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ADDENDUM TO INVESTIGATIVE REPORT

Vermont HRC Case PA15-0007

Complainant: "D.C."

Respondents: Vermont Agency of Human Services, Department of Mental Health and Department of Corrections

Charge: Discrimination in public accommodations based on disability

On March 24, 2016, an investigator for the Human Rights Commission made recommendations to the Human Rights Commission that it find reasonable grounds to believe that the Department of Corrections (DOC) had discriminated against D.C. based on his disability. The investigator further recommended that the Commission find no reasonable grounds to believe that the Department of Mental Health (DMH) discriminated against D.C. on the basis of disability. The investigator's recommendation in Findings #4 and #5 was based primarily on available documentation of the continuing effects of Tropical Storm Irene in 2014 on DMH's ability to timely place D.C. in a Level I bed.

After hearing, the Commission determined that regardless of the continuing effects of Tropical Storm Irene[1], the DMH and DOC have a *joint responsibility* pursuant to 28 V.S.A. §907(4)(G)-(H) and 18 V.S.A. §7201 for administration of a system that complies with the mandates of the American's with Disabilities Act (ADA) and the Vermont Fair Housing and Public Accommodations Act (VFHPAA). The Commission found that DMH failed to exercise its responsibility to make sure that the services received by D.C., while in the custody of the DOC and awaiting a Level I bed, were adequate to meet his mental health needs. Based on this, the Commission overturned Findings #4 and #5 of the investigative report and found reasonable grounds to believe that both DMH and DOC discriminated against D.C. based on his disability.[2]

[1] The Commission further noted that T.S. Irene happened in 2011 and the incidents complained of by D.C. occurred in 2014.

[2] While there are no specific findings with regard to the Agency of Human Services (AHS), both DMH and DOC are under the umbrella of AHS which is ultimately responsible for ensuring that departments under its authority are working together to meet the mental health needs of Vermonters.

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INVESTIGATIVE REPORT

Complainant: "D.C." - Vermont HRC Case PA 15-0007

Respondents: Vermont Agency of Human Services, Vermont Department of Mental Health and Department of Corrections

Charge: Discrimination in public accommodations on the basis of disability.

BACKGROUND AND SUMMARY OF COMPLAINT:

On October 16, 2013, D.C. was given a citation for spitting at a police officer who entered his motel room in response to a 911 call.[1] An arraignment date of January 21, 2014 was set. On October 30, 2013, D.C. was committed in-patient to Brattleboro Retreat (BR), where he stayed until he was released on January 17, 2014. Two days after his release, on January 19, 2014, he was found in an ATM alcove without shoes and covered in feces. He was taken to Brattleboro Memorial Hospital (BMH) where he was admitted and emergently evaluated for possible in-patient placement. He remained at BMH until January 22, 2014, and therefore missed his arraignment. As a result, a warrant for failure to appear (FTA) was issued and a $500 bail was set. Records suggest that the FTA warrant was served as he was released from the hospital. On January 23, 2014, the court committed D.C.

[1] It is not clear who made the call to the police. He was charged with violating 13 V.S.A. § 1028(b)(1) (prohibiting persons from "intentionally caus[ing] blood, vomitus, excrement, mucus, saliva, or urine to come in contact with a [law enforcement officer] while the officer is performing a lawful duty").

to the Department of Mental Health (DMH) for the purpose of evaluating his competency to stand trial and his criminal responsibility.[2]

However since there were no available "acute" (Level 1) beds in which to house him as he awaited the evaluation, the court committed him to the custody of the Department of Corrections (DOC) and ordered that he be held at Southern State Correctional Facility (SSCF) to await the evaluation. He was evaluated by Dr. Paul Cotton on February 2, 2014. Dr. Cotton found him incompetent to stand trial[3] and "insane."[4] At this point, his commitment to DMH ended, but since he could not make bail, he continued to be held in the custody of the DOC. He spent 40 days at SSCF until March 3, 2014, when an acute bed became available at Green Mountain Psychiatric Care Center (GMPCC). Ten of those days were spent in Alpha unit which is known as the "Mental Health Stabilization Unit" (MHSU) and which also serves as a segregation unit. After ten days he was moved to Bravo unit, also known as the "Mental Health Transitional Unit," where he stayed until he was transferred to GMPCC.

D.C.'s HRC complaint asserts that DMH, DOC and AHS collectively violated the Vermont Fair Housing and Public Accommodations Act in that, 1) "incarceration was not required for [D.C.'s] mental health needs or to address any criminogenic needs; and 2) that respondents denied D.C. "access to receiving services in and living in the most integrated setting appropriate to his needs by their collective failure to coordinate placement and provision of services to him" and that this denial caused him harm.

SUMMARY OF RESPONSE

All Respondents deny violating the sections of the VFHPAA applicable to this case. First, the State argued that "Given D.C.'s mental condition and his inability to post bail, the SSCF Mental Health Stabilization Unit (MHSU) (and then

[2] 13 V.S.A. § 4815.

[3] In other words, to assist in his defense by communicating with his lawyers and having a grasp of court proceeding and personnel, such as the role of the prosecution, defense and judge.

[4] The use of the word "insane" is somewhat archaic. Dr. Cotton was assessing D.C.'s level of criminal responsibility, i.e. whether "a person is not responsible for criminal conduct if at the time of such conduct as a result of mental disease or defect he lacks adequate capacity either to appreciate the criminality of his conduct or to conform his conduct to the requirements of law."

later the less restrictive Bravo unit) was the best available option for D.C. at the time."

Second, the State refuted D.C.'s integration argument and lack of access to services charge by stating that "SSCF Medical personnel carefully evaluated him and determined that he was not fit to be placed in the general population. Once SSCF medical staff determined that it was medically appropriate for him to be housed with the general population he was moved into the Intermediate Mental Health Treatment Unit." The result, the State argued, was that "under the circumstances and given D.C.'s history and mental health issues, D.C. was in fact held in the most integrated setting appropriate to his needs."

Third, the State asserted that the length of time D.C. had to wait for an acute, Level 1 bed, was a "direct result" of Tropical Storm Irene and the loss of the Vermont State Hospital (VSH) in August of 2011 and "was not due to the failure of Vermont's DMH, the Administration or the Legislature to plan ahead or adequately fund mental health care services."

PRELIMINARY RECOMMENDATIONS:

1) This investigation makes a preliminary recommendation to the Human Rights Commission to find there are **reasonable grounds** to believe that the Department of Corrections discriminated against D.C. on the basis of his disability and violated the VFHPAA's "integration mandate" of 9 V.S.A. §4201(c)(2) and the general prohibition related to denial of access to services etc. codified at 9 V.S.A. §4201(c)(1).

2) This investigation makes a preliminary recommendation to the Human Rights Commission to find there are **no reasonable grounds** to believe that the Department of Mental Health discriminated against D.C. on the basis of his disability with respect to either the integration mandate or that it denied him access to services. Thus, there is no violation of either section of the VFHPAA.

DOCUMENTS

- Act 79 – An Act relating to reforming Vermont's Mental Health System
- Admitting Guidelines:
  - Brattleboro Retreat
  - Rutland Regional Medical Center
  - Vermont Psychiatric Care Hospital
- Alpha Unit Tracking Log – all shifts
- Brattleboro Police Department Law Incident Tables – September 2013-December 2013
- Brattleboro Retreat Inpatient Records October 30, 2013-January 17, 2014
- Brattleboro Memorial Hospital Records – Admission/Discharge Records – January 19, 2014-January 22, 2014
- Bravo Unit Tracking Log
- Case Law
- Complaint of Public Accommodations Discrimination – November 2, 2014
- Correspondence from Bill Reynolds, AAG responding to *Trueblood v. Washington State*, C14-1178 MJP – June 5, 2015
- Court Documents
  - Transport Order - January 22, 2014
  - Order for Inpatient Psychiatric Evaluation – January 23, 2014
  - Mittimus to Lockup or Correctional Facility – January 23, 2014
  - Competency Evaluation - Dr. Paul Cotton
- Department of Corrections Policies & Procedures and Administrative Rules 351-375
- Department of Mental Health Care-Manager Entry Notes re D.C.
- Department of Mental Health Fact Sheet – June 20, 2013
- Designated Hospital Information
- Documents generated at Southern State Correctional Facility:
  - Case Plan
  - Any other psych evaluations done at SSCF
  - Complaint filed by D.C. while at SSCF
  - Discharge Summaries
  - Contact Notes
  - Movement History and Legal Status
  - Incident Infraction History
  - End of Shift Reports
  - Cell Assignment

- Provider Progress Notes
- SSCF Offender Social History Sheet
- VT DOC Non-Offender Personal Data
- Mental Health Provider Orders
- Medical History and Physical Assessment
- Nursing Progress Notes
- Staff Referral Forms
- Health Service Requests
- Self-Harm Watch-MH Observation Notes
- Mental Health SFI [Significantly Functionally Impaired] Notes
- Initial Psychiatric Evaluation Notes
- Receiving and Screening Documentation
- Initial Needs Survey documentation

- Emails between DMH, DOC and Correct Care Solutions (CCS) Personnel and Brattleboro Retreat
- "Emergency Involuntary Procedures" – Memorandum –John McCullough, Project Director, and Ed Paquin, Disability Right Vermont
- "Involuntary Psychiatric Inpatient Services Provided by Designated Hospitals" – Department of Mental Health – undated
- Qualified Mental Health Professional, (QMHP), Guide For Involuntary Psychiatric Evaluations And Hospitalization – November 2006
- Report of the Mental Health Oversight Committee – December 2013
- Progress Report of the Mental Health Oversight Committee – January 2012
- Report to the Legislature on the Implementation of Act 79 – January 15, 2013 to Mental Health Oversight Committee
- State's Response – April 3, 2015
- State's Amended Answer – April 3, 2015
- Supreme Court Entry Order – Docket No. 2014-241 – Appeal from an Order of Hospitalization – In re D.C.
- Vermont Statutes Annotated
- Wait List:
  - Bed Occupancy Report
  - Waiting List for Acute Inpatient Beds
  - Placement Decisions
  - Number of Persons Committed to DMH and their wait times
  - Waiting lists for all persons for beds

- "Who's Keeping Watch?" – A Review of the Department of Corrections Oversight and Management of Mental Health Services Contracts - Office of the State Auditor – Elizabeth Ready – State Auditor – April 17, 2004
- Visit to Brattleboro Retreat and Alpha and Bravo Units at SSCF.

