DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
OFFICE OF INTERNAL AUDIT
INVESTIGATION REPORT

DBHDS OIA Investigators:
Randy Sherrod, DBHDS IA Director
Thomas Bland Jr., DBHDS Internal Auditor

BACKGROUND:

On April 22, 2015, Mr. Jamycheal Mitchell was arrested and incarcerated in Portsmouth, Virginia, charged with petit larceny and trespassing. Mr. Mitchell was incarcerated in the Hampton Roads Regional Jail in Portsmouth, Virginia. On May 21, 2015, a Competency Restoration Order (CRO) was issued by Judge Whitlow in the Portsmouth General District Court. The CRO mandated that Mr. Mitchell be sent to Eastern State Hospital (ESH) to restore his competency to stand trial. Although the Portsmouth General District Court allegedly mailed this CRO to ESH on approximately May 27, 2015, representatives from ESH stated that they did not receive this order, and there was no record found that this CRO was mailed by the Portsmouth General District Court or received by ESH. Another CRO was faxed to ESH on July 31, 2015. It should be noted that on August 4, 2015, the Forensic Log at ESH showed there were 34 individuals on a wait list to be admitted to ESH. The August 4th log was the first weekly Forensic Log prepared after July 31, 2015. Mr. Mitchell's name was not on the August 4th, 11th or 18th, 2015 ESH Forensic Logs. Mr. Mitchell remained incarcerated at the Hampton Roads Regional Jail until his death on August 19, 2015.

On September 1, 2015, the Department of Behavioral Health and Developmental Services (DBHDS) Commissioner requested that the DBHDS Office of Internal Audit complete an investigation into this matter.

TIMELINE OF EVENTS:

- April 22, 2015 – Mr. Jamycheal Mitchell was arrested, charged with petit larceny and trespassing in Portsmouth, Virginia (Portsmouth General District Court Records)
- April 29, 2015 – Court order, signed by Judge MV Whitlow of the Portsmouth General District Court, was received by the Portsmouth Department of Behavioral Healthcare Services (PDBHS). This order mandated that a mental health assessment be done to determine whether Mr. Mitchell would qualify for Jail Diversion Services provided by PDBHS. (Portsmouth General District Court Records)
- April 30, 2015 – Mr. Mitchell was assessed by PDBHS for Jail Diversion Services at 1:30 p.m. PDBHS electronic health records state "Mr. Mitchell was offered re-entry to PDBHS for

outpatient treatment. Mr. Mitchell stated that he did not want to go to PDBHS…. Mr. Mitchell is appropriate for Jail Diversion but he is refusing" (PDBHS Electronic Health Records)

- May 21, 2015 – Dr. Evan S. Nelson, Ph.D., Forensic Psychology Associates, faxed Mr. Mitchell's Court Ordered Psychological Evaluation to Portsmouth General District Court. The Order for Treatment of Incompetent Defendant, also known as the CRO, is signed by Judge MV Whitlow and dated May 21, 2015 (received with signature stamp of Jody Davis – Clerk of the Portsmouth General District Court) (Portsmouth General District Court Records)
- May 27, 2015 –CRO was allegedly mailed and faxed to Eastern State Hospital by the Portsmouth General District Court (as reflected on the clerk's case file cover sheet given to Investigator by DBHDS representative in the Office of the Attorney General). Note there is no record of ESH ever having received this order.
- May 29, 2015 – Review of case by Portsmouth General District Court. The case is marked as "Continued" and the Hearing Type is listed as "Review Progress." An order for continued custody while Mr. Mitchell waited for a bed at ESH was entered (Portsmouth General District Court Records, PDBHS Electronic Health Records)
- July 30, 2015 –Mr. Mitchell was sent to the emergency room at Bon Secours Maryview Medical Center in Portsmouth, Virginia, and Mr. Mitchell refused treatment. (HRRJ Staff and The Virginian-Pilot)
- July 31, 2015 – Court date for Mr. Mitchell in Portsmouth General District Court. The case is marked as "Continued" and the Hearing Type is listed as "Review Progress." Judge Whitlow mandated that the CRO for Mr. Mitchell be sent to Eastern State Hospital. This CRO was faxed to ESH on 7/31/2015. (File provided by Portsmouth General District Court, ESH records)
- July 31, 2015 – Hampton Roads Regional Jail (HRRJ) requested, at 9:33 a.m, an assessment of Mr. Mitchell be done by PDBHS for the purpose of determining whether Mr. Mitchell met the criteria for involuntary hospitalization. Additionally, another call was received from HRRJ at 3:42 p.m. by PDBHS. The 3:42 p.m. call was to speak to Candace Mundy - PDBHS Clinical Therapist. (PDBHS Electronic Health Records)
- August 3, 2015 – Hampton Roads Regional Jail called PDBHS at 11:00 a.m. to inform the CSB that Mr. Mitchell was waiting for a bed at Eastern State Hospital. (PDBHS Electronic Health Records)
- August 19, 2015 – Mr. Mitchell died at the HRRJ. (PDBHS Electronic Health Records)
- August 24, 2015 –The cover sheet of the CRO faxed on July 31, 2015 was found at Eastern State Hospital. (Based on interviews investigators conducted at ESH)
- February 25, 2016 – Christy Sughrue – Administrative Assistant in the Tidewater District Office of the Virginia Medical Examiner's Office stated to DBHDS Investigator Sherrod that the cause of Jamychael Mitchell's death was probable cardiac arrhythmia accompanying wasting syndrome of unknown etiology. Ms. Sughrue added that the manner of death was undetermined.

INVESTIGATION SUMMARY:

The investigation included interviews of employees from Eastern State Hospital (ESH), Hampton Roads Regional Jail (HRRJ), Portsmouth Department of Behavioral Healthcare Services (PDBHS), and the Portsmouth General District Court (PGDC), as well as a review of documents pertinent to the investigation. This included City of Portsmouth phone records, DBHDS forensic admission waitlists, PDBHS electronic health records, and Portsmouth General District Court records. The information gathered from the interviews and review of documents is as follows:

Portsmouth Department of Behavioral Healthcare Services (September 4, 2015):

On September 4, 2015, Candace Mundy - PDBHS Clinical Therapist, Ronald Scott - Case Manager, and Tana Irby - Office Manager, were interviewed by Randy Sherrod and Thomas Bland Jr. regarding the circumstances surrounding the death of Mr. Mitchell at the Hampton Roads Regional Jail. Ms. Kathy Starling, Risk Manager/Quality Manager at PDBHS, and Gracie Taylor, Executive Director, provided DBHDS investigators with notes from Mr. Mitchell's PDBHS electronic health record because DBHDS investigators requested specific dates of services provided to Jamychael Mitchell by PDBHS.

September 4, 2015 3:10 p.m.:

Ms. Mundy was asked about providing an assessment for Mr. Mitchell prior to his death. She stated that attempts were made to see Mr. Mitchell on the morning of July 31, 2015, but Ms. Mundy stated that she was told by Renee Edwards – HRRJ Licensed Clinical Social Worker, that Mr. Mitchell was in court on July 31, 2015. The notes in CREDIBLE (PDBHS Electronic Health Records system) show that Ms. Mundy noted at 11:40 a.m. that she went to Hampton Roads Regional Jail to see Mr. Mitchell, waited 40 minutes, and then was told that Mr. Mitchell was in court [**I-16003 WP 3.16 CREDIBLE notes from Portsmouth Dept of BHS Mitchell.pdf**] Ms. Mundy stated that an assessment would have initiated the Temporary Detention Order evaluation process.

September 4, 2015 3:27 p.m.:

Ronald Scott was asked about Mr. Mitchell, and Mr. Scott stated that he (Mr. Scott) attended Mr. Mitchell's court appearance on May 29, 2015. Mr. Scott added that this was the last time he (Mr. Scott) saw Mr. Mitchell. Mr. Scott stated that a CRO had been issued and that Mr. Mitchell was being mandated to Eastern State Hospital to have his competency to stand trial restored. [**I-16003 WP 3.19 Order for Treatment of Incompetent Defendant 5 21 2015 Competency Order.pdf**]. Mr. Scott stated that he believed that the Portsmouth General District Court would send the Competency Restoration Order promptly to ESH.

Based on the review of Mr. Mitchell's records in CREDIBLE, Mr. Scott wrote that he (Mr. Scott) attended Mr. Mitchell's court appearance in the Portsmouth General District Court the morning of May 29, 2015 at which Judge Ottinger ordered that Mr. Mitchell be sent to Eastern State Hospital to have his competency to stand trial restored. [**I-16003 WP 3.16 CREDIBLE notes from Portsmouth Dept of BHS Mitchell.pdf**]

September 4, 2015 3:39 p.m.:
Tana Irby was asked about Mr. Mitchell and the notes she made in Mr. Mitchell's CREDIBLE PDBHS electronic health record file. Ms. Irby stated that the only thing she did was forward the calls from the Hampton Roads Regional Jail to Ms. Candace Mundy– PDBHS Clinical Social Worker. Specifically, this refers to the 9:33 a.m. call on July 31, 2015 from Renee Edwards - Hampton Roads Regional Jail requesting an emergency evaluation and the 3:42 p.m. follow-up call from Ms. Edwards. Ms. Irby stated that she is not sure what Ms. Mundy did with the messages from her (Ms. Irby). There was a note made by Ms. Irby at 07/31/2015 at 9:33 a.m. in the PDBHS Electronic Health Record (CREDIBLE) that said the call was forwarded to Ms. Mundy. There was also a log of the call on a Portsmouth Emergency Services Call Sheet dated 7/31/2015 [**I-16003 WP 3.17 Portsmouth Emerg Srvcs Call Sheet Mitchell page 1.pdf**]. The log was made by Ms. Irby and stated that the on-call worker contact was Ms. Mundy and the time of the call to the on-call worker was 9:36 a.m. on July 31, 2015 and that Ms. Mundy responded or received the call at 9:36 a.m.

