DRM Downs Rachlin Martin PLLC
Business Sense·Legal Ingenuity

REPORT OF INVESTIGATION

TO: The Vermont Agency of Human Service

FROM: Downs Rachlin Martin, PLLC

DATE: November 12, 2020

RE: *Report on the Death of Kenneth Johnson*

I. Introduction

The Vermont Agency of Human Services ("AHS") engaged Downs Rachlin Martin, PLLC ("DRM") to investigate the events surrounding the death of Kenneth Johnson on December 7, 2019. Mr. Johnson was an inmate at the Northern State Correctional Facility ("NSCF") at the time of his death.

II. Investigation Methodology

During the course of its investigation, DRM interview DOC staff, reviewed video footage, and analyzed DOC documentation, including medical records. DRM attempted to interview the health care providers who treated Mr. Johnson on December 6-December 7, 2019 and otherwise attempted to obtain information and medical records from Centurion Vermont, LLC ("Centurion"), which was contracted with DOC to provide medical services at NSCF. Centurion refused to cooperate in this investigation.

III. Facts

A. Background

At the time of his death, Mr. Kenneth Johnson was a sixty-year-old man who had been incarcerated at NSCF as a pretrial detainee since September 23, 2017. Mr. Johnson, who was African-American, experienced a health crisis during the late evening through

the early morning hours of December 6 to December 7, 2019, that ended in his death. In the hours leading up to his death, DOC Officers and Centurion nurses were called on three occasions to the infirmary to respond to Mr. Johnson's health problems via so-called "10-25" distress calls. Mr. Johnson repeatedly told staff that he could not breathe and was in obvious physical distress throughout the evening. Despite this crisis, neither DOC staff nor the health care providers transferred Mr. Johnson to the hospital. At approximately 2:00 AM, other inmates in the prison infirmary found Mr. Johnson to be apparently unresponsive with no pulse and not breathing. They alerted the nurses, who in turn alerted corrections staff. Mr. Johnson was found unresponsive, an emergency transport was arranged to North Country Hospital where he was declared dead upon arrival.

B. December 6-7, 2019

1. Introduction

The acute health crisis that ultimately resulted in Mr. Johnson's death occurred on the evening of December 6 and the early morning hours of December 7, 2019. This timeframe is encompassed by Third Shift at NSCF, which begins at 10:00 PM and ends at 6:00 AM the following day.

Corrections Officer (CO) Robert Wright was the Shift Supervisor for Third Shift and therefore the senior DOC official present at the facility. The Charge Nurse was Nurse 1. Nurse 2 was also on duty.[1]

[1] In addition to Nurses 1 and 2, the on-call health care provider (Nurse 3), also a Centurion employee, was involved in Mr. Johnson's care, as described below. Nurse 4 was also present for the First 10-25 call pertaining to Mr. Johnson, as discussed below, but appears to have gone off duty at approximately 10:00 PM prior to the Second 10-25 call.

Since November 18, 2019, Mr. Johnson was housed in the facility infirmary. Also residing in the unit on December 6-December 7, 2019, were inmates Donald Griggs and Raymond Gadreault. Mr. Johnson was subject to DOC's medical observation protocol while in the infirmary. According to DOC Protocol 403.4, inmates who have been placed on medical observation can be subject to three levels of observation:

- Routine Observation: Physical observation at least every 30 minutes at staggered intervals.
- Close Observation: Physical observation at least every 15 minutes at staggered intervals.
- Constant Observation: Continuous uninterrupted observation.

Each observation by DOC staff must be documented on the Special Observation Form, which includes columns to record the time of the observation, the signature of the observing officer, and any comments or observations by the officer. DOC Protocol requires the following from observing officer:

> a. Observation checks will include visual observation of the inmate, ensuring that they are not under physical duress, engaging in self-destructive behavior, or engaging in other unauthorized behavior.
>
> b. Observation checks will include the visual observation of bodily movement or, if the inmate is awake, engaging in conversation to ensure that he/she is not under physical duress.
>
> c. The Shift Supervisor will visit inmates on any observation status daily each shift, and document the visit on the Special Observation Monitoring Sheet.
>
> d. Inmates on any observation status will receive visits from Qualified Medical and Mental Health Professionals in compliance with the governing directive for the observation status the inmate is on. The QHCP or QMHP will document each visit on the Special Observation Monitoring Sheet.

DOC Protocol 403.4. Moreover, a Supervisor has the authority to increase the level of supervision that a particular inmate receives. *Id.*

During the December 6-December 7, 2019 timeframe, Mr. Johnson was under Routine Supervision and was thereby required to receive observation checks at staggered intervals of at least every 30 minutes. DOC has produced Special Observation Forms for Mr. Johnson during the pertinent period, which reflect that observations were made at the required intervals. These observations are discussed in further detail below. Neither Shift Supervisor Wright nor Charge Nurse 1 increased Mr. Johnson's observation level during that night.

In the hours immediately preceding Mr. Johnson's death, there were three 10-25 calls pertaining to Mr. Johnson's health situation. A 10-25 call is when a DOC staff member initiates a facility-wide urgent request for assistance. All available officers must immediately respond to a 10-25 call. The three 10-25 calls are discussed in detail below.

2. First 10-25 Call

The Special Observation Form for the evening period of Second Shift (which ends at 10:00 PM) does not document anything of note. The officer's comment section reflects that Mr. Johnson was sitting on his bunk or lying awake watching TV. Officer Mercer recorded the first entry on Special Observation Form during Third Shift at 10:04 PM. At that time, Officer Mercer documented that Mr. Johnson was "on bunk."

The subsequent Special Observation Form entry is recorded at 10:37 PM and contains the note "medical." Officer Mercer also completed this entry. This entry corresponds with the first 10-25 Call pertaining to Mr. Johnson during the December 6-December 7, 2019 time period.

Video Footage:

The video footage in the infirmary that corresponds to the first 10-25 call shows Mr. Johnson rocking back and forth on this bed in notable distress.[2] Both Mr. Griggs and Mr. Gadreault are awake and appear to take note of Mr. Johnson's condition.[3] It appears as though Mr. Griggs calls or signals through the infirmary door to attract Officer Millett's attention.

Once Officer Millett enters the infirmary, he appears to have a brief conversation with Mr. Johnson and then places his hands on Mr. Johnson and helps him to roll over from his back to his side. Officer Millett remains with one hand on Mr. Johnson's back until, within less than 30 seconds, three nurses enter the room: Nurses 1, 2 and 4.

With Officer Millett's help, the nurses assist Mr. Johnson into a sitting position, and appear to apply a blood pressure cuff, check his breathing with a stethoscope, take his temperature, and use a finger-application pulse oximeter device. During this encounter, Nurse 1 records some handwritten information on a piece of a paper prior to assessment of the pulse oximeter.[4] After assessment of the pulse oximeter, additional entries do not appear to be made during the portion of this encounter on the video.