INTERVIEWS

- Roy Aldridge – 1/5/16 – COI – Correctional Officer, SSCF
- Christina Granger – CSS – Caseworker, SSCF
- Kathy Grebos – 1/5/16 – CCO (Community Correctional Officer), formerly a COI at SSCF
- Deb Hart – 1/5/16 - COI – Correctional Officer
- Bill Krulish – 12/22/15 – Mental Health Coordinator, Correct Care Solutions (CCS), SSCF
- Jennifer Lyon-Horne – 1/12/16 – DMH Care Manager
- John McCullough, III, Mental Health Law Project Director, Vermont Legal Aid – 1/27/14
- Kristy McLaughlin – 1/12/16 – DMH Care Manager
- Neil Metzner – 12/23/15 – Director of Behavioral Health Services, Correct Care Solutions (CCS), SSCF
- Rebecca Moore – 12/22/15, 2/24/16 – Social Services Chief, DMH, formerly Licensed Psychiatric Social Worker at GMPCC
- Susan Onderwyzer – 1/12/16 - formerly Director of Quality Management, DMH, now employed at the University of Vermont
- Kirk J. Woodring, LICSW, Vice President, Quality and Clinical Services, Brattleboro Retreat – by email – 2/8/16 and 2/9/16

ACRONYMS

- **BMH** - Brattleboro Memorial Hospital
- **BR** -- Brattleboro Retreat
- **CCS** – Correct Care Solutions
- **DMH** – Department of Mental Health
- **DOC** – Department of Corrections
- **DR** – A disciplinary report for an institutional infraction – also known as being "written up" or getting a "ticket"
- **EE** – Emergency Examination

- **GMPCC** – Green Mountain Psychiatric Care Center in Morrisville
- **MHSU** – Mental Health Stabilization Unit (Alpha unit) at SSCF
- **MHU** – Mental Health Unit (at SSCF, staffed by Correct Care Solutions staff, social workers Bill Krulish, Paul Cappiello, Angela Trauth and Director of Mental Health Services, Neil Metzner)
- **MHTU** – Mental Health Transitional Unit (Bravo), also known as the Intermediate Mental Health Treatment Unit.
- **RRMC** – Rutland Regional Medical Center
- **SSCF** – Southern State Correctional Facility
- **VSH** – Vermont State Hospital

TIMELINE OF EVENTS

- **10/16/13** – D.C. receives citation for assault with bodily fluids for spitting at a police officer.[5]
- **10/30/13-** D.C. admitted to the Brattleboro Retreat (BR) on an Emergency Examination (EE).
- **1/17/14** – D.C. discharged from the BR.
- **1/19/14** – D.C. is found sleeping in an ATM booth without shoes, covered in feces and is taken to Brattleboro Memorial Hospital (BMH).
- **1/21/14** - Arraignment held for the spitting charge – D.C. fails to appear because he is in the hospital – a warrant for failure to appear is issued.
- **1/22/14**
  - D.C. discharged from BMH into the custody of police;
  - warrant served, $500 bond set;
  - spends night at SSCF.

- **1/23/14**
  - D.C. arraigned; committed to DMH for purposes of performing a competency and responsibility evaluation;

[5] In his affidavit, the Officer Jonathan Whiteman responded to the scene at the local Motel 6 where EMT's had been called to a report of a person having a stroke. According to the officer: "Upon arrival I spoke with [D.C.] DOB: 7/30/1953. [D.C.] was sitting on the edge of his bed in his room. When asked by members of Rescue what he was experiencing, [D.C.] said 'fuck you.' Members of rescue advised me that [D.C.] was not exhibiting any of the warning signs of a stroke. After speaking with [D.C.] for a few minutes he agreed to go with rescue to Brattleboro Memorial Hospital for evaluation. While in the process of leaving I said to [D.C.] that his room was dirtier than usual. [D.C.] then looked at me and said 'who the fuck are you, cock sucker.' [D.C.] then spit in my face. I placed [D.C.] into custody and transported him to Brattleboro Memorial Hospital ER for evaluation."

- Mittimus and commitment to DOC because no acute in-patient beds available;
- E-mail from Meredith Larson, Chief of Mental Health Services at DOC to Neil Metzner, Dr. Pamela Fadness, (Psychiatrist); Mark Potanas, Superintendent, Caroline Marsh, Assistant Superintendent, and Bill Krulish: **"[P]lease enter him as SFI"** (Significantly Functionally Impaired –statutory definition);
- First visit with staff person Bill Krulish from the Mental Health Unit (MHU) run by Correct Care Solutions (CCS);
- Placed in "safety smock;"
- Placed on 15 minute safety checks.

- **1/24/14**
  - Second visit from MHU staff;
  - D.C. put on 15 minute "self-harm watch;"
  - D.C. assigned to the Alpha segregation unit also known as the Mental Health Stabilization Unit at SSCF;
  - D.C. is prescribed trazadone, 100 mg, by Pam Fadness, M.D. (psychiatrist) for 14-day period.

- **1/26/14** – Safety smock removed.

- **1/28/14**
  - MHU staff person Cappiello visits – no recommendations – observations only;
  - Initial Psychiatric Evaluation Note done by Psychiatric Nurse Practitioner (PNP) Jerry Caltrider;
  - PNP notes historical difficulties with sleep; notes prior hospitalizations;
  - PNP notes that D.C. has historically been prescribed trazadone, but orders that it be allowed to expire without renewal – unclear when D.C. stopped getting it;
  - No record of PNP Caltrider consulting with Dr. Fadness over change;
  - Records from BMH show D.C. was prescribed 100mg of trazadone at bedtime for sleep.

- **1/29/14**
  - MHU staff person Cappiello visit - no action taken –observations only;
  - Non-contact visit from caseworker Chris Grainger;

- D.C. expresses a desire to move to Bravo Unit and complains of being confined to his cell.

- **2/1/14**
  - mentions needing something for sleep to his nurse;
  - CO notes on first shift "Finally laying down in his bed and napping. Previous shifts I have not seen him get any sleep." (Alpha).

- **2/2/14**
  - Evaluated at DOC for competency/sanity by Dr. Paul Cotton;
  - Psychiatrist opines he is incompetent and not criminally responsible;
  - Commitment to DMH ends;
  - D.C. remains unable to post bail.

- **2/3/14** – visit with caseworker Grainger, expresses a desire to leave

- **2/4/14** – D.C. moved from Alpha to Bravo Unit.

- **2/5/14** – D.C. has a visit with caseworker Grainger– says he is happy to be in Bravo.

- **2/6/14**
  - Complains he is not getting enough sleep "I think my meds are wrong;"
  - D.C. receives a "DR" from a CO for refusing to shower;
  - tells nurse he is worried he will get sick - too cold to shower.

- **2/7/14**
  - D.C. submits Health Service Request (HSR) regarding lack of sleep;
  - LPN Carney submits a Staff Referral Form for him for sleep and showering issues and directs Request to "Psychiatric Provider" and "Mental Health Professional." Writes: **"Please see him soon."**;
  - HSR not reviewed for three days, until **2/10/14** by MHU; note says only "See MH SFI progress note of 2/10/14, referencing the order for a sleep study (see 2/10/14 below).

- **2/9/14** – D.C. receives another DR for refusing to shower.

- **2/10/14**
  - D.C. complains of inability to sleep;

- Nursing and CO ask for MHU to come see D.C. – it has been 12 days since MHU's last visit;
- MHU staff person Trauth orders 48-hour sleep study in response to Health Service Request and staff referral of **2/7/14**;
- MHU staff person Trauth removes D.C. from 15-minute self-harm checks.

- **2/11/14**
  - MHU returns – recommends "f/u per SFI protocol as needed."
  - No indication or details of what that entailed.

- **2/12/14**
  - Sleep study "chart" signed as reviewed by MHU staff person Trauth;
  - No record of follow-up or interpretation of chart and results.

- **2/15/14**
  - D.C. asks RN Vegh for 100mg trazadone;
  - she writes in her nursing progress note that order expired;
  - she writes that she will contact provider to reauthorize;
  - there is no record that she made any Staff Referral Request.

- **2/17/14**
  - D.C. tells LPN Porter he cannot sleep due to lack of trazadone;
  - LPN nursing progress notes reflect her telling him she would refer him to Mental Health for sleep concerns;
  - LPN Porter's Staff Referral note located – marked **urgent** for all level of mental health staff including psychiatric provider, mental health nurse or mental health professional;
  - LPN Porter writes "Patient reporting sleep difficulties since trazadone d/c'd";
  - D.C. participates in group recreational therapy.

- **2/19/14**
  - MHU staff person Trauth returns after eight day gap;
  - Helped D.C. fill out a referral form to speak to caseworker Grainger.

- **2/20/14**
  - "Locked in" cell on 1st shift until 4 p.m. for not attending an unspecified meeting;

- TV removed during this period.

- **2/21/14**
  - D.C. commitment hearing in court;
  - all parties stipulate to Dr. Cotton's report and agree D.C. is incompetent;
  - D.C. returned to SSCF;
  - D.C. submits another Health Service Request (HSR) stating "Not receiving all my medication."