Eastern State Hospital (September 8, 2015):
On September 8, 2015, Christine Armstead - ESH Clinical Director, Dr. Kristen Hudacek - Director of Psychology and Pretrial Admissions, Patricia Chiapetta - Program Coordinator, and Gail Hart - Admissions Coordinator were interviewed by Randy Sherrod, Thomas Bland Jr., and Dr. Michael Schaefer – DBHDS Assistant Commissioner for Forensic Services, regarding the circumstances surrounding the death of Mr. Mitchell.

September 8, 2015 10:54 a.m.:
Ms. Armstead informed the Investigators of ESH's process for receiving Competency Restoration Orders (CROs). CROs go to Gail Hart, ESH Admissions Coordinator, and then Ms. Hart adds these to the Forensic Log. (Note: The Forensic Log is the list of individuals waiting for a bed at ESH. These individuals have been referred to ESH through a CRO or other forensic court order.). [**I-16003 WP 3.25 ESH Admission Log June 2 2015.xlsx**]. Ms. Armstead was asked when she was made aware of Mr. Mitchell's CRO. Ms. Armstead stated that on August 24, 2015 she learned that the CRO was faxed from the Portsmouth General District Court to ESH on July 31, 2015. Ms. Armstead added that ESH management did not learn about the existence of the fax until August 24, 2015, five days after Mr. Mitchell's death. Ms. Armstead was asked specifically about the Forensic Log, which is sent every Tuesday by Ms. Hart to ESH management. Ms. Armstead stated that she did not notice Mr. Mitchell's name on the Forensic

Log. Ms. Armstead went on to say that the faxed CRO was in a file in a drawer in Ms. Hart's office and had not been entered on the Forensic Log. Ms. Armstead added that in addition to that CRO, other CROs had not been logged as well. Ms. Armstead stated that as of today (September 8, 2015), all CROs had been added to the Forensic Log. Ms. Armstead acknowledged that there were a significant number of CROs that had not been entered. When asked how this could have happened, Ms. Armstead said that Ms. Hart was overwhelmed due to the increased number of admissions and the loss of staff in the Admissions department. Ms. Armstead was asked whether management knew that Ms. Hart was behind in updating the Forensic Log with the CROs. Ms. Armstead stated that when Ms. Hart discovered the file was in her desk on August 24, 2015 after Mr. Mitchell's death on August 19, 2015, Ms. Hart was astonished and distraught. Ms. Armstead finished by saying that Mr. Frank Gallagher, ESH Hospital Director, stated to her (Ms. Armstead) that he's taking over admissions to help ensure the timely processing of CROs.

September 8, 2015 11:50 a.m.:
Dr. Kristen Hudacek was asked about her knowledge of the CRO that had been issued for Mr. Mitchell. When asked, Dr. Hudacek stated she did not know of any e-mails [**I-16003 WP 3.35 Genesis of Emails From Russell Payne DBHDS.pdf**] sent on August 24, 2015 to Gail Hart from Russell Payne, DBHDS Behavioral Health Consultant, requesting background on Mr. Mitchell and his pending admission to Eastern State Hospital. However, when Dr. Hudacek found out about Mr. Mitchell's death, she (Dr. Hudacek) looked on the Forensic Log and did not see Mr. Mitchell listed.

Note: Ms. Roxanne Adams, Mr. Mitchell's aunt, left three messages on August 20, 2015 for Russell Payne regarding the death of Mr. Mitchell. Mr. Payne contacted, via email, Deb Lochart, DBHDS Office of Human Rights; Michael Schaefer, DBHDS Assistant Commissioner for Forensic Services; Chuck Hall, Hampton-Newport News Community Services Board's Executive Director; and Derek Curran, Hampton-Newport News Community Services Board's Clinical Administrator for Crisis Response Services, on August 21, 2015 at 12:01 p.m. Chuck Hall contacted Dean Barker, Natalie Ward, and Patty Hartigan of Hampton-Newport News Community Services Board about any information they may have regarding Mr. Mitchell. Dean Barker, CIT Coordinator for Hampton-Newport News Community Services Board, responded via email with background information about Mr. Mitchell and this email was forwarded by Mr. Hall to Russell Payne on August 21, 2015 at 2:49 p.m. Russell Payne emailed Gail Hart on Monday, August 24, 2015 at 8:41 a.m., copying David Lyon and Michael Schaefer from DBHDS. In the email, Mr. Payne requested background information on Mr. Mitchell and Mr. Mitchell's pending admission (to Eastern State Hospital). Ms. Gail Hart forwarded the email from Russell Payne to Dr. Kristen Hudacek at 10:37 a.m. on August 24, 2015 asking Dr. Hudacek if she recalled anything about Mr. Mitchell. Ms. Hart stated in the email forwarded to Dr. Hudacek that she, Ms. Hart, did not remember Mr. Mitchell. Dr. Hudacek replied via email to Mr. Payne on Wednesday, August 26, 2015 at 7:25 a.m. that she knew nothing about the

Mitchell case. **(I-16003 WP 3.35 Emails From Russell Payne DBHDS.pdf located on the X Drive at X:\COMMON\Investigations\I-16003 HRRJ Jail Death)**

Dr. Hudacek stated that the CRO for Mr. Mitchell was not input onto the Forensic Log because on July 31, 2015, this order was placed into a desk drawer in Ms. Hart's office, by Ms. Hart, and was not entered on the Forensic List as Ms. Hart was supposed to do. Dr. Hudacek stated that when she discovered this issue on August 24, 2015, she (Dr. Hudacek) also discovered that there were 10 – 12 other CROs that Ms. Hart had failed to enter onto the Forensic Log. Dr. Hudacek stated that she (Dr. Hudacek) entered the 10-12 outstanding CROs onto the Forensic Log so the potential clients would be on the waiting list.

When asked if she knew why Ms. Hart had not entered the CROs onto the Forensic Log, Dr. Hudacek stated that Ms. Hart had told her (Dr. Hudacek) that she (Ms. Hart) was overwhelmed and that the admissions department handles a large number of CROs. Dr. Hudacek stated that Barbara Ingram helped her (Dr. Hudacek) enter orders. As of September 8, 2015, Dr. Hudacek believes ESH is caught up on the current orders.

Dr. Hudacek finished by saying that she had requested to have discussions with J. Frank Gallagher, ESH Hospital Director, about concerns regarding issues within the Admissions Department and had requested of ESH management that she be given more responsibility and authority over the Admissions Department. Email documentation discovered by investigators between February 29, 2016 and March 3, 2016 outlines discussions held by ESH management between April 7, 2015 and September 1, 2015. These discussions centered around court orders ,the forensic waitlist and jail team at Eastern State Hospital.

September 8, 2015 2:05 p.m.:
Ms. Patricia Chiapetta stated that she was Ms. Gail Hart's supervisor and that she (Ms. Chiapetta) reports to Ms. Christine Armstead. Ms. Chiapetta stated that the admission rate at ESH has grown rapidly and a good amount of Ms. Hart's current time has been spent catching up on work that is late. To address this issue, Ms. Chiapetta stated that an assistant administrator was hired to help in the admissions department, but that this hire did not alleviate the problems within the admission suite at Eastern State Hospital.

When asked about the CRO for Mr. Mitchell, Ms. Chiapetta stated that she knew nothing about the July 31, 2015 fax, but knew that CROs hadn't been logged based on overhearing Ms. Hart stating that she (Ms. Hart) needs to catch up on entering the orders [on the Forensic Log]. Ms. Chiapetta stated that Ms. Hart made this comment in July 2015, and added that currently they're doing the best they can to manage the work load in admissions.

September 8, 2015 3:05 p.m.:

Ms. Gail Hart stated that she has been at ESH for over 30 years and that Ms. Chiapetta is her supervisor. Regarding the CRO process, Ms. Hart stated that when CROs come in from courts, she (Ms. Hart) receives them by mail or fax. Ms. Hart stated that she (Ms. Hart) normally receives the CRO and indicates receipt of the CRO by date on the Forensic Log. Letters, if necessary, are sent to courts to obtain missing documentation, and it is noted on the Forensic Log that follow up has been done. Ms. Hart stated that the log is kept chronologically by the date the CRO was received. Once the CRO is at Eastern State Hospital and information is ready to be added to the Forensic Log, Ms. Hart would contact the respective jail to obtain medical clearence. Ms. Hart stated that she would then update the Forensic Log with the admission date if applicable. Individuals that ESH has received CROs for are added to the Forensic Log, but may not be immediately admitted due to there being a waitlist.