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[2] The video footage from inside the infirmary that DOC has provided to DRM does not contain chronological data that would permit an observer to know from this video footage alone when a particular event has occurred. DOC has explained that such data is not available for the footage from inside the infirmary. Where possible, DRM has attempted to estimate the timing of occurrences by referring to additional documentary evidence and the video footage from the hallway outside the infirmary, which does contain what appears to be accurate chronological data. DOC has been unable to provide hallway footage from December 6, 2019, however.

[3] All the video footage lacks audio.

[4] These handwritten notes are not included in the medical records. Nor are any vital signs from this encounter recorded in the medical records.

Within less than a minute of the nurses entering the infirmary and while they are administering care to Mr. Johnson, Supervisor Wright enters the infirmary and observes what is occurring from near the foot of Mr. Johnson's bed.

As the nurses attend to him, Mr. Johnson is sitting on his bed and it is clear that his chest is heaving, consistent with having difficulty breathing. At one point, he gestures toward his throat.

The nurses eventually bring Mr. Johnson a nebulizer device which he inhales from. While doing so, he repeatedly touches and gestures toward his throat.

At one point, while Mr. Johnson is sitting on his bed using the nebulizer, Officer Zahn enters the infirmary and speaks with Mr. Johnson. Officer Zahn eventually brings ice into the infirmary and places some in a cup, which she provides to Mr. Johnson. Officer Zahn is the last DOC employee to depart from the infirmary. When she leaves, Mr. Johnson appears to be resting in bed and in less distress. In total, DOC staff spend approximately 20 minutes in the infirmary with Mr. Johnson after the first 10-25 was initiated.

Officer Millett:

Corrections Officer Millett initiated the first 10-25 call at approximately 10:25 PM on December 6, 2019. According to his written narrative report, Officer Millett observed Mr. Johnson in the infirmary and Mr. Johnson "appeared to be gasping for air" so Officer Millett entered the infirmary, called the 10-25 and placed Mr. Johnson "in our DOC Trained recovery position so Medical could get him a breathing treatment and necessary equipment for treatment." According to Officer Millett's report, Mr. Johnson "seemed to breath [sic] a little better being in the recovery position because he was talking a little and his gasping was less than I first observed." After medical personnel

arrived, Mr. Johnson requested ice and stated that he "couldn't breathe well." After "breathing treatment, vitals being taken and an albuterol treatment," Nurse 1 "deemed that no medical transport was needed" and Officer Millett retrieved ice for Mr. Johnson.

During his interview with DRM, Officer Millett explained that he was walking past the infirmary at approximately 10:25 PM because he was completing the facility's fire-safety compliance check. As he did so, he observed through the infirmary window that Mr. Johnson looked as though he was "gasping." For this reason, Officer Millett entered the infirmary and spoke with Mr. Johnson. When Officer Millett first entered the infirmary, he could both see and hear Mr. Johnson gasping for breath. When asked whether he believed Mr. Johnson was exaggerating or faking symptoms, Officer Millett noted that he is not a medical professional and that DOC staff are trained to treat all inmate's claims of medical symptoms as legitimate. Nevertheless, he conceded that he was "generally concerned" which is why he initially entered the infirmary and then called the 10-25.

Supervisor Wright:

According to Supervisor Wright's written narrative report concerning the first 10-25 call, when Supervisor Wright entered the infirmary in response to the call, he observed Officer Millette and nursing staff helping Mr. Johnson. Mr. Johnson was "having trouble breathing." Nursing staff "took vitals and administered albuterol treatment" and Nurse 1 "deemed that no medical transport was needed."

During his interview with DRM, Supervisor Wright reiterated that Officer Millette called the 10-25 because Mr. Johnson was having trouble breathing. Supervisor Wright was present when the nurse provided Mr. Johnson albuterol. Supervisor Wright

noted that he is familiar with albuterol as a treatment for shortness of breath because he suffers from asthma.

Officer Mercer:

During his interview with DRM, Officer Mercer recalled responding to the first 10-25. He recalled that the 10-25 was initiated because Mr. Johnson had reported that he could not breathe. Officer Mercer also recalled that, after some time, it appeared that Mr. Johnson felt better and that he returned to bed but remained awake. The video footage does not appear to show Officer Mercer entering the infirmary during the first 10-25 call.

Officer Mercer was the officer assigned to the infirmary and was therefore responsible for performing the observations. Officer Mercer reviewed the Special Observation Form for Mr. Johnson and confirmed that he was the officer who completed and initialed the Special Observation Form during the time periods between the first 10-25 call, which occurred at approximately 10:35 PM on December 6th and the second 10-15 call, which occurred at approximately 12:38 AM on December 7th.

Donald Griggs:[5]

On December 6-December 7, 2019, Mr. Griggs was an inmate at NSCF lodged in the infirmary [redacted]. During his interview with DRM, Mr. Griggs recalled that, at approximately 9:00 PM on the evening of December 6, 2019, Mr. Johnson began stating that he could not breathe. Nevertheless, Mr. Johnson was reluctant to press his emergency button because of concerns about how staff might react.

[5] DRM also interviewed Raymond Gadreault. Although it did not appear that Mr. Gadreault was being intentionally deceptive, his recollection of events varied greatly from other witnesses' statements, documentary evidence, and the video footage. For example, although Mr. Gadreault recalled Mr. Johnson's difficulty breathing and subsequent death, he recalled that a nurse other than Nurse 1 and Nurse 2 was principally involved, contrary to the clear video and witness statements.

Mr. Griggs recalled that, at approximately 10:00 PM, Officer Millett came in to check on Mr. Johnson because Mr. Griggs banged on the window to get his attention. Mr. Johnson told Officer Millett that Mr. Johnson could not breathe and Officer Millett called a 10-25. According to Mr. Griggs, three nurses (Nurses 1, 2 and 4) came into attend to Mr. Johnson as well as officers, including Supervisor Wright.

Mr. Johnson told staff that he could not breathe. Nursing staff checked Mr. Johnson and told him that his vitals were fine and his blood pressure was a little elevated. They provided Mr. Johnson with medicine via a nebulizer. They encouraged him to stay in his bed and relax. Mr. Griggs believed that Nurses 1 and 2 became somewhat agitated with Mr. Johnson although Nurse 4 did not seem to be bothered.

3. Second 10-25 Call

At approximately 12:38 AM on December 7, 2019, Officer Mercer called the second 10-25 after he discovered Mr. Johnson on the floor of the infirmary bathroom. The Special Observation Form entry, which Officer Mercer completed, records the second 10-25 call pertaining to Mr. Johnson as having occurred at 12:38 AM on December 7, 2019. Officer Mercer's note reads, "on floor bathroom 10-25."