- **2/23/14**
  - RN Roberts notes trazadone was allowed to expire per order of PNP Caltrider on 1/28;
  - RN Roberts responds to HSR from 2/21; she lists meds D.C. takes without commentary;
  - RN Roberts reports that D.C. as saying "I'm not getting half of my mental health meds, and when I do I'm not getting them consistently. I'm bipolar you know and I'm not getting much sleep. I'm used to 7-8 hours and now I'm getting 3 hours. They won't give me my trazadone that I have taken for 20 years. It is for sleep, but it is also an anti-depressant and I am bi-polar";
  - RN Roberts says she will submit a referral to mental health;
  - No indication that RN Roberts submits referral to mental health;
  - LPN Goodrich sees D.C. on next shift and he complains of being unable to sleep and that he needs trazadone and that he is hearing voices;
  - LPN Goodrich submits **"urgent"** Staff Referral Request for all level of mental health staff including psychiatric provider, mental health nurse or mental health professional;
  - Writes "report of not sleeping trazadone discontinued also 'hearing voices.'"

- **2/24/14**
  - Accused of lying about how many times he went to mess hall
  - Locked in cell with no TV
  - A major "A 12" disciplinary report for alleged lie. Later dropped.
  - Spoke to LPN Goodrich again about needing Trazadone for sleep
  - She told him that "multiple referrals were sent to mental health."

- **2/25/14** – Participates in group recreational therapy for one hour.

- **2/26/14**
  - Issued a DR for not showering even though he claimed he did;
  - Nursing notes indicate he was in "lock down on the unit today."

- **2/27/14**
  - CO "reviews" the DR he received for not showering the prior day;
  - D.C. insists he did shower;
  - CO believes he is continuing to "lie";
  - CO gives him "2 nights ELI w/no TV.";
  - CO notes he is "still complaining" about not getting "all his meds";
  - LPN Cawvey notes D.C. as saying at @ 3 a.m. "I'm not sleeping very well. I'm tired of not being able to sleep. This is poor medical care. I am bi-polar and need meds for it. It's not being treated.";
  - LPN Cawvey advises him to turn his TV and lights off, lie down and try to relax. He says this does not work and he wants to see a doctor. Says she will put in a referral.

- **2/27/14**
  - Dr. Fadness reinstitutes trazadone at 50 mg dose;
  - LPN Nelson notes on her pm rounds at @10:30 that he was "happy" to see she had trazadone for him

- **3/1/14** -- "Major" DR issued for not showering.
- **3/2/14** – Reference made to a sanction sheet he might have been on, but sanction not specified

- **3/3/14**
  - Released from DOC to Green Mountain Psychiatric Care Center (GMPCC).
  - MHU visits and makes referral for SFI protocol even though he leaves

- **11/24/14** -- HRC Complaint filed by DRVT o/b/o D.C.

INTRODUCTION: D.C.'S BACKGROUND

During the time frame of this report, D.C. was a 60-year old male, primarily residing in the Brattleboro area. According to records from the Brattleboro Retreat, D.C. has "been hospitalized many times." Information from his competency evaluation shows he was hospitalized for two weeks at the New Hampshire State Hospital in March of 2010.[6] A month later, on April 24, 2010 he was admitted to the Vermont State Hospital (VSH) where he stayed until July 13, 2010. He was sent to VSH for a second inpatient hospitalization on December 5, 2010, and was transferred to the Retreat on February 4, 2011. However he was non-complaint with the admission process and was returned to VSH on February 10, 2011 and finally discharged on February 12, 2011. He was readmitted to VSH on April 27, 2011 and was discharged on July 15, 2011. Prior to the incident which brings this case before the Commission, he was hospitalized from June to August of 2103, only to be readmitted, as noted above, on October 30, 2013 and discharged on January 17, 2014.[7]

D.C. was diagnosed with Bi-Polar disorder in 1975. However he was compliant with his medication regimen and went to Alcoholics Anonymous and stayed sober for about 26 years. He was employed and attended SUNY at Stonybrook at some point. In 2008 he suffered a major stroke. This event plunged him into a mental health crisis and he stopped taking his medication and resumed

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[6] Competency Evaluation, February 2, 2014.

[7] The only police-related records this investigation was able to review were provided by Disability Rights Vermont although they were requested from the State but not provided. Often D.C. was not charged, or just cited and it is unknown how many of these encounters ever went to court. Reports showed the same kinds of encounters –calls to police because D.C. was agitated, disoriented, unkempt – which resulted in his being asked to leave hotels, making illogical decisions concerning his own well-being (refusing to take his boots with him after being discharged from the ER) and pushing away and cursing at those trying to help him, from his sister, to police and emergency room staff. However D.C. does not appear to be a "criminal" as the State asserts. This investigation was able to review some uncertified police reports which paint a picture of "public nuisance" problems devolving out of his mental illness. On September 27, 2013, an officer arrived at the Brattleboro Motel 6 for a complaint of noise disturbance. Motel 6 employees told the police they wanted D.C. out because he was being disruptive. His sister came to get him to take him to the BMH for evaluation and he tried to exit her car while it was moving. It did not appear he was charged with an offense. The next month, on October 7, 2013, Brattleboro police officers found him in the parking lot of a Wendy's and were advised he had been taking off his pants. When the officer spoke to D.C., D.C. told him he was "being cooked...[and] that his feet would burn if he didn't have something to stand on." During this encounter, D.C. told the officer that the officer was going to burn and cursed at him. He was eventually cited for Disorderly Conduct but was taken to BMH for evaluation. It is unknown whether the charge "stuck" or not. The reports reviewed consistently show D.C. as being agitated, disoriented, unkempt – being asked to leave hotels, making illogical decisions concerning his own well-being and pushing away and cursing at those trying to help him, from his sister, to police and emergency room staff.

drinking. Since his stroke, providers have variously diagnosed him with bi-polar disorder – manic type with psychosis, schizophrenia, alcoholism, and substance abuse. He also has a host of other medical issues, including diabetes, high blood pressure, asthma and heart disease.

Over time, D.C.'s mental illness has increasingly dovetailed with other developing neurological issues such as the possible onset of dementia and continuing "mini"-stroke activity. BR notes from December of 2013, just before he went to SSCF, indicated that the "admission history from the June admission and [t]he most recent admission evaluation and subsequent progress notes are notable for Mr. C's inability to comprehend and rationalize his current circumstance or to acquire new information sustaining it and applying it day to day."[8]

It is clear from the records that at this point in his life D.C. needs shelter, structure and safe surroundings. He cannot care for himself and according to all providers interviewed, tends to decompensate quickly when released from structured settings. He lacks judgment and insight into his circumstances and makes poor decisions with regard to his welfare and safety. Discharge notes from the Brattleboro Retreat on January 17, 2014, stated that: "Patient has exhibited a slow and steady decline in cognitive functioning while on the psychiatric inpatient unit. Patient has multiple medical challenges that need constant monitoring. Patient was offered to stay on a voluntary basis (until a more solid aftercare plan could be established) but patient declined. Patient will be homeless when leaving this hospital."[9]

D.C. appears unable to form consistent, positive relationships with anyone or to participate in a structured therapeutic milieu with the goal of improving his mental health. He is paranoid and behaviorally mercurial. On October 31, 2013, a doctor from the Retreat wrote: "The prospects for a substantial, meaningful degree of cognitive recovery are limited. Specifically, I think it unlikely that Mr. C. will be able to act in his own self-interest, consistently, rationally and effectively, in matters of finance, housing or medical decision making. I support the treatment team's recommendation of guardianship. Legal oversight of the guardian would protect his rights and interests. A living setting with 24-hour supervision will likely be necessary for his safety and that of others."[10]

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[8] Progress Notes, 12/31/13, Brattleboro Retreat, Neuropsychological Consultation.
[9] Brattleboro Retreat Records, January 2014.
[10] Id.

The VFHPAA defines disability as someone who has "a physical or mental impairment which limits one or more major life activities" or who has a "history or record of such an impairment" or as being "regarded as having such an impairment."[11] Physical or mental impairment" means, in D.C.'s case, "any mental or psychological disorder, such as...emotional or mental illness."[12] Clearly, in light of the information above, D.C. is a person with a disability.

LEGAL ISSUES

I. Statutory Framework

The statutory basis for D.C.'s complaint against both the DOC and the DMH lies in two separate sections of the VFHPAA. The first is found at 9 V.S.A. §4502(c)(2), and incorporates the "integration regulation" (also known as the "integration mandate") of the American with Disabilities Act (ADA) and interpretive case law.[13] This section of Vermont's statute sets forth an affirmative requirement that places of public accommodation provide "goods, services, facilities, privileges, advantages, and accommodations to an individual with a disability ***in the most integrated setting which is appropriate for the needs of the individual.***" (Emphasis added). D.C. has alleged that the respondents "denied [him] access to receiving services in and living in the most integrated setting appropriate to his needs by their collective failure to coordinate placement and provision of services to him...[and] that such denial caused D.C. suffering and harm."

The second applicable statutory section generally prohibits disability-based discrimination – that is, the "exclu[sion] from participation in or [] deni[al] [of] the benefit of the services, facilities, goods, privileges, advantages, benefits, or accommodations, or [that the individual] be subjected to discrimination by any place of public accommodation on the basis of his or her disability." It requires that places of public accommodation "provide an individual with a disability the

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[11] 9 V.S.A.§4501(2)(A)-(C).

[12] 9 V.S.A. §4501(3)(B).

[13] 42 U.S.C. §12101(a)(2): "historically, society has tended to isolate and segregate individuals with disabilities, and, despite some improvements, such forms of discrimination against individuals with disabilities continue to be a serious and pervasive social problem." *See also* 42 U.S.C. § 12101(a)(5) and Olmstead v. L.C., 527 U.S. 581 (1999), interpreting the "integration regulation" reflected in 28 CFR §35.130(d).

opportunity to participate in its services, facilities, privileges, advantages, benefits, and accommodations."[14]

The DOC[15] and the DMH are both places of public accommodation to which VFHPAA applies[16] since each provides "goods, services, facilities, privileges, advantages, and accommodations"[17] to individuals, some of whom may be disabled as is D.C. AHS is the "parent" agency to both, as such, is an appropriately named respondent however only the DOC and the DMH will be referenced in this report.

II. Elements of the Prima Facie Case

In order to prevail, D.C. must make a prima facie case of discrimination by proving all of the required elements:

1) He is an individual with a disability; (See the **Introduction** section above).