Regarding the CRO issued for Mr. Mitchell, Ms. Hart acknowledged that she did not add this CRO to the Forensic Log. When asked why she did not enter the order onto the Forensic Log, Ms. Hart stated that there is one admissions coordinator at ESH and that there are too many CROs to enter. Ms. Hart stated that more time is spent on temporary detention order (TDO) referrals since her office is responsible for every TDO order that comes into ESH. Mr. Mitchell's order was a CRO. Ms. Hart stated that by law, every TDO must be admitted to a state hospital if there are no community beds available due to changes in the Code of Virginia making DBHDS the facility of last resort. Ms. Hart added that the ESH Admissions Office was down two clerks during this time and acknowledged that this CRO was kept in a drawer in her (Ms. Hart's) office after it was faxed to ESH on 07/31/2015. Ms. Hart stated that she did not look at the CRO again until 08/24/2015, after she received the e-mail regarding Mr. Mitchell's death from Ms. Armstead. Ms. Hart stated that as of August 24, 2015, she was still adding items to the Forensic Log from May 2015 and that she did not get a fax from Portsmouth General District Court for Mr. Mitchell before July 31, 2015.

Hampton Roads Regional Jail (September 9, 2015):

September 9, 2015:

On September 9, 2015, Renee Edwards - HRRJ LCSW, Sergeant Eugene Taylor - Assistant Superintendent, and Carolyn Poe - Classifications Manager, were interviewed by Randy Sherrod and Thomas Bland Jr. regarding the death of Mr. Mitchell at the Hampton Roads Regional Jail.

September 9, 2015 2:38 p.m.:

Ms. Renee Edwards stated that she is a Licensed Clinical Social Worker. Ms. Edwards stated that on July 31, 2015, Mr. Mitchell was in court and that she wanted to see what happened in court to determine what was to be done next. Ms. Edwards did acknowledge that she called the PDBHS regarding a psychiatric evaluation, but then said she called back to tell the CSB that Mr. Mitchell was in court and not to come right away.

Regarding the call at 3:42 p.m., Ms. Edwards stated that she called the CSB to tell them that Mr. Mitchell had been ordered to go to the state hospital and that Mr. Mitchell had come back from court with this information.

On August 3, 2015, Ms. Edwards said she called back to the CSB to find out the name of the person that she talked to at the CSB regarding Mr. Mitchell. Ms. Edwards stated that she (Ms. Edwards) was not sure what else was said. Ms. Edwards said that there was no more contact with PDBHS after August 3, 2015.

September 9, 2015 3:10 p.m.:
Mr. Eugene Taylor – HRRJ Assistant Superintendent, stated that on May 29, 2015 the CRO was issued for Mr. Mitchell to be sent to Eastern State Hospital and that he (Mr. Taylor) believed that on July 31, 2015, the CRO was reaffirmed by the court.

September 9, 2015 3:15 p.m.:
Ms. Poe stated that, usually, when a CRO comes into the facility, HRRJ follows through on the process and sends the individual to ESH, if a bed is available. Ms. Poe stated that ESH would call HRRJ when a bed was available.

Portsmouth Department of Behavioral Healthcare Services (September 9, 2015):
September 9, 2015 3:45 p.m.:
On September 9, 2015, Ms. Gracie Taylor - Executive Director PDBHS, called and informed Investigators that the City of Portsmouth now has a new city manager. The new City Manager would like Ms. Taylor, and any other individual that works for PDBHS, to get a legal representative from the City Attorney's Office to be in attendance for any future meetings with DBHDS regarding the Mitchell case.

Portsmouth General District Court (September 9, 2015):
September 9, 2015 3:50 p.m.:
On September 9, 2015, Ms. Judy Davis - Portsmouth General District Court Clerk, called and informed Investigators that she could not meet with them. Ms. Davis stated that the attorney from the Virginia Office of the Attorney General (OAG) who represents the courts wanted to approve any contact with Court officials. Investigators stated they would get their representative from the OAG to contact the Portsmouth General District Court OAG representative.

Portsmouth Department of Behavioral Healthcare Services (September 10, 2015) in the Portsmouth City Hall Building:
On September 10, 2015, Candace Mundy – Clinical Therapist, Gracie Taylor - Executive Director, Nathan Woodard - Clinical Manager of Long Term Care Services, and Tana Irby -

Office Manager, were interviewed by Randy Sherrod and Thomas Bland Jr. regarding the circumstances surrounding the death of Mr. Mitchell at the Hampton Roads Regional Jail.

September 10, 2015 2:18 p.m.:
Ms. Mundy confirmed that she's been a Clinical Therapist for 6 years at PDBHS. Ms. Mundy informed investigators that the call at 9:33 a.m. on July 31, 2015 from Ms. Renee Edwards, LCSW at Hampton Roads Regional Jail, was forwarded to her. Ms. Mundy stated that the call was to request an assessment be done of Mr. Mitchell. Ms. Mundy stated she wouldn't normally know about a CRO and that she does not meet with the individual until an evaluation is requested. Ms. Mundy stated that she just found out, 4 business days ago, (09/04/2015) about the calls that occurred on July 31, 2015 from HRRJ at 3:42 p.m. and on August 3, 2015 at 11:00 a.m. Ms. Mundy stated that she went in the notes and saw that she never got the calls from Tana Irby. The calls that were received after the July 31, 2015 9:33 a.m. call were noted by Ms. Tana Irby in CREDIBLE, PDBHS's Electronic Health Record, and were allegedly forwarded to Ms. Mundy by Ms. Irby. Ms. Mundy stated that if she had received the messages or calls, she would have notated it in CREDIBLE. Ms. Mundy stated she did not go back to HRRJ, but left a message for the security officer to request Ms. Edwards to contact her (Ms. Mundy) once Mr. Mitchell got back from court. Ms. Mundy stated the only time she spoke with Ms. Edwards was on 07/31/2015.

Ms. Mundy stated that, at times, it can be 3-4 hours later before she gets her messages and that Ms. Irby would take it upon herself to give callers advice. This is based on what other colleagues have mentioned to her (Ms. Mundy) about Ms. Irby as well as her own experience of working with Ms. Irby. Ms. Mundy stated that Ms. Irby was reprimanded by her (Ms. Irby's) former supervisor for not forwarding calls properly. Ms. Mundy stated that she was very angry when she found out (on 09/04/2015) that she was not forwarded the calls from HRRJ regarding Mr. Mitchell. Ms. Mundy mentioned to Ms. Donna Stover, Ms. Irby's supervisor, that she didn't appreciate not being told about the calls.

Ms. Mundy stated that she feels that once a court order to a hospital has been issued, this takes the CSB out of the process as they are waiting for a bed at ESH.

September 10, 2015 2:55 p.m.:
Ms. Taylor stated that PDBHS has redone the phone system related to who will answer crisis intervention calls. Ms. Taylor stated that Ms. Irby will write what's said in the CREDIBLE record (electronic health record). Regarding Ms. Irby, Ms. Taylor stated that even if Ms. Irby didn't pass on the call, she would have taken notes of the call. (Note - Investigators requested Portsmouth City phone records from July 31, 2015 to August 19, 2015 from Portsmouth Deputy City Attorney Cheran Cordell [**I-16003 WP 3.2a, b, c, d** and **WP 3.11-3.13**]). Ms. Taylor stated that there probably should have been a follow up or return call since the issue had not been

resolved and Mr. Mitchell still remained in the Hampton Roads Regional Jail after July 31, 2015. Ms. Taylor added that she feels that the CSB is inconsistent with follow ups on cases that are being worked.

September 10, 2015 3:50 p.m.:
Mr. Nathan Woodard was asked about the phone process at PDBHS and informed the Investigators that PDBHS has fixed the issues by instituting a new process. Mr. Woodard explained that the new process has all calls to Emergency Services coming into one phone number (757-393-8990) and that this number was outside of Safe Haven (see footnote for information on Safe Haven). Mr. Woodard stated that the new process has been reiterated to staff, including Ms. Mundy.

September 10, 2015 4:40 p.m.:
Tana Irby was asked how, in the electronic health record system CREDIBLE, someone can tell what employee made the note in the record. Ms. Irby stated that if her name is at the top of the electronic health record, she entered the note in CREDIBLE.

Ms. Irby provided Investigators with logs from her phone calls [**I-16003 WP 3.17 Portsmouth Emerg Srvcs Call Sheet Mitchell page 1.pdf**] and stated that if she received a call, she would then direct it to the respective worker.