Video Footage:

The video footage from both the hallway and inside the infirmary shows that, at approximately 12:34 AM, Mr. Johnson gets out of bed and walks to the infirmary bathroom. At the time, Nurse 1 can be seen standing in the nurse's office. The nurse's office is across the hallway from the infirmary and both the infirmary and the nurse's office have lengthy sets of windows that appear to permit the nurses to observe the interior of the infirmary directly from their office. The nurse's windows are not directly across from the infirmary windows, however. Accordingly, it is not possible to

determine from the video footage whether the nurses could see Mr. Johnson's bed from their vantage point in the nurse's office. Nevertheless, it does appear that Nurse 2 could have seen Mr. Johnson as he walked to the bathroom.

Approximately three minutes pass, at which point Officer Mercer can be seen conducting an observation through the window of the infirmary door. It appears that Officer Mercer observes that Mr. Johnson is missing from his bed and enters the infirmary. Within seconds, both Nurse 1 and Nurse 2 enter the infirmary, apparently in response to Officer Mercer's 10-25 call.

Corresponding video footage from inside the infirmary shows Officer Mercer finding Mr. Johnson on the bathroom floor. Shortly thereafter Nurse 1 and Nurse 2 and Supervisor Wright arrive. Officer Mercer and Supervisor Wright help Mr. Johnson back to his bed. Mr. Johnson appears to be in distress and can be seen rocking back and forth in bed. Officers Zahn, Bathalon, and Blanchard eventually enter the infirmary as well.

Nurse 1 can be seen taking Mr. Johnson's temperature, which she records on a piece of paper.[6] Nurse 1 also appears to place a pulse oximeter device on his right hand and looks at it. Nurse 1 turns away from the pulse oximeter device while Nurse 2 attends to applying the pulse oximeter, rubbing Mr. Johnson's finger. When she turns away from the pulse oximeter, Nurse 1 does not make any notation on her notepad, but instead picks up a blood pressure cuff and returns to Mr. Johnson's bedside. Nurse 2 leaves the infirmary without recording any readings from the pulse oximeter. Nurse 1 appears to obtain a blood pressure reading.

[6] Again, these handwritten notes were not part of the medical record that DRM was provided.

During this time period, Mr. Johnson can be seen rocking back and forth in his bed in apparent distress. At points, he also seems to be attempting to get out of his bed. At some point, Officer Bathalon moves to a position directly over Mr. Johnson in his bed in what appears to be an effort to discourage Mr. Johnson from getting up. Nurse 1 and Officer Bathalon gesture toward Mr. Johnson's bed and appear to be ordering him to stay in bed. From his body language and positioning, it seems reasonably clear that Officer Bathalon is using his physical presence to control Mr. Johnson to ensure he remains in bed.

When the nurses are finished with Mr. Johnson, the other officers depart the infirmary and Mr. Johnson is left alone with Nurse 2 and Supervisor Wright. Supervisor Wright and Nurse 2 gesture toward Mr. Johnson, who is again sitting up in his bed and rocking back in forth in obvious distress. From their gestures and body language, it appears they are ordering Mr. Johnson to get into his bed. Mr. Johnson appears to attempt to comply. Nurse 1 then returns to the infirmary and provides Mr. Johnson what appears to be medicine, which he takes. Both nurses then depart leaving Supervisor Wright with Mr. Johnson. Supervisor Wright makes several gestures toward Mr. Johnson and then the hallway. During this timeframe, it is clear that Mr. Johnson is uncomfortable lying down in bed as directed. From Supervisor Wright's gestures and body language, as well as other evidence, it is likely that Supervisor Wright is telling Mr. Johnson to remain in his bed or he will be placed in a holding cell.

In total, DOC staff spend approximately 13 minutes in the infirmary with Mr. Johnson after the second 10-25 was initiated.

Supervisor Wright:

According to Supervisor Wright's narrative report for the second 10-25:

> Nursing staff arrived then COII Mercer and I assisted him to his feet and escorted him back to his bed.
> Nursing staff assisted him, took vitals and called the on call provider.
> Inmate Johnson was flailing all over and would not sit still, stating he was getting dizzy when he laid down.
> He kept panting and making a fuss saying he couldn't breath, [sic] but was talking fine.
> He was then informed by nursing staff to stay in his bed and stop standing up and getting gout [sic] of bed.
> Inmate Johnson was given some decongestant pills.
> He took the pills and mouth check completed.
> He was again informed he was not to get out of his bed and was given a portable urinal bottle to use.
> He was also informed that if he continues not to follow nurses instructions per the on call provider, he was going to be place out in holding.
> Staff were sent back to normal duties.
> I informed inmate Johnson to knock it off or he would be moved to holding per the provider and I returned to my normal duties.

During his interview with DRM, Officer Wright stated that he could not tell whether Mr. Johnson's medical claims were legitimate but that he was skeptical about Mr. Johnson's claim that he was unable to breathe because Mr. Johnson was talking fine. Supervisor Wright referenced his own asthma and noted that when he is having an asthma attack he has difficulty speaking.

According to Supervisor Wright, the nurse left the infirmary and contacted the health care provider by phone. Supervisor Wright was not privy to his conversation but when the nurse returned she instructed Mr. Johnson to remain in bed, and it was the nurse who initially warned Mr. Johnson that he would be placed in the holding cell if Mr. Johnson did not remain in bed.

Supervisor Wright stated that, after the nurse spoke to Mr. Johnson about remaining in bed, Mr. Johnson was still sitting up in bed, rocking back and forth and

claiming that he could not breathe. Supervisor Wright told Mr. Johnson that he needed to stop and behave. He instructed Mr. Johnson that the holding cell was not the right place for Mr. Johnson and that Mr. Johnson did not want to go there in his condition. Supervisor Wright told Mr. Johnson that he himself would not want be in the holding cell while suffering an asthma attack.

In reference to his narrative report, Supervisor Wright was asked what he meant when he told Mr. Johnson to "knock it off." Supervisor Wright explained that, by telling Mr. Johnson to "knock it off" he was telling Mr. Johnson to stay in bed.

Supervisor Wright conceded that Mr. Johnson was not violating any DOC rules and was not being violent or combative. The sole issue was that the nurse and health care provider had instructed Mr. Johnson to remain in bed and Mr. Johnson needed to follow that advice for medical reasons.

When asked whether Mr. Johnson should have been placed on a higher, more stringent observation level after the second 10-25 call in which Mr. Johnson was found lying in the bathroom, Supervisor Wright asserted that he lacked the authority to raise an inmate's observation level for medical reasons.

Supervisor Wright stated that he had called Superintendent Rutherford after both 10-25s and informed him of the situation. Supervisor Wright related to Superintendent Rutherford that Mr. Johnson had stated he could not breathe. Superintendent Rutherford did not order a higher level of observation for Mr. Johnson.

