance was called.

An investigation was then conducted. Inmates around the area at the time of the incident were interviewed. An hour following the incident, Inmate #2 admitted to hitting inmate Nicholson.

The security cameras show that Inmate #2 entered the bathroom at 2:53pm. Nicholson was already inside the facilities. An officer checked in the bathroom during his rounds at 2:56pm and reports seeing no altercation at the time. At 2:57pm Inmate #2 walks out of the bathroom. Twenty-six seconds later, Nicholson is found on the floor of the bathroom.

After admitting to the altercation, Inmate #2 was taken to medical and then to segregation. Around 5pm, Nicholson was loaded in a helicopter and brought to the UK hospital.

According to confidential interviews with clients, Mr. Nicholson precipitated an altercation with Inmate #2 after months long period of antagonizing Inmate #2 by punching him in a bathroom. Inmate #2 responded punching Mr. Nicholson who fell into a sink. Purportedly Nicholson threw 2 punches, and Inmate #2 threw 4 punches as part of the affray. Almost immediately thereafter guards entered the bathroom.

Because Nicholson approached Inmate #2 and threw the first punch, Inmate #2 says he was charged with a DR for fighting, rather than assault.

Two days following the incident, Inmate #2 met with Kentucky State Police. He said he was read his Miranda rights and then chose to remain silent. He said he had no further interaction with the police. No criminal charges have ever been brought.

PRO REVIEW:

Investigation into the circumstances of Mr. Nicholson's death was performed by PRO Investigator Anne Vachon, under the supervision of Senior PRO Investigator, Rubin Jennings, with consultation by the Defender General, Matthew Valerio.

Investigator Vachon acquired relevant incident reports from DOC, and interviewed willing inmate/clients to try to determine what if any impact the injuries sustained in the April 2, 2015 affray had on the death of Mr. Nicholson. Ms. Vachon also reviewed what if any role the level of supervision of CCA employees had on the precipitation of the affray, and whether the affray could have been prevented.

The Kentucky Autopsy Report was provided to the Defender General directly by DOC Commissioner Pallito.

CONCLUSION:

It is likely that the death of Mr. Nicholson was primarily caused by numerous medical conditions including heart disease, hypertension and diabetes. It is unclear if the affray that occurred on April 2, 2015 had some impact on Mr. Nicholson's sudden death, as such the manner of death, per the Kentucky Medical Examiner, cannot be determined.

Regarding the responsibility of CCA officials to keep Mr. Nicholson safe, it is the responsibility of the Department and its contractor in this case, CCA, to keep all in its custody safe. In this case, some blame could be attributed to CCA given their lack of knowledge of the ongoing tension or dispute between Mr. Nicholson and Inmate #2. That having been said, on April 2, 2015, it appears that CCA officials were very diligent in attempting to keep peace in the facility, as the security cameras indicate that the affray apparently took place between 2:56 and 2:57 PM, and an officer had just checked the area at 2:56 PM. CCA personnel responded to that area 26 seconds later to find Mr. Nicholson. It appears that CCA personnel did about all that they could do – short of staying in the bathroom with the inmates – to prevent the affray.

Even at that, there is no evidence to tie the death of Mr. Nicholson on May 18, 2015 to the affray that took place on April 2, 2015.

Summary of Preliminary Investigative Report
Defender General, Prisoners' Rights Office
6 Baldwin Street, 4th Floor
Montpelier, VT 05633-3301

Name Deceased Inmate: Patrick E. Fennessey
Date of Birth: July 1st 1980
Date of Incident: April 23rd 2015
Date of Death: April 25th 2015
Cause/Manner of Death: Suicide
Place of Incident: SSCF – Building GHI (India Unit) near sink.
Place of Death: Dartmouth Hitchcock Medical Center, Lebanon, NH
Residence of Deceased (time of death): Southern State Correctional Facility (SSCF), Springfield VT.

PRELIMINARY NARRATIVE SUMMARY:

BACKGROUND:

Mr. Fennessey has a voluminous criminal history dating back to his teen years. Most all of the offenses are nonviolent misdemeanors and low end felonies, with violations of probation and parole. He routinely failed to appear for court, and violated conditions of release.