Notes in CREDIBLE, dated 7/31/2015 at 3:42 p.m. and 8/3/2015 at 11:00 a.m., read that Ms. Irby transferred calls to Ms. Mundy regarding Mr. Mitchell. The notes indicate that Ms. Irby created those two notes on 07/31/2015 and 08/03/2015. When asked what the phone records would indicate, Ms. Irby stated that she believes that the phone records will show that she (Ms. Irby) transferred the calls to Ms. Mundy. Ms. Irby stated that she completes a phone call sheet for incoming calls that she (Ms. Irby) receives. Ms. Irby stated she does not do additional call sheets for follow-up calls. Ms. Irby reiterated that the call sheets would just be filled out for the initial call received. Ms. Irby was asked whether she had been disciplined previously for not transferring calls, and Ms. Irby stated that she had not been disciplined. Ms. Irby added that she was supervised previously by Ms. Debra Hall and Ms. Hall would say she (Ms. Irby) does exceptional work. Ms. Irby went onto then say that as soon as she gets off the phone, she transfers the call and that there were probably one or two times when there was a call she didn't get to with the new phones. **Note:** Investigators did see a call sheet, that had been completed by Ms. Irby, for the call to PDBHS from the HRRJ on July 31, 2015 at 9:33 a.m.. This is the call from Renee Edwards at the HRRJ regarding Mr. Mitchell. [**I-16003 WP 3.17 Portsmouth Emerg Srvcs Call Sheet Mitchell page 1.pdf**]

October 9, 2015 10:47 a.m.:
DBHDS Internal Auditor Director was provided the cover sheet of the clerk's file by the DBHDS OAG representative that had an entry that suggested that the CRO pertaining to Mr. Mitchell was mailed and faxed to ESH on May 27, 2015 per Portsmouth General District Court personnel.

Eastern State Hospital (October 13, 2015):
On October 13, 2015, Christine Armstead - ESH Clinical Director, Dennis Murray - Executive Administrative Assistant, Betty Shaughnessy – ESH Mail Room Manager/AOS 3, and Dr. Kristen Hudacek - Director of Psychology and Pretrial Admissions, were interviewed by Randy Sherrod and Thomas Bland Jr. regarding the circumstances surrounding the death of Mr. Mitchell at the HRRJ. During these interviews, specific focus was placed on the process for mail received at ESH.

October 13, 2015 2:20 p.m.:
Ms. Armstead confirmed that Ms. Hart is not employed at ESH any longer, as she retired on September 24, 2015.

Ms. Armstead stated she (Ms. Armstead) has no knowledge of the receipt at ESH of a mailed CRO for Mr. Mitchell. Ms. Armstead added that she does not know the process for receiving mail orders from Portsmouth General District Court. Ms. Armstead also stated that she isn't sure if there was a log for the incoming mail and stated investigators should speak to Betty Shaughnessy, as she is in charge of the ESH Mail Room

October 13, 2015 2:40 p.m.:
Mr. Dennis Murray – ESH Executive Administrative Assistant, was asked about logging orders that come into ESH, and he stated that there is no log kept of orders from the courts. Mr. Murray was asked whether he remembered any CRO for Mr. Mitchell being received at ESH. Mr. Murray stated that he did not recall anything being received regarding Mr. Mitchell.

Regarding the mail process at ESH, Mr. Murray stated that when mail comes in and it's determined after opening that it's forensic related, it goes to Barbara Ingram, ESH Administrative Coordinator. Mr. Murray added that there is no numbering or tracking mechanism provided to the mail room to help track mail received.

October 13, 2015 2:50 p.m.:
Ms. Betty Shaughnessy, ESH Mail Room Manager, was asked about the mail room process at ESH. Ms. Shaughnessy stated that she has been at ESH for 43 years and has worked mostly in the mail room. Ms. Shaughnessy stated that all mail comes through her department and that she feels that some items are of a confidential nature. Ms. Shaughnessy stated that those confidential

items would be addressed to the hospital and given to the appropriate person. Ms. Shaughnessy stated that she does not remember receiving the CRO for Mr. Mitchell in the mail room.

October 13, 2015 2:56 p.m.:
Dr. Kristen Hudacek was asked about the CRO for Mr. Mitchell. Dr. Hudacek stated that she has no recollection of the order being received via mail and added that she didn't see the order until the fax was shown to her.

Regarding the new admission process, Dr. Hudacek confirmed that all outstanding orders have been entered and that ESH is now incorporating date stamps to indicate receipt of orders.

Hampton Roads Regional Jail (November 6, 2015):
On November 6, 2015, Renee Edwards – HRRJ LCSW, Pam Johnson - Director of Nursing, and Sergeant Pamela Ellis – HRRJ Head of Internal Affairs, were interviewed by Randy Sherrod and Thomas Bland Jr. for follow up regarding the investigation of the death of Mr. Mitchell at the HRRJ.

November 6, 2015 11:18 a.m.:
Ms. Edwards stated that she has been with HRRJ for 3 years. Ms. Edwards was asked whether any further effort was made to contact the PDBHS after August 3rd, and Ms. Edwards stated that there were no further efforts made.

November 6, 2015 11:45 a.m.:
Ms. Pam Johnson is the Director of Nursing at HRRJ, contracted through NAPHCARE, Inc. Ms. Johnson stated that Mr. Mitchell was observed daily by nurses and refused to take medications. Ms. Johnson stated that Mr. Mitchell was sent to the emergency room on July 30, 2015, according to Mr. Mitchell's health records, and while there, Mr. Mitchell refused treatment and refused to answer any questions. Ms. Johnson stated that July 30, 2015 was the last time that Mr. Mitchell was sent to the emergency room. Ms. Johnson stated that they do not force medication on individuals and several nurses tried to provide medicine to Mr. Mitchell. Mr. Mitchell refused and as far as the nurses were aware, Mr. Mitchell was eating his food.

Ms. Johnson stated that when a death occurs, employees are surprised, especially when it's unexpected. Ms. Johnson was asked about any in-house investigation that was done by nurses, and she referred the investigators to a Mortality and Morbidity Report completed by NAPHCARE, Inc. Investigators were given the name of Giovanni Sneed, regional contact representative from NAPHCARE, to request further information and to request a copy of the Mortality and Morbidity Report. Ms. Johnson informed the investigators that Sergeant Pamela Ellis is the head of Internal Affairs. Ms. Johnson stated that, in the event of a death at the HRRJ, Sergeant Ellis would do an internal investigation in addition to the one that NAPHCARE does.

Ms. Johnson finished by saying that the documents from the nurses' review were sent to the NAPHCARE corporate office in Alabama.

November 6, 2015 12:10 p.m.:
Sergeant Pamela Ellis stated that she has been with HRRJ for 16 years and is the Head of Internal Affairs. Sergeant Ellis stated the investigation into the death of Mr. Mitchell is still ongoing. Sergeant Ellis stated that Mr. Mitchell's family told her that Mr. Mitchell starved to death, but Sergeant Ellis said other incarcerated individuals stated that Mr. Mitchell's food trays were empty, indicating that he was eating. In addition, Sergeant Ellis stated that other incarcerated individuals stated that Mr. Mitchell would ask them for their food. Sergeant Ellis stated that she did not know Mr. Mitchell so she could not make any first hand reference regarding his health.

Sergeant Ellis was asked whether there was a possibility of suicide or foul play. Sergeant Ellis stated that there was no indication from the staff or other incarcerated individuals that she had spoken with of suicide or foul play. Sergeant Ellis also stated that complaints came in saying staff mistreated Mr. Mitchell by not feeding him or by spraying water in his face. Sergeant Ellis stated that nothing was found to substantiate these allegations.

Eastern State Hospital (November 6, 2015):
On November 6, 2015, Barbara Ingram – ESH Administration Coordinator, and Patty O. Thomas - ESH General Administration Coordinator in Forensics, were interviewed by Randy Sherrod and Thomas Bland Jr. regarding the investigation into the death of Mr. Mitchell at the HRRJ. Specific focus was given to the receipt of the CRO at ESH.

November 6, 2015 2:35 p.m.:
When asked about the Mitchell case, Ms. Ingram stated that she didn't know about the Mitchell case. Related to mail and receiving CROs, Ms. Ingram stated ESH does not keep a log of the mail when it comes in. Ms. Ingram stated that the process for recording CROs has changed since Ms. Hart left Eastern State Hospital. She explained that the incoming mail or faxes come to her (Ms. Ingram) or Patty O. Thomas. Ms. Ingram stated that she does not recall receiving anything related to Mr. Mitchell.

Regarding bed space at ESH, Ms. Ingram stated that TDOs always come into the hospital regardless of the forensic admission waitlist. Ms. Ingram stated that TDOs trump everything and that individuals are pushed back if they are not classified as a TDO. Ms. Ingram added that discharges occur daily, so beds are potentially available.

November 6, 2015 3:45 p.m.:
Ms. Patty O. Thomas stated that she heard about the situation with Mr. Mitchell after the information came out at ESH. Ms. Thomas stated that she gets involved after an individual or

potential client is admitted. In some cases, when mail arrives in Ms. Thomas's office, she will take it to the admissions suite. Ms. Thomas added that a TDO issued to ESH must have a bed or a bed has to be found at another state hospital. TDOs are admitted daily, within 48 hours for emergency treatment, but treatment orders such as CROs are longer orders since they have to have other logistics in place before admission can occur. Ms. Thomas stated that there have been instances where a client was on the forensic admission waiting list after being issued a CRO, received a TDO, and was admitted. Ms. Thomas ended by providing investigators with different codes for patient statuses. The provided statuses were "47" for Restoration (orders), "51" for Pretrial (TDO) and "52" for Emergency Transfer Order (ETO). These are FIMS codes that are used by all DBHDS hospitals to note the forensic admission status of clients.