2) That DOC/DMH denied him the "goods, services, facilities, privileges, advantages, and accommodations in the most integrated setting" appropriate for his individual needs. **9 V.S.A. §4502(c)(2); AND/OR**

3) That DOC/DMH failed to provide him with an opportunity to participate in the benefit of services, facilities, goods, privileges, advantages, benefits, or accommodations. **9 V.S.A. § 4502(c)(1).**

4) Finally, D.C. would have to prove that the discrimination alleged in (2) and/or (3) above ***was by reason of his disability***. (Emphasis added).[18]

III. State's Defenses

If D.C. makes out a prima facie case of discrimination, the DOC and the DMH would have to establish an affirmative defense to both the integration regulation and the general prohibition against discrimination.[19] Both would have to demonstrate that the requested accommodations to integrate and provide access to

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[14] 9 V.S.A. §4502(c)(1). *See also* 42 U.S. Code § 12132.

[15] Department of Corrections v. Human Rights Com'n, 181 Vt. 225 (2006).

[16] Pennsylvania Department of Corrections v. Yeskey, 524 U.S. 206 (1998). Title II of the ADA applies to state prisons.

[17] 9 V.S.A. §4501(1).

[18] Fulton v. Goord, 591 F.3d 37, 43 (2nd Cir. 2009).

[19] Brooklyn Center for Independence of Disabled v. Bloomberg, 980 F.Supp.2d 588, 657 (2013) (citations omitted).

services would "fundamentally alter the nature of the service, program, or activity"[20] or "impose an undue hardship on the operation of [the] program."[21]

1. State: The integration mandate is not applicable to D.C., thus, neither the DOC nor the DMH should be liable under this provision.

First, the State asserts that "there is no precedent to support a finding that the integration mandate applies in a situation where there is a mix of criminogenic and mental health issues.[22] In support of this argument, it cites one Vermont case and references this investigator's reasoning in a prior "no reasonable grounds" HRC complaint."[23] There is no reference to a fundamental alteration or undue hardship defense. Nonetheless, assuming for the sake of argument that its position is that someone with D.C.'s disabilities should not be protected by the VFHPAA because to do so would be too costly or burdensome, or just that a criminal charge trumps his disabilities, the State's argument is incorrect.

In fact, the ADA regulations specifically require that correctional facilities follow the integration mandate with respect to inmates with disabilities which includes inmates with mental illnesses.[24] States can afford *greater* protections to individuals than federal law, but they cannot provide *less* protection. The State's argument appears to suggest that Vermont should afford less protection to D.C. than D.C. would have under federal law and this would be illegal.

FINDING #1: The VFHPAA covers D.C. regardless of whether he had a pending criminal charge since he is person with a disability.

[20] 9 V.S.A. §4205(5). *See also* 28 C.F.R. §35.130(b)(7).

[21] 9 V.S.A. §4205(6). *See also* 28 C.F.R. 41.53 enforcing the Rehabilitation Act, 29 U.S.C. §794. *See* Henrietta D. v. Guliani, 119 F.Supp.2d 181, 206 (2000) ""based on the close relationship between the two acts, [the ADA and the RA], cases interpreting the Rehabilitation Act are considered persuasive authority for interpreting the ADA.'"

[22] State's Response to HRC Request for Information, April 3, 2015.

[23] State v. J.S., 174 Vt. 619 (2002).

[24] 29 C.F.R. § 35.152: **Jails, detention and correctional facilities, and community correctional facilities.**
(b) Discrimination prohibited. . . .
(2) Public entities shall ensure that ***inmates or detainees with disabilities are housed in the most integrated setting appropriate to the needs of the individuals.*** (Emphasis added).

2. State: D.C.'s case has issues similar to another HRC case which resulted in a no reasonable grounds finding with respect to both the DOC and the DMH, thus, this case should be a no reasonable grounds finding as well.

The State's comparison to another HRC complaint as support for its position that D.C. is not protected by the integration mandate is essentially a comparison of "apples to oranges." In the other HRC case, an inmate with multiple convictions sought to be moved from prison back into a community setting in spite of multiple failed attempts while in community placements, including picking up new charges. His complaint was that the State had taken too long to place him and that he was languishing in prison in a holding pattern pending placement. In recommending no reasonable grounds, this investigation found that the State had made numerous efforts to place him and had in fact placed him numerous times. However he was unable to comply with community placements which made each subsequent placement effort more difficult.

In contrast, there is no evidence that D.C. had ever been in jail before and the State supplied no evidence of a criminal record in spite of this investigation's request that it do so.[25] In addition, D.C.'s integration argument must be broken down into two components. The first component is whether it was appropriate to segregate him for 10 days in the Alpha unit. The second is whether the 40 days he spent at SSCF awaiting an in-patient bed violated the integration mandate. D.C.'s final and separate-but-related allegation is that both the DOC and the DMH failed to provide appropriate services to him while he was at SSCF in both the Alpha and Bravo units.

[25] The State made a pointed effort to focus on D.C. as a "criminal" as opposed to primarily a person with a mental illness. This investigation believes this assessment is simplistic and unfortunate. The acts that resulted in D.C.'s criminal charge were a result of his mental illness and the attendant lack of judgment after being provoked by the taunt of a police officer about the state of his motel room. This investigation asked the State to provide a criminal history on D.C. since the State raised the "criminogenic" aspect of his case as a defense. The State's response was as follows: "I have confirmed with DOC that there is no criminal history in D.C.'s file. It appears that SSCF staff neglected to order one. The dissemination of criminal history records is strictly controlled by statute, see 20 V.S.A. [sic] 2015, et seq. I have conferred with counsel at DPS and I believe D.C. would be able to obtain a copy of his "criminal history record" by complying with the requirement set forth in set forth in 20 V.S.A. [sic] 2056f." The State has supplied criminal records in other HRC cases so it is unclear why they chose not to do so in this case. The State's failure to supply the requested information, prevented this investigation from assigning weight to that aspect of its argument.

FINDING #2: The two HRC cases are factually distinguishable and the State's argument is an inapplicable defense to either the integration mandate allegation or the general prohibition of discrimination with respect to both the DOC or the DMH.

3. State: Vermont case law supports a no reasonable grounds finding.

The State also cites a case to support its argument that D.C. is not covered by the integration mandate. This case is inapposite.[26] In *In re J.S.*, the defendant/appellant argued that the court itself should look for less restrictive alternatives to hospitalization[27] after appellant was found to be a danger to himself and others and thus a person in need of treatment.[28] D.C. is not challenging any of the court's actions in this complaint and the court's finding with respect to the fact that criminal charges can result from mental illness lends support to D.C.'s complaint with respect to DOC's violation of the integration mandate.[29] *J.S.* also involved civil commitment proceedings, whereas the request for a competency evaluation in D.C.'s case originated in criminal court.

FINDING #3: The facts of the cited case are not analogous to the facts of D.C.'s complaint and do not support a defense made by the DOC or the DMH.

4. State: The effects of Tropical Storm Irene should relieve the DMH of being liable for any violation of the integration mandate.

The State attributed the lack of acute bed capacity to the continuing impact of Tropical Storm Irene in August of 2011. This event is the cornerstone of the DMH's defense. In a June 2015 letter to the HRC, the State wrote that, "The shortage of inpatient psychiatric beds that existed in 2014 was a direct result of the loss of the VSH [Vermont State Hospital]. It was not due to the failure of

[26] *See supra* note 23.
[27] Id. at 622.
[28] Id.
[29] Id. at 619. Appellant was charged with the negligent operation of a motor vehicle and attempting to elude a police officer. *See also* Id. at 621.

Vermont's DMH, the Administration, or the Legislature to plan ahead and adequately fund mental health services."[30]

This investigation believes that this defense is an appropriate "fundamental hardship" and/or "undue burden" argument. The premise is that it would have been a fundamental hardship and/or undue burden for the DMH to have gotten D.C. into a bed more quickly because there simply were not enough beds or resources to provide more beds. It is an inescapable fact that there were shortages of acute beds post-Irene and that in 2014, this shortage continued to affect persons such as D.C. The Legislature passed Act 79 which authorized the creation of several new facilities for the "treatment and care of individuals with psychiatric disabilities, enhanced new and existing community services, and established a mechanism for coordinating the movement of individuals throughout the system."[31]

The State at that time had a "bed board" to keep up with "Delayed Placement Persons" (DPP's) such as D.C. and acute bed openings. While the bed board did not operate in "real time" at that juncture, it was an effort to keep track of openings. There was a process for communicating with the DOC as to bed availability for D.C. (and others). Internal emails within the DMH and between the DMH and the DOC show status reports and check-ins with respect to bed availability or lack-thereof, although there was little substantive information exchanged as to how D.C. was faring over the waiting period.

In response to this investigation's question about acute bed availability for persons like D.C. specifically, the State answered that "there were 14 beds available at the Brattleboro Retreat, 6 beds available at Rutland Regional Hospital, and 6 – 9 available at Fletcher Allen Health Care. All 3 of those facilities have additional psychiatric beds but none that are available to individuals who have needs such as D.C.'s. In addition, Green Mountain had 8 beds, all of which would have been available (if empty)." Rutland Regional Hospital, the Brattleboro Retreat and Green Mountain Psychiatric Care Hospital were all "no refusal" hospitals." The VSH had approximately 54 "non-refusal" beds, thus, the bed capacity was reduced from 54 to 28.

The State admitted that the procedure for identifying open forensic beds (those beds for people with mental health issues and criminal charges) for persons

[30] *See* 18 V.S.A. §7253; 18 V.S.A. §7255; 18 V.S.A. §7401 for the DMH's statutory mandates.
[31] Report of the Mental Health Oversight Committee, December 2013, p. 3.

like D.C. worked in triage mode: "There is no decision matrix. DMH care managers use a triage process to assess the clinical presentation of the individuals waiting for beds, based on their level of acuity, length of time waiting, location, and the availability of appropriate beds. In addition, a hospital may determine that it is unable to take a particular individual at a particular time, based on the acuity level of the patient and of the hospital unit itself, even when there is an empty bed and even if the hospital is part of the so-called "no reject" system. That is, a hospital could determine that, based on the acuity level of patients and the availability of staff to address that acuity, they are unable to accept a person waiting for a bed at a given time."