His sentence at the time of his death was left over from some 2007 convictions, the original sentence was 8-10 years to serve all suspended except 2 years to serve. He came in on a probation violations in 2010 and was sentenced to a 798 days, plus 11 months to 11 years, so he could be immediately furloughed – and he could keep his social security benefits. His last incarceration was the result of a furlough "violation" arising from the 2010 sentence.

He suffered from a complex combination of major mental illnesses combined with poly-substance abuse and trauma. As one might expect, Mr. Fennessey lived on the street for a period, while attempting to manage the disabling effects of various psychiatric conditions. Mr. Fennessey struggled to manage and to be compliant with his prescribed medications. DOC designated Patrick as Seriously Functionally Impaired (SFI).

DOC and particularly Meredith Larson, Chief of Mental Health Services, noted on November 8th 2012: "*Patrick Fennessey at SSCF presents a complex and challenging case, one that needs a plan that is well coordinated between psychiatry, behavioral services and facility management and security. Without casting any doubt on the skills, sincerity and efforts of his current providers, I nevertheless feel that it is time for a prompt and thorough case review…. That is not something that can be postponed … In the past Mr. Fennessey [has had] at least one very nearly lethal hanging attempt and we do not want to go down that path – or anywhere near it – again. But in the past he has had periods of doing quite well and that is the ground we want to regain*."

DOC well-recognized Patrick's mental health needs; he was classified as seriously functionally impaired (SFI). HCRS recognized his needs by providing a home health care provider to help Patrick with his daily tasks and maintain his prescription compliance.

During periods of incarceration, Patrick allegedly reported being harassed, bullied, teased and laughed-at while housed in Ida Unit, because of his sexuality. He reported that DOC personnel did nothing to protect him.

During what would be his final incarceration, Patrick was brought back into the system when his caregiver was found intoxicated at the residence. Patrick was then taken to Brattleboro Retreat where he remained until his insurance ran out, and he was then transferred to DOC custody and incarcerated.

Patrick began to feel he was headed down the same road as previously, where he was returned from an FSU community placement for a 30 day sanction and would instead remain for 19 months incarcerated. Patrick began to consider committing self-mutilation and other self-harm as a tool to encourage DOC, AHS, DMH and HCRS to communicate better and move faster to getting him back on FSU.

Patrick told his friends that he would attempt suicide to "make a mess" causing DOC and others to respond to why he remained incarcerated for an incident involving his assigned caregiver that was not his fault. These threats of self-harm were pervasive and well-known.

Patrick had committed self-mutilation and harm in the past, he also attempted suicide in the past. He believed this would be just another attempt in an effort to grab news headlines and force DOC, AHS, DMH and HCRS to account for why he remained incarcerated. The goal was, he would recover and be sent back into the community to live his life. That never happened as Mr. Fennessey succumbed to his suicide attempt on April 25, 2015.

There remains significant documentation to wade through, and the investigation is ongoing.

PRO REVIEW:

Investigation into the circumstances of Mr. Fennessey's death was performed by PRO Investigator, Rubin Jennings, with consultation by the Defender General, Matthew Valerio.

Investigator Jennings acquired relevant incident reports from DOC, and interviewed numerous willing family members, friends, DOC personnel and health and mental health care providers. Mr. Fennessey's case is complex with a significant paper trail and numerous witnesses.

As such the investigation is not complete.

Preliminary Findings: The Vermont Department of Mental Health (DMH), Vermont Agency of Human Services (AHS), Health Care Rehabilitation Services (HCRS), and Vermont Department of Corrections (DOC), each contributed to and failed to recognize the onset of the acute psychiatric episode that resulted in Patrick E. Fennessey taking his own life. Preliminarily, each department failed to adequately identify and address the well documented Serious Functional Impairment suffered by Mr. Fennessey, which resulted in unnecessary and prolonged incarceration without adequate treatment or intervention, and then failed to identify and respond to the warning signs relative to Mr. Fennessey's potential for self-harm.