Hampton Roads Regional Jail (phone call) (November 10, 2015):
November 10, 2015 10:30 a.m.:
On November 10, 2015, Giovanni Sneed - NaphCare, Inc. representative, was called by Randy Sherrod and Thomas Bland Jr. DBHDS Investigators contacted Ms. Sneed and requested to meet to discuss the investigation. Ms. Sneed stated she would get back to the investigators about the Mortality and Morbidity Report completed by NaphCare, Inc. and that she could meet with the investigators on November 30, 2015. DBHDS Investigators called Ms. Sneed back on November 25, 2015 at 11:09 a.m. and November 30, 2015 at 11:05 a.m. No call was made by Ms. Sneed to the DBHDS investigators as of December 1, 2015.

Department of Behavioral Health and Developmental Services - Central Office (November 10, 2015):
On November 10, 2015, Michael Schaefer, DBHDS Assistant Commissioner for Forensic Services, shared with Randy Sherrod and Thomas Bland Jr. information regarding Competency Restoration Orders and Temporary Detention Orders. The information sent was Virginia Code § 19.2-169.6: Inpatient psychiatric hospital admission from local correctional facility; an overview of a competency evaluation; the competency restoration and emergency treatment process in Virginia; and the proposed code changes to require acknowledgment of Receipt of Court Orders. [**I-16003 WP 3.26 VA Code Section 19 2-169 6.docx**], [**I-16003 WP 3.27 Competency Restoration Admission Processes - September 28 2015.docx**], and [**I-16003 WP 3.28 Proposed Code Changes to Require Acknowledgment of Receipt of Court Order.docx**].

Portsmouth Department of Behavioral Healthcare Services (November 24, 2015) in the Portsmouth City Hall Building:
On November 24, 2015, Angela McKinley – PDBHS Clinical Therapist, and Candace Mundy – PDBHS Clinical Therapist, were interviewed by Randy Sherrod and Thomas Bland Jr. as part of the investigation into the death of Mr. Mitchell at the Hampton Roads Regional Jail.

November 24, 2015 10:56 a.m.:

Ms. Angela McKinley stated that she's a Clinical Therapist, and she's been with PDBHS since 2013. Ms. McKinley informed the Investigators that Ms. Tana Irby, Office Manager, is no longer with the CSB. Ms. McKinley said that Ms. Mundy is her peer and they work cases together. Ms. McKinley stated that she was not directly involved with the Mitchell case. Ms. McKinley stated that if she was responsible for the Mitchell case, it would be in her pass down log and noted in the Electronic Health Record system - CREDIBLE. This pass down log is log of Ms. McKinley's work activities she's completed or working on and is a part of the CREDIBLE Electronic Health Record system. Investigators asked Ms. McKinley about a 3:51 p.m. call to Ms. Mundy on July 31, 2015, and Ms. McKinley stated that she was calling to see what cases were open and needed to be worked on during her (Ms. McKinley's) upcoming shift. Investigators noted there was a 34 minute call at 10:41 p.m. on July 31, 2015 from Ms. McKinley to Ms. Mundy. Ms. McKinley stated that Ms. Mundy and she call each other frequently, but that no mention of Mr. Mitchell was brought up during either call on July 31st. However, Ms. McKinley did state that Ms. Mundy mentioned information about a case at the HRRJ that she (Ms. Mundy) was working, but stated that Mr. Mitchell's name was not specifically mentioned. Ms. McKinley went on to say that Ms. Mundy told her that she (Ms. Mundy) would take care of the case at the HRRJ on Monday (August 3, 2015) and added that she (Ms. Mundy) was waiting for a call from the HRRJ. Ms. McKinley reiterated that she called Ms. Mundy to get a general pass down on July 31, 2015 at 3:51 p.m. and to figure out what took place during her (Ms. Mundy's) shift.

Ms. McKinley was asked about phone messages being forwarded by Ms. Irby. Ms. McKinley stated that there were occasional delays with Ms. Irby forwarding messages, but Ms. McKinley stated Ms. Irby did pass along the messages and calls. Ms. McKinley stated that Ms. Mundy did not mention to her (Ms. McKinley) anything about not receiving calls from Ms. Irby.

Ms. McKinley reiterated to investigators that if Ms. Mundy would have passed an assignment down to her to work on, she would have worked on it and noted it in the pass down log within the CREDIBLE Electronic Health Record system. Ms. McKinley stated that Ms. Mundy blamed Ms. Tana Irby and herself (Ms. McKinley) for not getting the pass down or taking on the assignment to evaluate Mr. Mitchell. Ms. McKinley stated that if she had received the pass down for Mr. Mitchell, she would have taken care of it. Ms. McKinley added that TDOs are usually not done if an individual is on a CRO. Ms. McKinley said that TDOs can be initiated when the medical clearance is done at Hampton Roads Regional Jail. Ms. McKinley stated that Ms. Mundy said to her that she (Ms. Mundy) was waiting on a medical clearance from the jail, and Ms. McKinley did not recall Ms. Mundy asking her (Ms. McKinley) for any advice on this case.

November 24, 2015 11:30 a.m.:
Ms. Mundy was asked to recollect, again, the events that occurred on July 31, 2015. Ms. Mundy stated that she received a verbal message around 10:00 a.m. that day from Ms. Irby. The message was that the HRRJ had called regarding a request for an evaluation of Jamycheal

Mitchell. Ms. Irby and Ms. Mundy were in the same office, Safe Haven, and that is how the message was delivered verbally. [1]Ms. Mundy stated that she (Ms. Mundy) called HRRJ back from the office phone after being given the message by Ms. Irby. Ms. Mundy reached Ms. Renee Edwards, LCSW, at HRRJ and was told by Ms. Edwards that an assessment was needed for Mr. Mitchell. Ms. Mundy stated that she then went to the HRRJ and waited 30-45 minutes before being told by HRRJ security officers that Mr. Mitchell was in court. Ms. Mundy stated that she asked the HRRJ security officers at the front desk to have Ms. Edwards give her (Ms. Mundy) a call back. Ms. Mundy stated that she did not hear anything back from Ms. Edwards. Ms. Mundy reiterated that she didn't hear anything about calls being made by Ms. Edwards to PDBHS on July 31, 2015 at 3:42p.m. and on August 3, 2015 at 11:00 a.m. until being told by DBHDS Investigators about the calls based on the Investigators' review of Mr. Mitchell's PDBHS electronic health record. Ms. Mundy said that she told Ms. McKinley about the case and specifically that she (Ms. Mundy) was waiting on a call back from HRRJ. Ms. Mundy added that Ms. McKinley knew the name of the case and that was done as a pass down of information. Ms. Mundy stated that this pass down was done verbally and that she (Ms. Mundy) did not make notes about the pass down in CREDIBLE (PDBHS electronic health record).

Ms. Mundy was asked about the pass down process in general. Ms. Mundy stated that pass downs are done through the CREDIBLE system or they are done verbally. Ms. Mundy went on to say that Ms. Irby usually passed messages on and this is how cases are assigned or work gets added to the case manager's caseload. Ms. Mundy stated that if the case is not finished before a shift is over, a pass down of that case to the next employee is done.

When asked again about the Mitchell case, Ms. Mundy stated that she heard nothing else about the case after the July 31st visit to the Hampton Roads Regional Jail. Ms. Mundy said that Ms. McKinley would call her daily to ask what happened that day and for any other pertinent updates. Ms. Mundy added that she has known Ms. McKinley for as long as Ms. McKinley has worked at PDBHS. Ms. Mundy responded to a licensing question by saying she's not licensed but has worked thousands of cases. Based on prior experience, Ms. Mundy continued to say that the majority of the time, if HRRJ doesn't call back, she (Ms. Mundy) feels that the situation has been resolved. Ms. Mundy stated that she has no control over Ms. Edwards calling her back, no control over Ms. Irby, and that she (Ms. Mundy) did her job. Ms. Mundy strongly reiterated that she (Ms. Mundy) did not do the assessment because she believed Ms. McKinley took the pass down or assignment. Ms. Mundy did not follow up with Ms. McKinley, saying she (Ms. Mundy) thought the case was closed. Ms. Mundy stated as a general principle to her if it's not notated, it

[1] Safe Haven - is one of two locations where the PDBHS provides crisis intervention and jail diversion services to individuals experiencing a mental health crisis. Safe Haven is a drop-off center, which operates 12 hours per day to provide the Portsmouth Police Department's Crisis Intervention Team an alternative to jail for individuals with mental illness who they suspect may have committed a crime. The program provides triage, assessment, and a "time out" space.

never happened, and repeated she did pass the case down to Ms. McKinley verbally. Ms. Mundy was asked again why she did not follow-up on the initial call she got at 9:33 a.m. on July 31, 2015. Ms. Mundy admitted that documentation should have been added to the Electronic Health Record (CREDIBLE) regarding the pass down of information. Ms. Mundy told the Investigators that she gave Ms. Renee Edwards at HRRJ her cell phone number 2 or 3 times, and she tries not to miss any calls. Ms. Mundy told investigators that she did not tell Ms. McKinley a follow-up would be done the following Monday (August 3, 2015). Ms. Mundy finished by saying that there's no jail support with the delay due to medical clearances and that it is very frustrating not getting calls forwarded to her. Ms. Mundy offered no reason as to why she did not follow-up on the initial call she received from the HRRJ on July 31, 2015.