According to Supervisor Wright, a holding cell is a small cell with a toilet next to the bed and nothing else. Although holding cells are used for inmates who are disregarding orders, violent or disruptive inmates are also placed in holding cells for

medical reasons and when they are admitted to the facility. According to Supervisor Wright, it is common to place inmates in holding cells for medical reasons including scabies, the flu, and "time out" for mental health reasons. As Supervisor Wright understood it, an officer can place an inmate in a holding cell for rule-breaking or safety reasons, but only medical personnel can place an inmate in a holding cell for medical reasons.

When asked if he had ever received implicit bias training from DOC, Supervisor Wright stated that he had never heard of implicit bias training and did not know what implicit bias was.

When asked his opinion about what went wrong with Mr. Johnson's care, Supervisor Wright opined that medical personnel had "dropped the ball" and should have taken Mr. Johnson to the hospital sooner. He admitted that he did not believe medical staff was making a mistake at the time and noted that "hindsight is 20-20."

Officer Mercer:

According to his narrative report regarding the second 10-25 Call, Officer Mercer found Mr. Johnson on the infirmary bathroom floor and observed that he was "breathing heavily and gasping for breath." Mr. Johnson complained that he was "dizzy."

During his interview with DRM, Officer Mercer recalled that Mr. Johnson repeatedly told DOC staff that he could not breathe. Officer Mercer disagreed with Supervisor Wright's assessment that Mr. Johnson was speaking fine. To the contrary, Officer Mercer recalled that Mr. Johnson was stating over and over that he could not breathe and appeared to be "struggling mightily to say that." Officer Mercer heard both the nurse and Supervisor Wright tell Mr. Johnson to stay in his bed. He also recalled Supervisor Wright telling Mr. Johnson to knock it off and he understood Supervisor

Wright's words to be a "threat." According to Officer Mercer, Supervisor Wright seemed agitated by Mr. Johnson and angry with him. From Officer Mercer's perspective, it did not appear that Supervisor Wright believed Mr. Johnson about his symptoms.

Officer Mercer denied that Mr. Johnson was combative or aggressive, but instead seemed to be "panicked that he could not breathe."[7] According to Officer Mercer, following this encounter he asked Nurse 1 "if someone could fake something like that." He asked this question because he had heard Supervisor Wright tell Mr. Johnson to "knock it off" and threatened him with placement in the holding cell. Nurse 1 told Officer Mercer that she did not think Mr. Johnson's symptoms could be faked.

In contrast to Supervisor Wright, based on Officer Mercer's experience, the holding cells are used for disciplinary and safety reasons. Inmates are placed in holding cells when they are intoxicated and out-of-control, engaged in rule breaking or violence, or suicidal. As far as Officer Mercer knew, nurses and other medical personnel do not have the authority to order an inmate into a holding cell. That authority lies with an officer, specifically the Shift Supervisor. Officer Mercer specifically stated that it was Supervisor Wright, and not the nursing staff, who wanted to send Mr. Johnson to the holding cell.

When asked, Officer Mercer stated that he was quite familiar with the concept of implicit bias, but had not received training on it from DOC.[8] Officer Mercer could not opine with certainty about whether race played a factor in DOC's treatment of Mr. Johnson. He stated that he believed medical personnel were genuinely trying to help Mr.

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[7] In her narrative report concerning the Second 10-25, Officer Zahn wrote that Mr. Johnson was "gasping for air and was unable to get comfortable [and] he indicated that it wasn't [sic] in his lung and reached to his neck and said 'it's up here.'"

[8] Officer Mercer is a person of color.

Johnson. On the other hand, in the past he had seen white inmates brought to the emergency room. Officer Mercer described the question as a "big if," and stated that he could not be certain, but acknowledged that race could have been a factor.

Officer Bathalon:

In his narrative report, Officer Bathalon described Mr. Johnson as having "the appearance of being uncomfortable and his breathing was labored and raspy and he was complaining of being dizzy." Officer Bathalon described his role as "making sure [Mr. Johnson] did not fall out of bed."

During this interview with DRM, Officer Bathalon stated that he did not have much recollection of the events beyond what is in his narrative report. He claimed to have no opinion about whether Mr. Johnson was faking his symptoms. Officer Bathalon did concede, however, that as far as he could recall Mr. Johnson had not broken any facility rules.

When asked about anti-bias training he had received as a DOC Officer, Officer Bathalon stated that, at the Corrections Academy, officers were trained to treat everyone equally regardless of race, gender, or sexual orientation. He believed DOC Officers, in general, were pretty fair.

Donald Griggs:

During his interview with DRM, Mr. Griggs recalled that Officer Mercer entered the infirmary, found Mr. Johnson on the bathroom floor, and called a 10-25. By this point, Nurse 4 had completed her shift so Nurses 1 and 2 responded. They were agitated by Mr. Johnson.

Both Nurses 1 and 2 told Mr. Johnson that he needed to go to bed and they were not going to play this game anymore. Although Mr. Johnson repeated that he could not breathe, they told Supervisor Wright that he needed to stay in bed. They stated that he had [redacted], has an appointment with a specialist at Dartmouth, and that there is nothing more they can do for him.

Nurse 1 told Nurse 2 and Supervisor Wright that if Mr. Johnson gets out of bed again, he will be put in a holding cell. Mr. Johnson could hear Nurse 1's statement. Supervisor Wright restated this direction to Mr. Johnson in a pointed way stating that he was not going to take any more of Mr. Johnson's bullshit and that Mr. Johnson was fine. Supervisor Wright wagged his finger at Mr. Johnson and told him, "if I come in here again, you are going in there"—meaning the holding cell.

After DOC staff left the infirmary, Mr. Johnson continued to state that he could not breathe. Nevertheless, neither Mr. Johnson nor Mr. Griggs were willing to push their emergency buttons for fear of Mr. Johnson being moved into a holding cell.

4. Events Immediately Preceding Mr. Johnson's Death

(a) Overview

From when DOC staff leaves Mr. Johnson in the infirmary after the second 10-25 call at approximately 12:51 AM until the third 10-25 call at approximately 2:17 AM, is a period of approximately 1 hours and 26 minutes. During this time period, video footage from inside the infirmary shows Mr. Johnson in obvious distress. He sits on his bed, rocks back and forth, moves to the floor, and is very clearly in very significant physical discomfort. As required, DOC Officers perform several observations of Mr. Johnson during this time period, which are detailed below.

(b) Observation at 1:14 AM

The hallway video shows Officer Zahn conducting an observation through the infirmary window at approximately 1:14 AM After looking through the window, she enters the infirmary where she remains for less than a minute. Officer Zahn does not appear to consult with Nurse 1 after departing the infirmary. But while walking past the nurse's station, Officer Zahn turns to Nurse 1 and shrugs her shoulders at Nurse 1 in an "I don't know" type gesture. Nurse 1 does not enter the infirmary to investigate after Officer Zahn's gesture.