The State's official explanation of whether there was a "waiting list" noted that while "DMH is aware of and has a list of every individual who is waiting for a bed in the State, the list is not a "waiting list" per se—it is a record of all individuals, regardless of their status, who need a bed. DMH, through the Admissions office at the state-owned hospital (then GMPCC, now VPCH), maintains and produces a report each 8-hour shift of all the individuals waiting for beds. The report is divided into categories: those individuals on involuntary status waiting in emergency rooms for a psychiatric bed; individuals voluntarily seeking a psychiatric bed waiting in an emergency room; and individuals for whom a criminal court has ordered a competency and/or sanity evaluation on an inpatient basis. D.C. fell into the latter category. The list also tracks minors waiting for beds." Finally, the State noted that "[t]he care managers from DMH, all of whom are clinicians, along with the physicians at the admitting hospital, make the decisions about who is admitted to which available beds."

Numbers requested by this investigation for the period January 1, 2013 to July 1, 2014 showed an average wait of 15.5 days for persons at the DOC pending placement at non-refusal facilities. Obviously, D.C.'s wait was longer than that. There were two other persons in that period who had even longer waits. One person waited 51.27 days and one 56.14 days for placement. One of those persons went to the BR and one went to GPMCC. For all persons waiting on involuntary beds, but NOT including those persons at the DOC, the wait was shorter and there were more beds due to the inclusion of Fletcher Allen. The average wait for that group was 3.12 days, and the longest wait for persons on that list was 19.07 days.

The aggregate impact of all of these competing issues made for an unavoidably imperfect system, but emails between the DMH and the DOC and case

manager logs show that D.C. was on the radar. Case notes from then DMH case managers Jennifer Lyon-Horne and Kristy McLaughlin show weekly entries recording contacts made to Level 1 facilities about acute bed availability although the entries do not list specific names or the substance of those contacts and have a "cut and paste" aspect to them. Emails between Neil Metzner, the Correct Care Solutions (CCS) contractor and the Director of Behavioral Health Services for all of the DOC and Kristy McLaughlin at the DMH on February 10, 2014 show that D.C. had a "near miss" for a bed at Rutland Regional Medical Center. There was hope he would be placed there however Kristy McLaughlin emailed Metzner that "they had a very rough weekend - 3 patients on 1:1 and two different assaults over the weekend," thus, D.C. could not be admitted.

The extent of the micro-level issues in play make it nearly impossible to determine whether D.C.'s wait had anything to do with the severity and extent of his disabilities. Under the circumstances in existence at the time, the DMH cannot be held liable for violating the integration mandate with respect to the length of time it took to place D.C. in an in-patient bed.

FINDING #4: The DMH did not violate the integration mandate by taking forty (40) days to place D.C. in an acute bed due to the continued impact of T.S. Irene. In order to place D.C. more quickly, there would have had to have been more beds and more personnel which would have been an undue burden to the DMH under the circumstances.

5. State: D.C. received the services from the DMH that the court ordered him to receive – that is, an evaluation for competency and responsibility[32]

The State argued that the DMH had no obligation to D.C. other than to perform a court-ordered competency and responsibility evaluation. With respect to the DMH, the only question at this point is whether the DMH was obligated to provide services to D.C. at SSCF. It appears that the DMH started looking for a bed for D.C. around January 19, 2014 and continued to do so until he was placed at GMPCC on March 3, 2014. This investigation has not been able to find the legal basis for its efforts in spite of consultation with the Mental Health Law Project and interviews with witnesses. It appears from the BMH records that a mobile crisis

[32] The State makes this same argument with regard to the DOC – that D.C. received the services he was supposed to receive. That argument will be addressed separately.

team from Brattleboro area's designated agency (DA) came and evaluated D.C. for a possible emergency evaluation (EE) on January 19, 2014 after he was hospitalized. However there is no formal record that one was actually done or any separate docket entry for the civil proceedings that would have had to accompany process. That civil process would have been separate from the criminal process that is the focus of this case.

In addition, by the time D.C. left BMH in the custody of the Sheriff on the failure to appear warrant, the discharging physician had deemed him stabilized and believed that he no longer qualified for an EE, so the reason for DMH's bed search are somewhat mysterious and the State has been unable to shed light on the issue. Perhaps the DMH staff disagreed with the BMH doctor's assessment, because they knew D.C. so well and they knew he would quickly decompensate upon release, so they continued to look for a bed. In fact, he did decompensate, almost immediately. He disrobed in the courthouse so his presence was waived by his attorney and he was not physically present before the judge. It is possible that the bed search was an administrative oversight, lost in the details of a system functioning in triage mode. Whatever the reason, D.C. was not "committed" to the DMH's custody in the sense that he had been found to be a person in need of treatment in a civil process.[33]

Thus, the limited-purpose court order for the competency/responsibility evaluation was the only reason that D.C. was in the custody of the DMH. This court order began on January 23, 2014 and expired upon completion of the competency examination which took place on February 2, 2014. Once the evaluation was done, the commitment to DMH ended. D.C. continued to be held in the custody of the DOC as an inmate for lack of bail as a pretrial detainee, however the DMH could not dictate where the DOC housed D.C. for the 10-day period he awaited the evaluation.

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[33] *See* 18 V.S.A. §7101(17). "A person in need of treatment" means a person who is suffering from mental illness and, as a result of that mental illness, his or her capacity to exercise self-control, judgment or discretion in the conduct of his or her affairs and social relations is so lessened that he or she poses a danger of harm to himself, to herself, or to others: (A) A danger of harm to others may be shown by establishing that:
(i) he or she has inflicted or attempted to inflict bodily harm on another; or (ii) by his or her threats or actions he or she has placed others in reasonable fear of physical harm to themselves; or (iii) by his or her actions or inactions he or she has presented a danger to persons in his or her care.
(B) A danger of harm to himself or herself may be shown by establishing that:
(i) he or she has threatened or attempted suicide or serious bodily harm; or
(ii) he or she has behaved in such a manner as to indicate that he or she is unable, without supervision and the assistance of others, to satisfy his or her need for nourishment, personal or medical care, shelter, or self-protection and safety, so that it is probable that death, substantial physical bodily injury, serious mental deterioration, or serious physical debilitation or disease will ensue unless adequate treatment is afforded.

It appears from emails that his DMH Care Manager, Kristy McLaughlin, and others knew he was in Alpha for a time. The few comments made about his being at the DOC simply reflected relief that he was not on the street. Ms. McLaughlin did not visit him while he was at the DOC and stated it was not part of her job to check in on him or to provide services. Her sole job was to get him in a bed. The roles of the DMH and the DOC were clearly bi-furcated at this point in time partially due to T.S. Irene – the DOC housed and was to provide mental health services, and the DMH was to find a bed and provide services once the person was admitted as an in-patient.

Prior to the destruction of the Vermont State Hospital, forensic patients like D.C. received mental health services while they awaited competency evaluations. They were assigned a social worker and a psychiatrist. They had their own rooms, albeit small ones. They were provided with therapeutic services both individually and in groups. They had recreational therapy. They were not purposefully isolated (unless they self-isolated), nor were they "punished" in the way that the DOC staff ended up "punishing" D.C., such as writing him up for disciplinary infractions, taking away his TV and locking him in his cell for actions that were very likely manifestations of his mental illness and other co-occurring medical issues affecting his mental health. As a result of T. S. Irene, services essentially fell by the wayside[34] so that persons who awaited beds at the DOC were known as "offenders" and "inmates," not patients and they were subjected to a completely different model of treatment (if it can be called that in the case of D.C.) by the DOC than they would have gotten had they been under the care of the DMH. Budget issues curtailed therapeutic efforts.

However there was recognition, even on the Legislative level, that this was a problem. In December 2013, just prior to D.C.'s incarceration, the Report of the Mental Health Oversight Committee addressed what it called "system overflow" – that is, what happened to people who could not be immediately placed in in-patient beds. It found that:

> DMH itself does not provide any treatment for these individuals; rather, a crisis clinician reevaluates the individual's condition at 12-hour intervals. Treatment for individuals waiting for services or an open bed at another facility is at the discretion of the emergency department director or Department of Corrections, respectively. [35]

[34] Telephone interview, Rebecca Moore, February 24, 2016.

[35] Report of the Mental Health Oversight Committee, December 2013, p. 6.

The recommendation of the Committee in light of this problem was clear:

> The Committee finds that the provision of short-term treatment for individuals waiting in an emergency department or correctional facility for a bed is **essential**. It renews its 2012 recommendation that the committees of jurisdiction explore methods for ensuring that temporary treatment for such individuals is provided, and sufficient numbers of level 1 beds are available.[36] (Emphasis added).

The problem the Committee recognized, of course, is that incarcerating people with severe mental illness and not providing them with treatment while they await placement can make them even more acutely ill. When they finally get placed, therapeutic progress is more difficult with the result that beds get tied up for longer periods of time because treatment takes longer. In sum, however, while there was recognition of the problem there were no resources made available to address it which required the DMH, at least within a particular period of time, to focus its resources on what it determined to be the most urgent areas. In light of these circumstances, the DMH can meet the fundamental alternation and undue burden defense.

FINDING #5: D.C. was placed in the custody of the DMH by the district court only for the purposes of having a competency/responsibility examination performed by a psychiatrist. Prior to T.S. Irene, D.C. would have received services while he awaited his evaluation and thereafter. However the continuing effects of T.S. Irene diminished resources on all levels with the result that the DMH can establish a fundamental alteration and undue burden defense. Thus, there are **no reasonable grounds** to believe that the DMH violated either section of the VFHPAA.