February 25, 2016 1:50 p.m.
Christy Sughrue, Administrative Assistant in the Tidewater District Office of the Virginia Medical Examiner's Office, stated to DBHDS Investigator Sherrod that the cause of Jamychael Mitchell's death was probable cardiac arrhythmia accompanying wasting syndrome of unknown etiology. Ms. Sughrue added that the manner of death was undetermined.

February 29, 2016 – March 3, 2016:
Email documentation discovered by Investigators between February 29, 2016 and March 3, 2016, outlines discussions by ESH management between April 7, 2015 and September 1, 2015. These discussions centered around court orders, the forensic waitlist and the jail team at Eastern State Hospital. These emails did not mention Mr. Mitchell. The full emails are in the file for this investigation.

On March 6, 2016, Dr. Hudacek was asked via email, by the DBHDS Investigator, to discuss the work ESH was doing in the Hampton Roads Regional Jail (HRRJ). Dr. Hudacek stated that Tanisha Carnes, DBHDS Counselor visits local jails to work with inmates on the Forensic Waitlist. This is part of the ESH Jail team. Dr. Hudacek added that she and Ms. Carnes worked off the Forensic Waitlist provided by admissions each Tuesday. Dr. Hudacek finished by stating that Ms. Carnes was at HRRJ at least 1-2 times per week seeing persons on the waitlist and that Ms. Carnes is on the distribution list for the Forensic Waitlist.

March 9, 2016:
Senate Bill 342 passed the Senate of Virginia on March 9, 2016 and House Bill 645 passed the Virginia House of Delegates on March 7, 2016. This bill details new processes regarding orders for evaluation for sanity, competency to stand trial, and competency restorations. The bill language is as follows:

HB 645 Criminal defendants; orders for mental health evaluations and treatment. Criminal defendants; orders for competency and sanity evaluations and hospitalization -

Requires the clerk of court to provide a copy of the order for an evaluation for sanity, competency to stand trial, and competency restoration to the appointed evaluator or hospital as soon as practicable but no later than the close of business on the next business day following entry of the order. The evaluator or hospital must acknowledge receipt of the order to the clerk on a form developed by the Office of the Executive Secretary of the Supreme Court of Virginia. The bill also requires the same verification of receipt procedures for an order for psychiatric hospitalization of an inmate from a local correctional facility. The bill also provides that no person will be liable for any act or omission relating to any requirement in the bill unless the person was grossly negligent or engaged in willful misconduct. This bill is identical to SB 342.

Analysis of Phone Records:

During the investigation, phone records for Portsmouth Department of Behavioral Healthcare Services phones were reviewed. These records were provided by Cheran Cordell – Interim City Attorney in the Portsmouth City Attorney's office. These records show calls made by or to the Hampton Roads Regional Jail, Portsmouth Department of Behavioral Healthcare Services crisis services, Candace Mundy – PDBHS Clinical Therapist, and Angela McKinley – PDBHS Clinical Therapist. These calls are summarized below:

757-735-4310

This number is assigned to Ms. Candace Mundy, PDBHS Clinical Therapist **[I-16003 WP 3.2d Mundy VoiceDetailsFor7577354310_7 31 to 8 4_SetB.xlsx**]. Investigators confirmed from the phone records that Ms. Mundy called Safe Haven at 10:42am on July 31, 2015. Ms. Mundy noted in CREDIBLE (PDBHS Electronic Health Record) on July 31, 2015 at 11:39 a.m. that she (Ms. Mundy) went to Hampton Roads Regional Jail to see Mr. Mitchell, waited 40 minutes, and then was told by the front desk security officer at HRRJ that Mr. Mitchell was at the Portsmouth General District Court.

Ms. Mundy received a call from Ms. McKinley at 3:51p.m. on July 31, 2015. Ms. McKinley was arriving at PDBHS and wanted to get information on open cases or cases that needed to be worked on that were in Ms. Mundy's queue. Additionally, Ms. Mundy received a call at 10:41 p.m. from Ms. McKinley that lasted for 34 minutes. Ms. Mundy and Ms. McKinley could not recall what was discussed during this 34 minute call but both mentioned that they talk on the phone quite often. Based on the investigators' review of Ms. Mundy's phone records, no calls were transferred to Ms. Mundy from PDBHS.

757-393-8152

This number is associated with Safe Haven. Investigators noted calls were made to this number from Hampton Roads Regional Jail on July 31, 2015 at 9:26 a.m., 9:36 a.m., 9:40 a.m., 1:46p.m., 3:42p.m., and 4:18p.m. [**I-16003 WP 3.2b Extension 5745 - Expanded Detail by Date.xls**].

Investigators confirmed from the notes in CREDIBLE, PDBHS Electronic Health Record that Ms. Tana Irby noted at 9:33 a.m. on July 31, 2015 that Ms. Renee Edwards, LCSW at the HRRJ, called to request an evaluation of Mr. Mitchell who (as noted in CREDIBLE) "had been psychotic since arrival to the facility (HRRJ), hostile, not receptive to taking medicine, has medical issues, and was uncooperative." Ms. Irby noted at the end of the note in CREDIBLE that she (Ms. Irby) forwarded the call to Ms. Mundy.

Ms. Irby noted in CREDIBLE at 3:42p.m. on July 31, 2015 that Ms. Renee Edwards called to speak to Ms. Candace Mundy about Mr. Mitchell. Ms. Irby added that Ms. Mundy was notified of the call [**I-16003 WP 3.16 CREDIBLE notes from Portsmouth Dept of BHS Mitchell.pdf**].

On August 3, 2015, Investigators noted a call was made from Hampton Roads Regional jail to 757-393-8152 at 10:52 a.m. Investigators observed from the notes in CREDIBLE, PDBHS's Electronic Health Record, at 11:00 a.m. on August 3, 2015, that Ms. Irby made a note that Ms. Renee Edwards, LCSW at HRRJ, called and stated, ""Client (Mr. Mitchell) is waiting on bed at ESH" and this message will be forwarded to Ms. Candace Mundy." Ms. Candace Mundy stated in the above mentioned interviews that calls were not provided to her (Ms. Mundy) and she was unaware of their existence until Investigators mentioned the calls to her. Investigators confirmed that no calls were transferred out to Ms. Mundy from this number (757-393-8152) Note: investigators read CREDIBLE and learned of the phone calls.

757-391-3167

This number is also associated with Safe Haven. Investigators noted that a call was placed from Ms. Candace Mundy's PDBHS cell phone to this Safe Haven number at 10:43am on July 31, 2015. Investigators matched this call with Ms. Mundy's PDBHS cell phone records. Investigators did not confirm any calls were transferred out to Ms. Mundy from this number (757-391-3167).

757-393-8991

This number is another number associated with Safe Haven. Investigators noted that no calls were made from the Hampton Roads Regional Jail to this number. Additionally, no calls from Ms. Candace Mundy were made to this number nor were there any calls transferred to Ms. Candace Mundy from July 31, 2015 to August 4, 2015.

From August 4, 2015 to August 19, 2015, Investigators obtained call logs of the same numbers above. However, nothing was found related to the Mitchell case. Investigators also confirmed in the aforementioned interviews that no more communication was made between Hampton Roads Regional Jail and the Portsmouth Department of Behavioral Healthcare Services after August 3, 2015 related to the Mitchell case.

Analysis of the Forensic Log (Wait List) – Eastern State Hospital

Investigators received the ESH Forensic Logs for May 26, 2015, June 2, 2015, August 4, 2015, and August 25, 2015 from Michael Schaefer - DBHDS Assistant Commissioner for Forensic Services. The Forensic Logs are a list of names that show the individuals waiting to be admitted to Eastern State Hospital that are to be admitted under a court issued order for inpatient treatment to restore competency to stand trial. For each individual waiting to be admitted to ESH, the list includes the name of the court and judge that ordered them to ESH, type of order, date the order was signed, date the order was received by ESH, their next court date, the associated Community Services Board, the charge issued to the individual, the name of the jail where the individual is incarcerated, and information on the status of admission. The Forensic Log is prepared weekly for distribution on Tuesdays. ESH management sends the log to Dr. Michael Schaefer at DBHDS.