Video footage from inside the infirmary during this timeframe shows Mr. Johnson getting in and out of his bed and rocking in clear discomfort while in his bed.[9]

Officer Zahn's entry on the Special Observation Form for this check (which she records as having occurred at 1:10 AM) contains the note, "agitated."

(c) Observation at 1:41 AM

The hallway video shows Officer Mercer conducting an observation through the infirmary window at approximately 1:41 AM. Officer Mercer looks through the window directly across from Mr. Johnson's bed and then enters the infirmary. Corresponding footage from inside the infirmary appears to show Officer Mercer speaking with Mr. Johnson. Mr. Johnson still appears to be in physical distress. Mr. Johnson is sitting up in bed and is rocking back and forth with his head down.

After approximately one minute, Officer Mercer leaves the infirmary. From the video footage at least, it does not appear that he consults with Nurse 1. During his interview with DRM, Officer Mercer stated that he entered the infirmary to speak with

[9] The corresponding video footage from inside the infirmary does not show Officer Zahn's entry. It is possible that she did not enter far enough into the infirmary to fall within the camera's coverage.

Mr. Johnson because Mr. Johnson was still awake and appeared to be having difficulty. During this conversation, Mr. Johnson asked to be put in the holding cell. Officer Mercer explained to Mr. Johnson that he lacked the authority to move Mr. Johnson to the holding cell. Although Officer Mercer did not understand why Mr. Johnson made this request, he speculated that Mr. Johnson may have been somehow trying to prove that he was being honest and not trying to cause a problem.

Officer Mercer's entry on the Special Observation Form for this check (which he records as having occurred at 1:42 AM) contains the note, "awake."

(d) Observation at 2:07 AM

The hallway video shows that at approximately 2:07 AM, Officer Mercer performs another observation. He quickly looks through the infirmary window and then walks away. Officer Mercer's entry on the Special Observation Form for this check (which he records at having occurred at 2:07 AM) contains the note, "awake."

During his interview, Officer Mercer stated that, during this observation he looked at Mr. Johnson through the infirmary window and could see he was still having difficulty. According to Officer Mercer, the nurses could also have seen Mr. Johnson's condition from their station if they had been paying attention.

Footage from inside the infirmary shows that, at approximately 2:02 AM, Mr. Johnson assumes what is ultimately his last position in bed prior to his death. Mr. Johnson can be seen on his back in bed with his left knee up. From this point onward, Mr. Johnson's movements are, at best, minimal. Approximately three to four minutes later, Mr. Gadreault gets out of bed to use the bathroom. While he is returning from the bathroom, foam appears to come from Mr. Johnson's mouth, although it is difficult to determine for certain from the footage.

Approximately six to seven minutes after this, it appears that Mr. Johnson's left leg moves slightly although, again, it is difficult to determine movement with certainty. It appears that Mr. Johnson does not move again.

5. Third 10-25 Call

Hallway video shows that, at approximately 2:17 AM, Nurse 2 enters the infirmary. Shortly thereafter, she leaves the infirmary and quickly gestures to Nurse 1, then quickly returns to the infirmary with Nurse 1. Corresponding footage from inside the infirmary shows that Mr. Gadreault and Mr. Griggs have perceived that Mr. Johnson is in trouble and have signaled for the nurses. This corresponds to an entry on the Special Observation Form (recorded at 2:20 AM) with the annotation, "medical 10-25."

Subsequent video shows a number of officers responding within seconds and beginning to attempt CPR and life-saving procedures on Mr. Johnson. Ultimately, paramedics arrive who assist in the lifesaving attempts and eventually transport Mr. Johnson to the hospital where he was declared to be deceased upon arrival.

C. Medical Records

The medical records of Kenneth Johnson's treatment while under Department of Corrections custody on December 6 and 7, 2019, such as they are, support the conclusion that all was not done that could have been done to address Johnson's emergent medical condition.

The records of Johnson's medical care during this critical period are sparse. The paucity of medical information we have been able to glean has been exacerbated by Centurion's, the corporation with whom the State of Vermont contracted to provide care to inmates in its custody, refusal to cooperate in this investigation by permitting

interviews of the providers who treated Mr. Johnson or providing records or other information.

The very limited medical records available to the investigation include the following:

December 6, 2019 Daytime:

During the daytime of December 6, 2019, DOC staff administered several orders for [redacted] without incident. The records provided do not indicate any acute condition or response to these treatments during the day of December 6, 2019. At 3:55 PM, Nurse 4 provides a [redacted] treatment of previously prescribed [redacted], which was prescribed for up to four times a day, as needed. This medication was not to be kept on the patient. The medical record does not indicate the reason this medication was prescribed, but [redacted] is commonly used to prevent and treat difficulty breathing, wheezing, shortness of breath, coughing, and chest tightness caused by lung diseases such as asthma and chronic obstructive pulmonary disease.

December 6, 2019 Evening -December 7, 2019 Early Morning:

At 9:53 PM on December 6, 2019, Nurse 4 notes an earlier encounter with Mr. Johnson occurring at 5:30 PM for 2 minutes. She notes him to have been [redacted]' No actions were taken, and Nurse 4 signed off on the note at 9:57 PM

At 10:47 PM on December 6, 2019, Nurse 1 documented in a nurse progress note her dealings with Mr. Johnson. Nurse 1's 10:47 PM progress note stated that she was called to the medical health unit at the facility because Mr. Johnson was complaining that "[redacted]" She recorded his vital signs as [redacted], Temperature [redacted]

Pulse [redacted], Pulse oxygen [redacted] and respirations [redacted]. She noted Mr. Johnson's [redacted] An [redacted] was given. She noted the patient started the [redacted] treatment and then "[redacted]" He picked it up later to finish, her note said. "[redacted]."

At 1:53 AM on December 7, 2019, minutes before Johnson was found unresponsive in his infirmary bed and the third 10-25 was called, an encounter note recounting a prior call between Nurse 1 and the medical provider, Nurse 3, was dictated by Nurse 1. The note is described as Phone Call to S-BAR and recounts a call made to the provider at 12:10, roughly the time of the second 10:25. The note recounts Mr. Johnson's current problem list as including [redacted]. The note also lists a number of medications prescribed to Mr. Johnson. The note lists his vital signs as Blood Pressure: [redacted], Temperature: [redacted], Pulse: [redacted], Respiration: [redacted], Pulse Oxygen: [redacted].

The 1:53 am note documents a call at 12:10 am to the on-call provider, Nurse 3, which is noted as being returned at 12:10 am. The situation preceding the call is described as "[redacted]." The note states that Mr. Johnson's blood sugar was [redacted]. The assessment/action part of the note states that "[redacted]." The provider recommendations were medications ordered [redacted]." The face to face time was recorded as 30 minutes and the administrative time as

30 minutes. Nurse 1 signed this note at 1:59 am on December 7, 2019. The verbal medication order from the on-call provider, Nurse 3, was entered at 2:05 am on December 7, 2019.