IV. The DOC's violation of the VFHPAA

The State's remaining argument is that D.C. got necessary care and appropriate services while he was at SSCF from the DOC's mental health

[36] Id.

contractors – Correct Care Solutions (CCS).[37] The State asserts that D.C. was housed appropriately at SSCF based upon a professional assessment, both in terms of location and length of time – initially Alpha unit for 10 days, then moved to Bravo where he stayed until he was moved to GMPCC. This argument seeks to address both the integration mandate issue and the alleged violation of the general prohibition against discrimination. The DOC asserted that D.C. was provided with meaningful access to services and reasonable accommodations and was able to "participate in the benefit of services, facilities, goods, privileges, advantages, benefits, or accommodations."[38]

However, this investigation found serious deficits in D.C.'s care and a lack of meaningful access to services and attempts at reasonable accommodation. As a contextual reminder, D.C. was (and is), an aging, severely mentally ill man suffering from paranoia. His communication skills varied – sometimes he was coherent, sometimes he was not. He was almost completely unable to care for himself, and at the time of his incarceration, likely experiencing the onset of dementia as well as a host of other health issues.

He belonged, at all times, in a therapeutic setting, not in a punitive one. Instead, at the DOC, he found himself surrounded by mental health staff who did not visit as frequently as they should have and who offered him no options for alternative living arrangements. He found himself coping with correctional officers who lacked training in how to deal with severe mental illnesses and co-occurring disabilities. He found himself dealing with medical providers, one of whom unaccountably cut off an important medication that controlled his bi-polar disorder and helped him sleep. Some of the other medical providers in the nursing staff made no effort, or ineffective efforts to refer him for psychiatric intervention when he complained, although some did make the effort. The nature and extent of D.C.'s disability required more care and attention – not less. His requests for accommodation occurred at all points in his stay, but they were not met, he was not provided with meaningful access to services and he was placed in a non-integrated environment that was not appropriate for his needs.

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[37] December 12, 2012 Memorandum from then DOC Commissioner Andrew Pallito to then Secretary of Administration Jeb Spaulding detailing Correct Care Solutions' (CCS) contract with the State and requested amendments. Contract #16601.

[38] *See* Disabled in Action v. Bd. of Elections in City of N.Y., 752 F.3d 189 (2d Cir.2014) ("to demonstrate that individuals were deprived of an opportunity or benefit or discriminated against by reason of their disabilities, Plaintiff's must demonstrate that Defendants failed to undertake ***some feasible measure*** to improve accessibility) (emphasis added).

The documentation provided by the State and gained through interviews, paints a picture of a Mental Health Unit (MHU) whose staff took advantage (albeit not in a malicious way) of D.C.'s inability to effectively communicate and his lack of an advocate, by providing him only minimal services – essentially "3 hots and a cot." Indeed, Bill Krulish stated in his interview that the primary goal of the DOC and MHU was to provide food and shelter to D.C. and to "stabilize" him. However the law requires more of the DOC (and thus its contractors).

The Mental Health Unit (MHU) run by CCS appears to have provided very little in the way of services period – substantive or otherwise. If they provided more services of substance, they failed to document it. Mr. Krulish was asked about the lack of documentation and he was unable to account for it. Due to their lack of training, some of the correctional officers viewed D.C. with exasperation and suspicion. They let the behaviors he exhibited as a result of his disability personally affect them – his paranoia made them paranoid. They assigned a malicious intent to his actions - actions which were actually typical for him in any setting and were manifestations of his mental illness and other co-occurring disabilities such as dementia.

Thus, the final question for this investigation is whether the DOC violated the integration mandate and the general prohibition against discrimination. The State's defense seems to be that the extensive documentation generated during D.C.'s stay is proof that the DOC did not violate the VFHPAA. The DOC has a number of statutory duties to D.C. regarding mental health treatment that are distinct from those of the DMH. The DOC also has internal rules and policies that govern the treatment of mentally ill inmates and its rules with respect to the treatment of mentally ill inmates have the force of law.[39] This theory suggests that D.C. accommodations were not reasonable ones, and that to do more would require the institution to somehow compromise its safety and security.

D.C. has not alleged intentional discrimination and proof of intentional discrimination is not required. The Second Circuit, (and courts beyond, including the U.S. Supreme Court), recognize that public accommodations may illegally deprive persons with disabilities of "meaningful access"[40] to benefits they are statutorily entitled to through actions (or lack of actions) that amount to "benign

[39] 28 V.S.A. §3(5). See DOC Policy & Procedure 371.01 which further defines "inmates." D.C. was classified as an inmate rather than an "offender." Offenders are defined at 28 V.S.A. §3(8). Offenders have been sentenced – inmates have not.

[40] Henrietta D. v. Guliani, 119 F.Supp.2d 181, 206-07 (2000), *quoting* Alexander v. Choate, 469 U.S. 287, 301 (1985).

neglect."[41] Accordingly, meaningful access may require that a public accommodation make "reasonable accommodations" so that there is "equal opportunity" for persons with disabilities, not just "equal treatment."[42] Where a person's disability is obvious, as is that of D.C., the public accommodation is "on notice" that an accommodation will be needed and it is incumbent upon the public accommodation to provide it/them.[43]

1. Specific Areas of Violation

This investigation finds that the DOC failed to provide meaningful access to services and/or violated the integration mandate in the following ways:

1. By placing D.C. in a "safety smock" for three (3) days when it was contraindicated by DOC's policy on usage, and the assessments done by intake staff and the MHU.

2. By placing D.C. in a segregated unit, (Alpha Unit), for ten (10) days where he was locked in his cell for up to twenty-three (23) hours a day with minimal human contact outside of correctional officers and nurses.

3. By failing to provide meaningful access to mental health services and psychiatric referrals while D.C. was in Alpha Unit.

4. By depriving D.C. of a necessary medication for approximately three weeks, resulting in a severe inability to sleep.

5. By failing to train its correctional officers about persons with severe mental health issues and co-occurring disorders as required by statute and rule.

6. For the failure of the MHU staffs to monitor how correctional officers were treating D.C. while he was in Bravo Unit.

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[41] Brooklyn Center for Independence of Disabled v. Bloomberg, 980 F.Supp.2d 588, 597 (S.D.N.Y. 2013).
[42] Alexander at 301.
[43] *See* Robertson v. Las Animas Cnty. Sheriff's Dep't, 500 F.3d 1185, 1197-98 (10th Cir. 2007).

7. For the failure of the MHU to provide meaningful access to therapeutic services while D.C. was in Bravo Unit.

8. For subjecting D.C. to punitive measures, including locking him in his cell, taking away his TV, access to common areas and activities, and issuing him disciplinary reports – "DR"'s for minor issues that were manifestations of his mental illness and co-occurring disabilities.

2. Statute Governing the Treatment of SFI Inmates: 28 V.S.A.§907.

The statutory section that details the mental health services that the Department of Corrections is required to provide is found in 28 V.S.A. §907. Its directives are extensive and mandatory, not discretionary. It sets forth a method for screening inmates who have a "serious functional impairment" (SFI)[44] and directs the DOC to develop and implement an "individual treatment plan" for those inmates who have an SFI.[45] Persons with SFI are to be screened within 24 hours of arrival.[46] The statute also requires a "thorough trauma informed evaluation" conducted in a timely and reasonable fashion by a [QMHP]."[47]

The statute *requires* that SFI inmates have access to follow-up evaluations, crisis intervention, crisis beds, residential care within a correctional institution, clinical services provided within the general population of the correctional facility, and services provided in designated special needs units (presumably Alpha and Bravo).[48] While the statute requires that the DMH and the DOC coordinate to provide "[o]ther services" that both departments "jointly determine to be appropriate,"[49] the DOC is not relieved of its obligations by what the DMH does or does not do. The statute also requires "[s]pecial training to medical and correctional staff to enable them to identify and initially deal" with seriously mentally ill (SMI)

[44] "Serious functional impairment" is defined in 28 V.S.A. §906(1) as (A) "a disorder of thought, mood, perception, orientation or memory as diagnosed by a qualified mental health professional which substantially impairs the ability to function in the correctional setting; or (B) a development disability, traumatic brain injury or other organic brain disorder, or various forms of dementia or other neurological disorders, as diagnosed by a qualified mental health professional, which substantially impairs the ability to function in the correctional setting."
[45] 28 V.S.A. §907(3).
[46] 28 V.S.A.§907(1).
[47] 28 V.S.A. §907(2). QMHP's are defined in 28 V.S.A. §906(2).
[48] 28 V.S.A. §907(4)(A)-(F).
[49] 28 V.S.A. §907(4)(H).

inmates.[50] To that end, the statute lists nine (9) requirements specific to staff training. In January 23, 2014, Meredith Larson, the Director of Mental Health Services for the Department of Corrections sent out an email to several people, including Bill Krulish of CCS and who worked at the Mental Health Unit at SSCF and his supervisor, Neil Metzner of CCS, the Director of Behavioral Services, that D.C. was designated as an SFI inmate. This triggered a number of statutory and rule-based obligations. There is no indication from the evidence provided to this investigation, that the DOC met the bulk of these requirements.

3. Administrative Rule 11: The Use of Administrative and Disciplinary Segregation for Inmates with Serious Mental Illness.

The Corrections website states: "An APA Rule is a general statement which implements or interprets law or policy and which has been adopted as required by the State of Vermont's Administrative Procedures Act. Rules have the force of law unless amended or revised or unless a court determines otherwise."[51] The DOC Rule 11 specifically focuses on the placement of inmates with a "serious mental illness"[52] (which includes those with an SFI designation) in segregation.[53] It recognizes that "Inmates with serious mental illness may often experience exacerbation of their underlying illness when segregated. The use of segregation for inmates with a serious mental illness will not occur without the direct approval of a physician."[54]

The Rule describes two types of segregation – administrative and disciplinary. Administrative segregation is defined as:

> A form of separation from the general population [gen-pop] 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 or orderly running of the institution. Inmates pending

[50] 28 V.S.A. §907(6)(A)-(I).