It has been acknowledged by ESH that Mr. Mitchell was not added to the Forensic Log. The following is information on where Mr. Mitchell would have been listed had he been added to the log. For the May 26, 2015 Forensic Log, Mr. Mitchell would have been listed as number 29 on the waitlist. May 26, 2015 is significant because Portsmouth General District Court stated they mailed the Competency Restoration Order to Eastern State Hospital in Williamsburg, VA for Mr. Mitchell on May 27, 2015, the day after the Forensic Log was generated. On the next Forensic Log (June 2, 2015), Mr. Mitchell was also not listed. Investigators questioned individuals at Eastern State Hospital in the above discussions about the receipt of the competency restoration order dated May 21, 2015 and were told that no CRO was received in the mail. There was no record found that a CRO was mailed by the Portsmouth General District Court nor received at ESH. [**I-16003 WP 3.6 ESH Forensic Admission Waitlist 5-29-2015.xlsx**] and [**I-16003 WP 3.25 ESH Admission Log June 2 2015.xlsx**].

On the August 4, 2015 Forensic Log, Mr. Mitchell would have been listed as number 35 to be admitted to Eastern State Hospital. This date is important as there is a record that a fax of the CRO was received by ESH on July 31, 2015 and the August 4, 2015 Forensic Log would have been the first one created after this date.
[**I-16003 WP 3.34 ESH Admission Log Aug 4 2015.pdf**], [**I-16003 WP 3.24 ESH Admission Log August 25 2015.xlsx**], and [**I-16003 WP 3.33 ESH Admission Log Sept 1 2015.pdf**].

CONCLUSION:

This investigation was conducted at the request of the DBHDS Commissioner to complete an investigation into the death of Mr. Jamycheal Mitchell. The DBHDS investigators have had the opportunity to review processes, procedures, analyze various documents, and have discussions

with individuals from Portsmouth Department of Behavioral Healthcare Services, Eastern State Hospital, Hampton Roads Regional Jail, Portsmouth General District Court, and NaphCare, Inc.

The following has been concluded as a result of the investigation:

- The CRO issued for Mr. Mitchell, by the Portsmouth General District Court, was not entered into the ESH Forensic Log and was not discovered by ESH management until after Mr. Mitchell's death. The CRO was received by ESH admissions staff prior to Mr. Mitchell's death.
- On July 31, 2015 at 9:33 a.m., a Hampton Roads Regional Jail staff member contacted, via phone call, the Portsmouth Department of Behavioral Healthcare Services to request that an evaluation be done of Mr. Mitchell. An evaluation of Mr. Mitchell was not completed by the Portsmouth Department of Behavioral Healthcare Services. After August 3, 2015, there is no documented contact regarding Mr. Mitchell, between the Portsmouth Department of Behavioral Healthcare Services and the Hampton Roads Regional Jail.

RECOMMENDATIONS:

As a result of the investigation into the death of Mr. Mitchell at the HRRJ, the following recommendations are being made. We believe that these recommendations will benefit the Behavioral Health and Developmental Services system in Virginia. It should be noted that recommendations are only being made for DBHDS related entities as this office only has jurisdiction over DBHDS.

- **Eastern State Hospital (ESH)** – DBHDS Internal Audit recommends that ESH Administration ensure that management at ESH educate mailroom staff and others who receive and process mail of the importance of insuring that the admission staff promptly receive all court orders without delay. Admissions staff are to log those court orders as received to ensure orders are not lost or misplaced.

- **Virginia Department of Behavioral Health and Developmental Services (DBHDS)** – It is recommended that DBHDS develop more uniform guidelines pertaining to how courts should convey court orders to DBHDS. These guidelines should include a standard (preferred) method for receiving court orders, standardized procedures for logging court orders, sending of confirmation to courts/attorneys acknowledging receipt of court orders, and more standardized processes for forensic admissions. DBHDS should convey these guidelines to all courts, Commonwealth Attorneys, and the defense bar to ensure all parties understand the admission process. Finally, DBHDS should explore the feasibility of developing a single point of entry for court orders so that orders are always sent/transmitted to one location regardless of the location of the court, the role

of the person sending the order, or the type of court order. This would bring more uniformity to the system but would also allow for more accurate tracking of court orders.

APPENDIX:
The following are Code of Virginia statutes pertinent to this case:

§ 19.2-169.1: Evaluation of Competency to Stand Trial
A. Raising competency issue; appointment of evaluators. -- If, at any time after the attorney for the defendant has been retained or appointed and before the end of trial, the court finds, upon hearing evidence or representations of counsel for the defendant or the attorney for the Commonwealth, that there is probable cause to believe that the defendant, whether a juvenile transferred pursuant to § 16.1-269.1 or adult, lacks substantial capacity to understand the proceedings against him or to assist his attorney in his own defense, the court shall order that a competency evaluation be performed by at least one psychiatrist or clinical psychologist who is qualified by training and experience in forensic evaluation.

B. Location of evaluation. -- The evaluation shall be performed on an outpatient basis at a mental health facility or in jail unless the court specifically finds that outpatient evaluation services are unavailable or unless the results of outpatient evaluation indicate that hospitalization of the defendant for evaluation on competency is necessary. If the court finds that hospitalization is necessary, the court, under authority of this subsection, may order the defendant sent to a hospital designated by the Commissioner of Behavioral Health and Developmental Services as appropriate for evaluations of persons under criminal charge. The defendant shall be hospitalized for such time as the director of the hospital deems necessary to perform an adequate evaluation of the defendant's competency, but not to exceed 30 days from the date of admission to the hospital.

C. Provision of information to evaluators. -- The court shall require the attorney for the Commonwealth to provide to the evaluators appointed under subsection A any information relevant to the evaluation, including, but not limited to (i) a copy of the warrant or indictment; (ii) the names and addresses of the attorney for the Commonwealth, the attorney for the defendant, and the judge ordering the evaluation; (iii) information about the alleged crime; and (iv) a summary of the reasons for the evaluation request. The court shall require the attorney for the defendant to provide any available psychiatric records and other information that is deemed relevant. The court shall require that information be provided to the evaluator within 96 hours of the issuance of the court order pursuant to this section.

D. The competency report. -- Upon completion of the evaluation, the evaluators shall promptly submit a report in writing to the court and the attorneys of record concerning (i) the defendant's capacity to understand the proceedings against him; (ii) his ability to assist his attorney; and (iii) his need for treatment in the event he is found incompetent but restorable, or incompetent for the foreseeable future. If a need for restoration treatment is identified pursuant to clause (iii), the

report shall state whether inpatient or outpatient treatment is recommended. No statements of the defendant relating to the time period of the alleged offense shall be included in the report.

E. The competency determination. -- After receiving the report described in subsection D, the court shall promptly determine whether the defendant is competent to stand trial. A hearing on the defendant's competency is not required unless one is requested by the attorney for the Commonwealth or the attorney for the defendant, or unless the court has reasonable cause to believe the defendant will be hospitalized under § 19.2-169.2. If a hearing is held, the party alleging that the defendant is incompetent shall bear the burden of proving by a preponderance of the evidence the defendant's incompetency. The defendant shall have the right to notice of the hearing, the right to counsel at the hearing and the right to personally participate in and introduce evidence at the hearing.

The fact that the defendant claims to be unable to remember the time period surrounding the alleged offense shall not, by itself, bar a finding of competency if the defendant otherwise understands the charges against him and can assist in his defense. Nor shall the fact that the defendant is under the influence of medication bar a finding of competency if the defendant is able to understand the charges against him and assist in his defense while medicated.

§ 19.2-169.2: Restoration to Competency to Stand Trial

"A. Upon finding pursuant to subsection E of § 19.2-169.1 that the defendant, including a juvenile transferred pursuant to § 16.1-269.1, is incompetent, the court shall order that the defendant receive treatment to restore his competency on an outpatient basis or, if the court specifically finds that the defendant requires inpatient hospital treatment, at a hospital designated by the Commissioner of Behavioral Health and Developmental Services as appropriate for treatment of persons under criminal charge. Any psychiatric records and other information that have been deemed relevant and submitted by the attorney for the defendant pursuant to subsection C of § 19.2-169.1 and any reports submitted pursuant to subsection D of § 19.2-169.1 shall be made available to the director of the community services board or behavioral health authority or his designee or to the director of the treating inpatient facility or his designee within 96 hours of the issuance of the court order requiring treatment to restore the defendant's competency. If the 96-hour period expires on a Saturday, Sunday, or other legal holiday, the 96 hours shall be extended to the next day that is not a Saturday, Sunday, or legal holiday.

B. If, at any time after the defendant is ordered to undergo treatment under subsection A of this section, the director of the community services board or behavioral health authority or his designee or the director of the treating inpatient facility or his designee believes the defendant's competency is restored, the director or his designee shall immediately send a report to the court

as prescribed in subsection D of § 19.2-169.1. The court shall make a ruling on the defendant's competency according to the procedures specified in subsection E of § 19.2-169.1.

C. The clerk of court shall certify and forward forthwith to the Central Criminal Records Exchange, on a form provided by the Exchange, a copy of an order for treatment issued pursuant to subsection A."