At 1:54 am on December 7, 2019, a blood sugar reading of [redacted] was recorded. The note does not say who took the blood sugar reading or indicate it was taken at a different time.

There are no chart entries by Nurse 2 on December 6 or 7, 2019 describing care she provided to Mr. Johnson. A January 11, 2020 email that was later apparently included as part of Mr. Johnson's medical record and was apparently authored by Nurse 2 describes her recollection of what happened to Mr. Johnson during the evening of December 6-7, 2019. The email states as follows:

> This is what I recall of the encounters with K. Johnson:
> We (Nurse 1 and Nurse 2) were called into the infirmary 3 or 4 times before the 10-25 incident. Each time we both entered the room, not together, but we both responded to the call signals. His complaint was that [redacted] On every occasion, [redacted]. His vital signs were taken on at least two occasions [redacted].
>
> At the first encounter, he was given a [redacted].
>
> At another time, he was found lying in the fetal position on the bathroom floor and assisted into his bed by DOC staff. [redacted] and instructed not to get out of the bed for any reason without first activating he call alarum for assistance, but he was later seen walking around in the room.

> On another occasion, Nurse 1 telephoned the on-call provider to provide information concerning Mr. Johnson's complaints and request orders. [redacted]
>
> The final call signal was activated by another inmate in the infirmary. I responded immediately because I was sitting in the nurses station documenting on the computer. This inmate reported, He is not making the noise he always makes when he breathes. I went to KJ's bedside, [redacted] DOC staff began responding immediately.
>
> I am sorry I cannot be more specific and give chronological details with times. It was a very busy chaotic night, and it has been a while since that night.

[Nurse 2]

At approximately 5:21 am on December 7, 2019 a Nurse Progress Note apparently dictated by Nurse 1 was entered into the chart. It stated that it was a late entry for 2:15 am. It further stated:

> At approx. 0215 cell mate rang call bell and said "he is not making the same noise he does when he is breathing." Co-worker, [Nurse 2] went in to check on patient [redacted]

Another encounter note entered shortly beforehand at 4:48 AM stated that at 2:18 AM "[redacted]" The nurse then called a 10:25 on radio. Mr. Johnson was noted to have "[redacted]" and "[redacted]" [redacted] the on call provider, Nurse 3, was called as an immediate intervention. The chart notes that the on call provider, Nurse 3, was called at 0230, and

the call was returned at 0230. The note specifies that Nurse 1 and Nurse 2 as well as four corrections staff were present for the 10:25 incident. 911 was called and the ambulance was noted as arriving at 2:41 am. The author of this encounter note is not recorded.

Apparently at the same time as the preceding encounter note, 4:48 am, a note entitled Emergency Response Documentation and containing much of the previous note information was dictated. In addition to the above notations, this Emergency Response Documentation note states:

Vital Signs previously taken.

VITAL SIGNS:
Blood Pressure: [redacted]
Temperature: [redacted]
Pulse: [redacted]
Respiration: [redacted] Pulse Oxygen: [redacted] Blood Sugar [redacted]

SECONDARY ASSESSMENT:
Pulse Rate: [redacted]
Respiratory Rate: [redacted]
Skin Temperature: [redacted]
BP: [redacted]
Sa02: [redacted]
FBG: [redacted]

The records do not reflect when this apparent initial and secondary assessment of Mr. Johnson's vital signs were taken or who took them. They match exactly the vital signs recorded in the 1:54 am encounter note by Nurse 1 recording the 12:10 AM call to the on-call provider, Nurse 3. The author of this encounter note is not recorded in the medical records, although a different part of the encounter note appears to list Nurse 1 as the attending provider.

D. Additional Information

1. Superintendent Rutherford

Joshua Rutherford, who was Superintendent of NSCF at the time of Mr. Johnson's death also provided an interview to DRM. According to Mr. Rutherford, he received a call from Supervisor Wright in the early morning hours of December 7, 2019. He was unsure of exactly when this call was, but estimates it was around 2:00 AM to 3:00 AM. He said Supervisor Wright informed him that there had been a serious medical event at the facility involving an inmate, that the ambulance was at the facility, and they were either working on the inmate or about to leave for the hospital. It was understood that the inmate would likely die.

The call with Supervisor Wright was short, and other than the above facts, Mr. Rutherford did not recall any other details being passed on. This was the only call Mr. Rutherford recalled receiving from Wright that evening. The call came in on his cell phone. After speaking with Supervisor Wright, Mr. Rutherford traveled to the facility This is corroborated by Supervisor Wright's Incident Report pertaining to Mr. Johnson's death, in which Supervisor Wright reports that, "I notified Superintendent Rutherford at approximately 0230 Hrs" and "Superintendent Rutherford on sight [sic] at approximately 0315 Hrs."

Notably, Supervisor Wright's claim that he called Mr. Rutherford after the first and second 10-25 calls is not corroborated by DOC documentation and is inconsistent with Mr. Rutherford's recollection of events.

2. *Autopsy Report*

Centurion completed a multidisciplinary mortality preliminary review report on December 9, 2019. A final report was completed on December 19, 2019. No cause of death was noted in this report.

A final report of autopsy was prepared by the State Medical Examiner after a full autopsy was performed on December 8, 2019. The State Medical Examiner determined the cause of death to be airway obstruction due to a laryngeal squamous cell carcinoma tumor. [redacted]

3. *Records Pertaining to Mr. Johnson's Prior Medical Treatment*

According to Shift Supervisor Dwyer's Narrative Report, on November 15, 2019, Mr. Johnson informed staff that he was experiencing "chest pain, night sweats, and shortness of breath." According to the Report, "Nurse [1] requested that inmate Johnson be housed in the infirmary until he could be seen by the provider in the morning. Nurse [1] stated that inmate Johnson should be ok until morning but at lease [sic] when he is in the infirmary medical staff will be able to keep a closer eye on the inmate."

According to available medical records, [redacted] DRM was not provided records [redacted]

[redacted]

According to an Officer's Narrative Report, on November 29, 2019, Mr. Johnson reported to staff that he could not get out of bed and that "he had burning in his legs." According to the report, Mr. Johnson was "clearly in distress" and was subsequently brought to the infirmary in a wheelchair. He was ultimately taken by ambulance to North County Hospital.

According to the medical records available, at the hospital, Mr. Johnson's chief complaint was [redacted] which he felt was brought on from a 9-day course of [redacted] treatment for [redacted]. He was also concerned that his [redacted] were abnormal, and he had been prescribed [redacted] which he had never used before. He was noted at the correctional facility to have [redacted]), but to be asymptomatic.