[51] *See* 25 V.S.A. §845(a) "Rules shall be valid and binding on persons they affect, and shall have the force of law unless amended or revised or unless a court of competent jurisdiction determines otherwise. Except as provided by subsections 842(b) and 844(e) of this title, rules shall be prima facie evidence of the proper interpretation of the matter that they refer to."

[52] "Serious Mental Illness" means "Substantial disorder of thought, mood, perception, orientation or memory, any of which grossly impairs judgment, behavior, capacity to recognize reality, or ability to meet the ordinary demands of life. This includes, but is not necessarily limited to, diagnoses of schizophrenia, schizoaffective disorder, psychotic conditions not otherwise specified, bipolar disorder, and severe depressive disorders." DOC APA Rule 05-049

[53] 28 V.S.A. §701a(b): Segregation means ""a form of separation from the general population which may or may not include placement in a single occupancy cell and which is used for disciplinary, administrative, or other reasons."

[54] Vt. Admin. Code 12-8-11:5.

investigation for trial on a criminal act or pending transfer may also be included.[55]

This type of segregation makes no mention of being locked inside of an individual cell twenty-three (23) hours out of a twenty-four (24) hour day. This definition could apply to Bravo Unit, the "Mental-Health Transitional Unit," which has individual cells that differ from the segregation cells in Alpha. Inmates can come and go from their cells to a common area as they please, unless a CO locks them in their cell for some sort of disciplinary infringement. It is a small population of inmates with a common area and a TV. A single CO stands at a podium at the front on the doorway keeping track of what is going in. Bill Krulish described it as a gen-pop unit, however it doesn't look like or function as a gen-pop unit and one of the COs who worked there did not describe it as a gen-pop unit. It is a unit segregated from larger units in other buildings which housed greater numbers of inmates.

Alpha Unit fits more into the Rule's definition of 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. [Emphasis added].[56]

It appears that the DOC created a hybrid type of segregation designation by terming Alpha the "Mental Health Stabilization Unit." On one hand D.C. was locked up in a cell 23 hours a day, which fits into the definition of disciplinary segregation. On the other hand however, he committed no "serious violation[] of conduct regulations" to get him there.

Essentially the DOC attempted to evade the requirements for administrative or disciplinary segregation by using terms like "Stabilization" and "Transitional" to allow it take actions which circumvent the plain language of Rule 11 as it is written. If the DOC had followed the rule to a letter, D.C. would have been placed in Administrative segregation, and therefore Bravo unit, because he had not committed a serious violation and so did not deserve to be locked up. The

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[55] Vt. Admin. Code 12-8-11:4.
[56] Id.

definitional distortions made by the DOC essentially allowed it to "punish" D.C. for being a severely mentally ill man with co-occurring disorders. It is difficult to imagine this manipulation of the Rule as an effort at making a reasonable accommodation and a way of providing meaningful access to services and it certainly did not result in the least restrictive environment appropriate for his needs.

It is worth noting that had the VSH still been in existence, or had D.C. gotten a bed right away, he would have experienced a completely different environment. He would have had his own room and a shared bathroom outside of his room. He would not have been locked in a room, isolated and segregated for 23 hour a day.[57] He could have participated in any activities he wished to participate, and chosen whether or not to socialize with others. He would have been assigned a social worker and a psychiatrist.

At that time, the Brattleboro Retreat placed new patients on a "Red Level" for 24 hours when they first arrived whether they were forensic patients or not. Patients on the Red Level were unit restricted but **not** room restricted. Patients are encouraged "to attend the groups that are clinically appropriate for them on the unit, no matter what level they are on. In fact, participating in treatment and group activities on the unit is an indication that the individual's illness is likely improving, allows the treatment team to "re-evaluate" and allows patients to work their way up to yellow and green level privileges. The Retreat also had a section of the unit for persons who had difficulty experiencing high levels of stimulation called Acute Low Stimulus Area (ALSA). Any patient assigned there "has a specific ALSA treatment plan in which they identify activities that they find soothing or otherwise therapeutic. Staff assigned to the ALSA area engage these patients in treatment and activities that are specially developed to promote a return to the larger milieu."

FINDING: The DOC created parallel "shadow" definitions which allowed for the segregation of people with severe mental illnesses. These definitions fall outside of Rule 11 which governs how the DOC implements the Vermont statutes governing the treatment of severely mentally ill inmates. By placing D.C. in a segregated unit that he did not qualify for by virtue of the DOC's own rules and definitions, the DOC violated the integration mandate and the general prohibition against discrimination.

[57] Interview with Psychiatric Social Worker Rebecca Moore, 12/22/15.

i. Criteria for Admission

There are further consequences resulting from the DOC's creation of a "special" segregation unit. The criteria for admission requires that an inmate be screened within 24 hours of arrival. Part of the screening involves the completion of an "Initial Needs Survey" (INS) to determine whether the inmate has "immediate treatment needs or is in need of further evaluation."[58] D.C.'s INS was done by a Correctional Officer I. There were nineteen (19) simple questions on the INS and a bizarre scoring system with no definitional key as to what the score meant. Bill Krulish described it as an "outdated form" said he paid no attention to survey scores between 1-4. D.C.'s first score was below a 4. The Shift Supervisor signed off on the form and Krulish signed off on the form the next day without comment or interpretation.

If an inmate is being considered for placement in either type of segregation unit, as defined by Rule 11, the Rule requires physician approval: "The use of segregation for inmates with a serious mental illness will not occur without the direct approval of a physician."[59] This investigation found no direct evidence that a physician reviewed D.C.'s situation and approved him for placement in segregation. The only document found was a form filled out by Krulish in which he wrote: "Recommend placement in Alpha. I do not believe he will fare well in any other unit at this time due to his poor social skills and paranoia."

The requirement of physician approval requires more than this statement. The Rule states "If a physician orders an inmate with a serious mental illness [sic] be placed in segregated housing, he/she will document the level of monitoring needed by a qualified health and mental health care professionals and the inmate will be provided with ongoing assessment and treatment as clinically indicated."[60] One might be able to dismiss the lack of proof of physician authorization as an oversight or the result of a missing document, however this was the only written documentation produced and it does not approximate what the rule requires generally or specifically.

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[58] 28 V.S.A. §907(1).
[59] Vt. Admin Rule 12-8-11:5.
[60] Id.

The Rule also requires that the Superintendent be kept in the loop and that he or she ensures that alternative living situations are considered, as well as "intermittent segregation."[61] Krulish thought D.C. might have had a couple of "visits" to Bravo while in Alpha, but he was "not 100%" sure. There was no documentation from Krulish, or any staff person in Krulish's unit, nor by any correctional officer on any shift, nor evidence in the nursing progress notes or caseworker notes or other facility meeting notes that he visited the Bravo unit. His caseworker's notes do reflect that D.C. communicated a desire to leave Alpha and to move there.

Krulish's recommendation placed D.C. in segregation where he was locked in a cell twenty-three (23) out of twenty-four (24) hours a day, give or take, for 10 days in spite of his obvious paranoia and anxiety and apparently never having been incarcerated before. He received food through a non-contact slot and had no access to TV except perhaps for one hour during "rec" time when he could also shower or walk outside in a small fenced area with a rusted out basketball hoop. Nursing notes reveal he had little understanding of why he was there. If D.C. was let out of his cell more frequently than one hour a day,[62] it also was not documented.

FINDING: There is no evidence that a physician properly authorized the placement of D.C. in a locked, segregated unit or proof that a physician documented "the level of monitoring [D.C.] needed by a qualified health and mental health care professionals" or the type of "ongoing assessment and treatment as clinically indicated." This is further evidence that the DOC violated the integration mandate and the general prohibition against discrimination.

ii. Treatment Plan

The Statute[63] and Rule[64] require the development of a treatment plan and require that the mental health staff conduct "regular mental health rounds....at least three (3) times a week and will document their findings in the health record."[65] A treatment plan might include any or all of the following:

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[61] Id.

[62] He left Alpha once with his caseworker to call his sister to ask for money.

[63] 28 V.S.A. § 907(3).

[64] Vt. Admin. Code 12-8-11:5.

[65] Id.

- individual or group psychotherapy designed to address the specific problems and concerns of the inmate as identified in the treatment plan
- cognitive-behavioral interventions
- stress management techniques
- psychoactive medications as prescribed
- crisis services as needed
- case management
- other approaches, including psychosocial support services, deemed appropriate for the goal of returning the inmate to general inmate population.

There was no evidence of a treatment plan and D.C. was not visited three times a week. Krulish stated in his interview that they (mental health staff) do not do a treatment plan because "we focus on stabilization." The forms the MHU personnel filled out reference a treatment plan, but none was evident. At the bottom of the "Mental Health SFI Progress Note" there is a box to check. The question is: "Does treatment plan require revision based on current status?" Each of the four times the box was checked "no" but again, there was no evidence of a treatment plan. The contract with Correct Care Solutions provided to this investigation states that "Failure to develop an individualized treatment plan for each inmate diagnosed with serious mental illness shall result in a penalty of $250.00 per occurrence."[66]

During his 40 day stay, records supplied by the State show that D.C. was individually seen four (4) times in Alpha and four (4) times in Bravo by a mental health staff person, so eight (8) times in forty (40) days (although he was seen the day he was discharged on March 3, 2014). Krulish saw D.C. twice and documented their interactions. He reported on his second visit that D.C. was alert but "Not clearly oriented to purpose and place. Uncertain of month and year." He noted he was a "bit agitated, but settled down over the course of the session." He described his mood as "anxious," his thought content as "paranoid," and his thought process as "tangential." His speech was described as "clear and coherent," and his affect "appropriate." Krulish saw no signs of suicidal ideation or self-harm.