§ 19.2-169.6: Emergency Treatment Prior to Trial

"A. Any inmate of a local correctional facility who is not subject to the provisions of § 19.2-169.2 may be hospitalized for psychiatric treatment at a hospital designated by the Commissioner of Behavioral Health and Developmental Services as appropriate for treatment of persons under criminal charge if:

1. The court with jurisdiction over the inmate's case, if it is still pending, on the petition of the person having custody over an inmate or on its own motion, holds a hearing at which the inmate is represented by counsel and finds by clear and convincing evidence that (i) the inmate has a mental illness; (ii) there exists a substantial likelihood that, as a result of a mental illness, the inmate will, in the near future, (a) cause serious physical harm to himself or others as evidenced by recent behavior causing, attempting, or threatening harm and any other relevant information or (b) suffer serious harm due to his lack of capacity to protect himself from harm as evidenced by recent behavior and any other relevant information; and (iii) the inmate requires treatment in a hospital rather than the local correctional facility. Prior to making this determination, the court shall consider the examination conducted in accordance with § 37.2-815 and the preadmission screening report prepared in accordance with § 37.2-816 and conducted in-person or by means of a two-way electronic video and audio communication system as authorized in § 37.2-804.1 by an employee or designee of the local community services board or behavioral health authority who is skilled in the assessment and treatment of mental illness, who is not providing treatment to the inmate, and who has completed a certification program approved by the Department of Behavioral Health and Developmental Services as provided in § 37.2-809. The examiner appointed pursuant to § 37.2-815, if not physically present at the hearing, shall be available whenever possible for questioning during the hearing through a two-way electronic video and audio or telephonic communication system as authorized in § 37.2-804.1. Any employee or designee of the local community services board or behavioral health authority, as defined in § 37.2-809, representing the board or authority that prepared the preadmission screening report shall attend the hearing in person or, if physical attendance is not practicable, shall participate in the hearing through a two-way electronic video and audio communication system as authorized in § 37.2-804.1. When the hearing is held outside the service area of the community services board or behavioral health authority that prepared the preadmission screening report, and it is not

practicable for a representative of the board or authority to attend or participate in the hearing, arrangements shall be made by the board or authority for an employee or designee of the board or authority serving the area in which the hearing is held to attend or participate on behalf of the board or authority that prepared the preadmission screening report; or

2. Upon petition by the person having custody over an inmate, a magistrate finds probable cause to believe that (i) the inmate has a mental illness; (ii) there exists a substantial likelihood that, as a result of a mental illness, the inmate will, in the near future, (a) cause serious physical harm to himself or others as evidenced by recent behavior causing, attempting, or threatening harm and any other relevant information or (b) suffer serious harm due to his lack of capacity to protect himself from harm as evidenced by recent behavior and any other relevant information; and (iii) the inmate requires treatment in a hospital rather than a local correctional facility, and the magistrate issues a temporary detention order for the inmate. Prior to the filing of the petition, the person having custody shall arrange for an evaluation of the inmate conducted in-person or by means of a two-way electronic video and audio communication system as authorized in § 37.2-804.1 by an employee or designee of the local community services board or behavioral health authority who is skilled in the assessment and treatment of mental illness and who has completed a certification program approved by the Department as provided in § 37.2-809. After considering the evaluation of the employee or designee of the local community services board or behavioral health authority, and any other information presented, and finding that probable cause exists to meet the criteria, the magistrate may issue a temporary detention order in accordance with the applicable procedures specified in §§ 37.2-809 through 37.2-813. The person having custody over the inmate shall notify the court having jurisdiction over the inmate's case, if it is still pending, and the inmate's attorney prior to the detention pursuant to a temporary detention order or as soon thereafter as is reasonable.

Upon detention pursuant to this subdivision, a hearing shall be held either before the court having jurisdiction over the inmate's case or before a district court judge or a special justice, as defined in § 37.2-100, in accordance with the provisions of §§ 37.2-815 through 37.2-821, in which case the inmate shall be represented by counsel as specified in § 37.2-814. The hearing shall be held within 72 hours of execution of the temporary detention order issued pursuant to this subdivision. If the 72-hour period terminates on a Saturday, Sunday, legal holiday, or day on which the court is lawfully closed, the inmate may be detained until the close of business on the next day that is not a Saturday, Sunday, legal holiday, or day on which the court is lawfully closed. Any employee or designee of the local community services board or behavioral health authority, as defined in § 37.2-809, representing the board or authority that prepared the preadmission screening report shall attend the hearing in person or, if physical attendance is not practicable, shall participate in the hearing through a two-way electronic video and audio

communication system as authorized in § 37.2-804.1. When the hearing is held outside the service area of the community services board or behavioral health authority that prepared the preadmission screening report, and it is not practicable for a representative of the board or authority to attend or participate in the hearing, arrangements shall be made by the board or authority for an employee or designee of the board or authority serving the area in which the hearing is held to attend or participate on behalf of the board or authority that prepared the preadmission screening report. The judge or special justice conducting the hearing may order the inmate hospitalized if, after considering the examination conducted in accordance with § 37.2-815, the preadmission screening report prepared in accordance with § 37.2-816, and any other available information as specified in subsection C of § 37.2-817, he finds by clear and convincing evidence that (1) the inmate has a mental illness; (2) there exists a substantial likelihood that, as a result of a mental illness, the inmate will, in the near future, (a) cause serious physical harm to himself or others as evidenced by recent behavior causing, attempting, or threatening harm and any other relevant information or (b) suffer serious harm due to his lack of capacity to protect himself from harm as evidenced by recent behavior and any other relevant information; and (3) the inmate requires treatment in a hospital rather than a local correctional facility. The examiner appointed pursuant to § 37.2-815, if not physically present at the hearing, shall be available whenever possible for questioning during the hearing through a two-way electronic video and audio or telephonic communication system as authorized in § 37.2-804.1. The examination and the preadmission screening report shall be admitted into evidence at the hearing.

B. In no event shall an inmate have the right to make application for voluntary admission as may be otherwise provided in § 37.2-805 or 37.2-814 or be subject to an order for mandatory outpatient treatment as provided in § 37.2-817.

C. If an inmate is hospitalized pursuant to this section and his criminal case is still pending, the court having jurisdiction over the inmate's case may order that the admitting hospital evaluate the inmate's competency to stand trial and his mental state at the time of the offense pursuant to §§ 19.2-169.1 and 19.2-169.5.

D. An inmate may not be hospitalized longer than 30 days under subsection A unless the court which has criminal jurisdiction over him or a district court judge or a special justice, as defined in § 37.2-100, holds a hearing and orders the inmate's continued hospitalization in accordance with the provisions of subdivision A 2. If the inmate's hospitalization is continued under this subsection by a court other than the court which has jurisdiction over his criminal case, the facility at which the inmate is hospitalized shall notify the court with jurisdiction over his criminal case and the inmate's attorney in the criminal case, if the case is still pending.

E. Hospitalization may be extended in accordance with subsection D for periods of 60 days for inmates awaiting trial, but in no event may such hospitalization be continued beyond trial, nor shall such hospitalization act to delay trial, as long as the inmate remains competent to stand trial. Hospitalization may be extended in accordance with subsection D for periods of 180 days for an inmate who has been convicted and not yet sentenced, or for an inmate who has been convicted of a crime and is in the custody of a local correctional facility after sentencing, but in no event may such hospitalization be continued beyond the date upon which his sentence would have expired had he received the maximum sentence for the crime charged. Any inmate who has not completed service of his sentence upon discharge from the hospital shall serve the remainder of his sentence.

F. For any inmate who has been convicted and not yet sentenced, or who has been convicted of a crime and is in the custody of a local correctional facility after sentencing, the time the inmate is confined in a hospital for psychiatric treatment shall be deducted from any term for which he may be sentenced to any penal institution, reformatory or elsewhere.

G. Any health care provider, as defined in § 32.1-127.1:03, or other provider rendering services to an inmate who is the subject of a proceeding under this section, upon request, shall disclose to a magistrate, the court, the inmate's attorney, the inmate's guardian ad litem, the examiner appointed pursuant to § 37.2-815, the community service board or behavioral health authority preparing the preadmission screening pursuant to § 37.2-816, or the sheriff or administrator of the local correctional facility any and all information that is necessary and appropriate to enable each of them to perform his duties under this section. These health care providers and other service providers shall disclose to one another health records and information where necessary to provide care and treatment to the inmate and to monitor that care and treatment. Health records disclosed to a sheriff or administrator of the local correctional facility shall be limited to information necessary to protect the sheriff or administrator of the local correctional facility and his employees, the inmate, or the public from physical injury or to address the health care needs of the inmate. Information disclosed to a law-enforcement officer shall not be used for any other purpose, disclosed to others, or retained.

Any health care provider disclosing records pursuant to this section shall be immune from civil liability for any harm resulting from the disclosure, including any liability under the federal Health Insurance Portability and Accountability Act (42 U.S.C. § 1320d et seq.), as amended, unless the person or provider disclosing such records intended the harm or acted in bad faith.

H. Any order entered where an inmate is the subject of proceedings under this section shall provide for the disclosure of medical records pursuant to subsection G. This subsection shall not preclude any other disclosures as required or permitted by law.”