Mr. Johnson was evaluated in the North Country ED. He was found to have normal [redacted] and a heart rate of [redacted] He was noted to have a raspy voice. He was noted to have [redacted] but [redacted]. On examination, he was noted to have no [redacted] ([redacted]), to have good [redacted], [redacted] His oxygen saturation was recorded at [redacted] (there was no documentation of O2 saturation not on nasal cannula). His heart rate on examination was tachycardic at [redacted]. A chest CT was taken. The central findings were no indications of [redacted], or [redacted], and no [redacted]

observed. [redacted]. Mr. Johnson was released with a recommendation that he be on [redacted] until his [redacted] were resolved and that he be considered for being placed on an increased [redacted] dose. His discharge diagnoses were [redacted] and [redacted] There is not documentation in his DOC medical chart of how these diagnoses and recommendations were followed up on by DOC medical staff.

IV. Conclusions

A. DOC Officers And Healthcare Providers Should Have Done More To Help Mr. Johnson

The Department of Corrections, both officers and the health care providers administering care to a person in DOC custody, could have and should have done more to assist Mr. Johnson during his health crisis. DOC is responsible for the care and safety of persons in the custody of the State of Vermont. Mr. Johnson persistently and credibly complained of acute breathing difficulties during the evening of December 6-7, 2019. He was clearly and visibly in substantial distress during that time period. While corrections staff did not completely fail in responding to these complaints, at the end of the day, their response was insufficient to keep Mr. Johnson from dying from a tumor-caused breathing obstruction. That should not have happened.

While the authors of this report acknowledge that the input of the medical staff—which did not recommend urgent transfer of Mr. Johnson to the North Country Hospital—put the corrections staff in a difficult position, DOC policies regarding communication and supervisory input and guidance for inmates presenting credible and reasonably substantiated concerns for acute medical conditions were inadequate to deal

with this situation. It should not be that an inmate complains persistently that he cannot breathe, requests to be seen by a doctor or taken to a hospital, and that does not happen. As part of this assessment, the authors of this report recommend that corrections staff be empowered, more strongly encouraged, or required to present critical case issues and decisions further up the supervisory chain given their importance and risks of the issues presented.

Similarly, the medical staff responsible for Mr. Johnson's care on behalf of the State of Vermont should have done more. This is a policy judgment and opinion, rather than a judgment about whether or not the care by the nurses was technically within the standard of care as defined by law. As a matter of policy, when presented with a patient persistently and credibly complaining of an acute medical condition with potentially grave ramifications – such as inability to breathe – sound policy should require the inmate be urgently evaluated by a physician. That did not happen here. Although the events occurred in a rural locale where provision of healthcare can present challenges, the facility is a short distance from a hospital with an emergency department and physician staff. Given Mr. Johnson's presentation with obvious significant breathing difficulties, as a matter of policy, more should have been done.

The evidence points to the conclusion that the threat of discipline was invoked by both corrections staff and medical staff to obtain Mr. Johnson's compliance with medical direction and the corrections staff direction. While it must be acknowledged that managing a corrections facility is a challenging endeavor, it must also be acknowledged that the State of Vermont, by holding persons in custody, has taken charge of providing them with appropriate health care. Nowhere but in a penal institution is a patient faced

with the choice of having to accept a particular course of medical treatment or face punishment. That should not happen in the Vermont Department of Corrections either, and stronger policies to protect against this situation are warranted.

Finally, taken as a whole the evidence in this case indicates that staff failed to accept as fully truthful Mr. Johnson's persistent complaints that he could not breathe. They compounded this failure by inadequately responding to the numerous signs that Mr. Johnson was in significant physical distress. DOC should rigorously examine its institutional culture and ensure that all staff—corrections and medical alike—are fully trained on, and committed to, the principle that every person in DOC custody is, first and foremost, a human being who possesses inherent worth and who must be afforded dignity, respect, and the appropriate medical care.

B. Policies And Protocols Regarding The Use Of Holding Cells Need To Be Clarified And DOC Officers And Healthcare Providers Need Additional Training

The conduct of DOC officers and healthcare providers, as well as officers' interview statements make clear that there is a significant weakness in both existing policy and training with respect to the use of a holding cell for medical purposes. Supervisor Wright and the healthcare providers appear to have threatened Mr. Johnson with transfer from the infirmary to a holding cell where Mr. Johnson would have indisputably been less comfortable. Supervisor Wright has claimed that this threat was initiated by the nurses for medical purposes and suggested that he was merely enforcing their medical directive. Mr. Griggs corroborated that a nurse first raised the possibility of placing Mr. Johnson in a holding cell. For his part, however, Officer Mercer recalled that the holding-cell threat originated with Supervisor Wright, not the nurses.

Regardless of who first articulated the threat that Mr. Johnson would be placed in the holding cell if he did not remain in bed, the impact of that threat is clear. According to Mr. Griggs, even though Mr. Johnson continued to struggle to breathe, he was reluctant to call for help for fear of being placed in the holding cell. Officer Mercer's recollections also support this conclusion. Most importantly, the video surveillance footage following the second 10-25 call very clearly shows Mr. Johnson experiencing a period of significant physical distress and yet he did not seek further help. It is reasonable to conclude that he was afraid of being removed from the infirmary and placed in a holding cell. Had Mr. Johnson been more comfortable seeking help, this tragedy may have been avoided.

Existing DOC policy distinguishes between Administrative Segregation and Disciplinary Segregation:

> Disciplinary Segregation: A form of separation from the general population in which inmates committing serious violations of conduct regulations are confined for short periods of time to individual cells separated from the general population. Placement in disciplinary segregation may only occur after finding of a rule violation at an impartial hearing and when there is not an adequate alternative disposition to regulate the inmate's behavior.
>
> . . . .
>
> Administrative Segregation: A form of separation from the general population when the continued presence of the inmate in the general population would pose a serious threat to life, property, self, staff or other inmates or to the security (e.g., escape planning) or orderly running of the institution (e.g., chronic, repetitive discipline problem). Inmates pending investigation for trial on a criminal act or pending transfer may also be included if they pose a threat.

DOC Policy 410.03 at 2.

None of the officers that DRM interviewed reported that Mr. Johnson was engaged in rule-breaking and therefore the policies with respect to discipline and Disciplinary Segregation are not implicated.

An inmate can be placed in Administrative Segregation for a variety of reasons that are defined with particularity in DOC policy, including "[u]pon the order of a physician or equivalent provider (Advanced Practice Nurse, Nurse Practitioner or Physician Assistant)." *Id.* at 3. There is a well-defined process in place for placing an inmate in Administrative Segregation, that includes the right to a hearing an appeal. *Id.* at 3-10.

It is unclear whether Supervisor Wright understood that placing Mr. Johnson in a holding cell would have constituted formal Administrative Segregation or would have been some type of less formal measure. Because Mr. Johnson was not actually moved from the infirmary, it is unknown whether the Administrative Segregation process and accompanying paperwork would have been triggered.

Notably, Officer Mercer and Supervisor Wright seemed to have a disparate understandings of how the holding cells were supposed to be used at NSCF. Supervisor Wright stated that the holding cells were used to house inmates for medical reasons whereas Officer Mercer perceived a transfer to a holding cell as a disciplinary measure. This leads to the following conclusion: DOC should rigorously re-examine its policies regarding when and how an inmate can be transferred—even temporarily—into a holding cell or a similar segregated environment for medical purposes. There should be a clearly defined set of protocols put in place about when this is and is not appropriate. No inmate

in DOC custody should be reluctant to seek medical care for fear of retribution in the form of segregation.

Finally, DOC should assess whether corrections staff on duty when Mr. Johnson died fully complied with existing DOC protocols, policies, and procedures regarding the use of segregation in the medical context. If DOC determines that violations occurred, it should consider the appropriate discipline in light of the terrible consequences that occurred.

C. Policies And Protocols Regarding Observation Checks Need To Be Clarified And DOC Officers And Healthcare Providers Need Additional Training

DOC has detailed policies regarding observation checks. DOC Policy 403.04. Three issues became apparent with respect to observation checks during the course of DRM's investigation.

First, DOC policy appears to permit a Supervisor to increase the observation level, i.e., the frequency of checks, of an inmate subject to observation for medical reasons.

> Inmates who are placed on a special observation (i.e., suicide or self-harm watch, medical observation, restraint status INCAP, or dry cell status) will be observed based upon the type of observation status they are placed on: Constant/Direct Observation, Close Observation, or Routine Observation, *unless otherwise increased by a Supervisor.*

DOC Policy 403.04 at 5 (emphasis added).

It does not appear that Supervisor Wright understood that he had the authority to increase Mr. Johnson's observation level without orders from nursing staff. Because nursing staff did not cooperate in this investigation, the nurses' understanding of their authority to increase an inmate's observation level is unclear.

Moreover, existing DOC policy does not appear to provide guidance on the appropriate criteria for a Supervisor to consider when determining how frequently an inmate should be checked.

DRM recognizes that DOC policy requires a multidisciplinary team comprised of health services and security staff to meet daily and discuss the needs of inmates housed in a facility's infirmary and that these meetings provide an opportunity for decisionmakers to consider adjusting an inmate's observation level. Nevertheless, as Mr. Johnson's case demonstrates, an inmate's health situation can be dynamic and changes can occur rapidly, requiring adjustments in the level of care provided.

Accordingly, DOC policy should provide greater clarity regarding who has the authority to increase an inmate's observation level for medical reasons and set forth criteria to be used in making that determination. For example, one potential criterium for increasing an inmate's observation level should be when an inmate credibly complains of an acute and potentially fatal medical condition, such as difficulty breathing or chest pain.

Second, DOC Policy requires that observation checks for inmates on special observation due to medical reasons "will include the visual observation of bodily movement or, if the inmate is awake, engaging in conversation to unsure that he/she is not under physical duress." DOC Policy 403.04 at 5. In Mr. Johnson's case, DOC Officers performed observation checks at the requisite intervals. Nevertheless, several of those checks occurred while Mr. Johnson was awake and in obvious distress and yet officers did not engage him in conversation as required. Given that Mr. Johnson had

repeatedly complained about being unable to breathe, this was a particularly important step.

Moreover, Officer Mercer's last check, which occurred at approximately 2:07 AM, contains the note "awake." Although it is difficult to determine the timing with precision because the surveillance footage inside the infirmary lacks time data, it appears that Mr. Johnson may not have been visibly awake at 2:07 AM

Third, the observation checks after the first and second 10-25 calls were performed by DOC officers without assistance from the nurses, despite Mr. Johnson's repeated claims that he could not breathe.

Accordingly, DOC should consider clarifying the policies with respect to what is required during an observation check and medical staff's role in performing those checks. DOC should provide further training to all staff on the importance of thorough observation checks by both medical and non-medical staff.

In addition, DOC should assess whether corrections staff on duty when Mr. Johnson died fully complied with existing DOC protocols, policies, and procedures regarding observation checks. If DOC determines that violations occurred, it should consider the appropriate discipline in light of the terrible consequences that occurred.

D. Policies And Protocols Regarding Contact With Superintendent And Senior Management Need To Be Clarified And Shift Supervisors Need Additional Training

There is a discrepancy between Mr. Rutherford and Supervisor Wright regarding their level of communication during the December 6-December 7, 2019 timeframe. Mr. Rutherford recalled that Supervisor Wright called him following the third 10-25 when Mr. Johnson was found unresponsive. Supervisor Wright stated that he called Mr. Rutherford after each of the 10-25 calls.

DOC does not appear to have policies that provide clear guidance on when a Shift Supervisor should seek guidance from a Superintendent or senior facility management regarding a medical situation. DOC should consider implementing policy that requires Shift Supervisors to consult with senior management whenever an inmate complains of an acute and potentially fatal medical condition.

E. DOC Should Implement Implicit Bias Training

It is impossible to determine with certainty whether racial bias played a role in this tragedy. Nevertheless, the fact is that Mr. Johnson—a person of color—was under the supervision and care of an almost entirely white staff, a number of whom apparently disbelieved his persistent and credible claims that he could not breathe and failed to respond to those claims in a manner that ensured his safety. Given these circumstances, it reasonable to conclude that implicit bias likely played a role in shaping staff's reaction to Mr. Johnson's medical crisis. A number of the DOC Officers that DRM interviewed stated that they had not received implicit bias training from DOC. A DOC supervisor explicitly disclaimed knowledge of the concept of implicit bias. DOC should provide all its staff with regular and rigorous training on implicit bias.

F. Culture Of Respect And Dignity

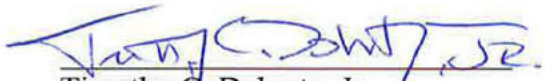
From viewing the video footage and some of the staff interactions with Mr. Johnson, a question is raised as to whether Mr. Johnson, for race or whatever reason, was consistently treated with the level of respect and dignity that should be accorded a person in the custody of the State of Vermont seeking medical care and believing he is facing a life threatening crisis. The Department of Corrections should examine this issue forthrightly, and if it finds such a broader cultural deficiency among staff about how inmates should be treated, it should implement proactive measures, ranging from training

to hiring standards to policy shifts and personnel actions, in order to address and rectify such a culture.

The foregoing is the investigative report and conclusions of the DRM investigative team into the Department of Corrections policies and actions regarding the death of Mr. Kenneth Johnson.

Respectfully submitted,

Tristram J. Coffin



Timothy C. Doherty, Jr.
DOWNS RACHLIN MARTIN, PLLC