Paul Cappiello, another MHU staff person appears to have barely interacted with D.C. at all. Instead, he described the behavioral affects he observed. His

[66] CCS 16601 Performance Guarantees Attachment Contract Analysis Memo for Amendment #1, §2.47.9b, p.6.

reports suggest that D.C. was decompensating from being in segregation. He checked a box describing D.C.'s mood as "depressed and surmised he was having "delusions." He noted that D.C.'s speech had gone from "clear/coherent" on January 23, 2014 and January 24, 2014 to "Poverty [of speech]." His affect had deteriorated from "appropriate on January 23, 2014 and January 24, 2014 to "Blunted." His only comment was "IM [inmate]had been decompensating and was paranoid." He noted "Unable to get a claear [sic] statement." He said he had used one "intervention" during the meeting – that of "reflective liasteng [sic]." Again, there are no referrals even though D.C. appeared to be worse off on January 28, 2014 than he had on January 23-24, 2014. The next day was no different. On January 29, 2014, there was not much change for the positive in D.C.'s mental status. The only new comment from Cappiello was "Client paranoind [sic] not able to make report at this time' [sic].

The first Bravo visit was initiated by a request from a CO and a nurse. Most of the MHU visits appear to have been without substance. There were no referrals. There was a lot of box-checking. There was an order for a "sleep study" made by Angela Trauth of the MHU which was the MHU's response to his (and some of the nursing staffs') repeated complaints of insomnia and D.C.'s (correct) claims that he was not getting the medication he needed both for sleep and for his bi-polar disorder. After the study, Trauth checked that per D.C.'s "Plan" (which, again, could not be found), there should be "f/u per MH SFI protocol as needed." There was no evidence of an SFI protocol requiring follow-up.

Bill Krulish said that D.C. would have had activities, meetings and services in Bravo but there is no documentation of that, other than two documented visits with a recreational therapist, and a note from a CO that said D.C. went to a "meeting." Krulish's understanding was that they were to see the SFI inmates at least once in a 30 day period. One of the COs was asked to describe the presence of the mental health staff on the unit. She said they were there 5-15 minutes and they would "check-in" with the inmates and try to speak with them in private and that they would do stretches with them.

The only evaluation this investigation found was a superficial, two-page psychiatric evaluation done by psychiatric nurse practitioner (PNP) Jerry Caltrider five days after he arrived. There is no evidence of any treatment plan resulting from his evaluation. The State supplied a document titled "Facility Case Plan," but that was created the day D.C. left SSCF and lacked content. Caltrider discontinued

trazadone – a key medication for D.C. indicated for sleep and bi-polar disorder. This was clearly contraindicated considering that one of the facility psychiatrists, Dr. Pam Fadness, had prescribed it upon D.C.'s arrival at SSCF and D.C.'s records from BMH and BR showed that he took it each day in the evening. There is no documentation whether Caltrider consulted with Fadness or made the decision on his own. The CCS contract also calls for a possible $250.00 penalty for "Failure to provide prescription drugs… in accordance with an inmate's treatment plan.."[67]

Had a treatment plan been created, the problems with sleep likely would have been avoided. A plan would have involved the MHU, psychiatry (hopefully) and nursing. The haphazard nature of service resulted in the discontinuance of trazadone and D.C.'s increasing in ability to sleep. The timeline at the beginning of this report reveals D.C.'s increasing complaints about lack of sleep and his repeated entreaties to nurses, COs and MHU staff to get his trazadone prescription. The timeline shows the number of times he requested it, when staff requested it and what actions were or were not taken. It took about three weeks for the prescription to be renewed. All the MHU did, as noted, was order a 48-hour sleep study and respond to nursing concerns about his lack of sleep with a referral to see the sleep study, which never seems to have been interpreted or utilized in any way. It is unclear why they did not have a psychiatrist check into the situation, or if they did, why they did not document it. None of their documents show a referral as noted.

D.C. did have a caseworker, who is not a mental health provider.[68] The caseworker stated she saw D.C. each day but she did not make a record of it. The records she did make show that her first visit to D.C. was on January 27, 2014. It was an on-unit, non-contact visit. Two days later she took him to her office to call his sister. In her notes she wrote that "he inquired about Bravo Unit and asked if he would be able to go there soon as he was sick of being confined to a cell. I advised him I would speak with Mental Health staff to see about getting him moved so long as his behavior was good and he had no outbursts." On February 3, 2014 she saw him again on the Alpha Unit "I spoke with Mr. [C.] while in Alpha. He reports he is hungry and sick of being here. He asked when he would be leaving." On February 5, 2014, she spoke to him again. He had been moved to Bravo and she wrote "He seems to be much happier out and about with others. He asked again how long he

[67] Id.

[68] Contact Notes of Christina Grainger.

would have to be here...I advised him I did not have an answer for him at this time. I told him it could likely take some time."

FINDING: The DOC's failure to provide a treatment plan and appropriate monitoring and necessary medication for D.C., denied him reasonable accommodations and meaningful access to services.

iii. Inmates with Concurrent Disabilities

Had Krulish et al. made a concerted effort to access D.C.'s records from the BR as required[69] they would have realized, as already noted, that D.C.'s social skills were poor as a rule and that he was paranoid as a rule,[70] so the behavior they observed was typical for him. One of other troubling detail for this investigation was that Krulish remarked in his notes that a transporting officer had told him that D.C. was "fecal smearing" in the community. D.C. was found covered with feces on January 19, 2014, but there is no evidence that he had been smearing feces. This instance of misinformation and Krulish's failure to determine its truth or falsity may have contributed to D.C. being placed in Alpha. There is no report of D.C. smearing feces[71] while he was at SSCF although he frequently refused to shower and his hygiene was often typically poor wherever he was. Assigning that behavior to him raised the specter that he would be someone who staff would have to clean up after – thus, containment was preferable. It made him a pariah on the basis of unsupported hearsay.

The Rule also makes a provision for inmates with "concurrent disabilities," which is important with respect to D.C.:

> [C]ognitive impairments, developmental disabilities, and traumatic brain injury (TBI), as well as an assortment of health conditions. Additionally, functional problems such as very low reading level, communication problems, and poor adaptive living skills[that] may

[69] 28 V.S.A. 907(2).

[70] D.C.'s paranoia often resulted in refusing or retracting permission for medical records or release of other information, however D.C. signed the consent to treatment.

[71] There is one report of him urinating on the floor in Bravo and of telling the CO he was not getting the medication which prevented that from happening.

> complicate the management, assessment, and treatment of seriously mentally ill inmates.

For those inmates the Rule acknowledged that "these conditions may not be readily apparent to correctional staff who supervises inmates…" Thus, the Rule required that:

> QMHPs and other clinical staff …assess these [sic] or refer for specialized assessment as needed and will assist in the development of both treatment and custody plans which accommodate these conditions. This includes not only diagnosis, but also recognition of the interaction between serious mental illness and other disabilities, and how this interaction manifests itself in the correctional environment.

This was clearly the case on Alpha and Bravo although it became very apparent while D.C. was in Bravo as reflected in shift notes. Had the MHU followed the Rule they would have had to accommodate D.C.:

> If the QMHP has reason to believe an inmate is unable to comply with behavioral requirements due to a concurrent condition or complication, the treatment plan will include accommodations to minimize confusion and allow alternative approaches to gaining the inmate's cooperation. An example is to provide verbal explanations of rules and expectations, rather than rely on written handbook instructions. Another is the use of positive reinforcement for successes.

It is logical to conclude that the failure of the MHU to adequately monitor D.C. at least didn't provide a check to the repeated disciplinary violations given to D.C. while he was in Bravo Unit. The MHU did not visit D.C. in Bravo until February 10, 2014, and only then because they were contacted by both nursing and correction's officer Deb Hart. MHU staff person Angela Trauth held a conversation with D.C. on February 10, 2014 and took some notes of his concerns. She noted he could not remember which unit he was on. He alleged assaults by DOC staff at a courthouse. He spoke briefly of his sister and his history of strokes. He stated he was cold and needed more blankets and heat. He asked "'why am I here?'" "'I shouldn't be here. I don't belong in prison.'" He also complained that he could not sleep. He complained of itchy skin. He told her he had gone to chapel. He denied being suicidal. Trauth removed him from Self-Harm Watch, i.e. mental health

checks and ordered the 48-hour sleep study and wrote "monitor for psychotic symptoms related to lack of sleep" showing at least an awareness that bi-polar disorder can be triggered and/or worsened due to lack of sleep. There were no other referrals to psychiatry or suggestions for other services.

FINDING: The DOC failed to provide meaningful access to services and appropriate reasonable accommodations by failing to take D.C.'s concurrent disabilities into account.

iv. Staff Training

As noted, many of the staff complaints about D.C. referenced behaviors that were manifestations of someone with concurrent disabilities. Some of the staff went beyond complaint and actually punished D.C. for the manifestation of his disabilities by locking him in his cell, depriving him of access to common areas, taking away TV and other privileges and by "writing him up" for failing to shower and allegedly lying. Note the **timeline** for dates and instances where D.C. was given disciplinary reports, locked in his cell and deprived of TV and access to common areas.

The statute and Rule require staff training in the following areas:

1) Recognition of signs and symptoms of mental and emotional disorders prevalent in the inmate population;
2) Recognition of signs of chemical dependence and the symptoms of drug and alcohol intoxication and withdrawal;
3) Recognition of adverse reactions to psychotropic medications;
4) Recognition of signs of developmental disability, especially mental retardation;
5) Recognition of the potential for concurrent disabilities;
6) Recognition of the unique considerations associated with serious mental illness in incarcerated women and younger offenders;
7) Recognition of potential mental health emergencies and instruction in appropriate action in crisis situations, including self-harm;
8) Identification of medical problems of inmate s housed in mental health units and proper referral for care;
9) Suicide prevention;

10) Instruction in the procedures for referring an inmate to mental health services for immediate evaluation;
11) Relevant Departmental Policy and Administrative Directives

None of the staff who wrote D.C. up or locked him in his cell had received any formal, structured training from the DOC with respect to how to manage inmates with severe mental illness.[72] Krulish stated in his interview that there was a "great effort" to put more experienced COs in Alpha and Bravo. This would of course clash with the bargaining unit and thus be contrary to what he represented. In fact the COs interviewed had bid into the units for the days off, or because they wanted to be there, or because sought after overtime, or ordered-in overtime was there. This investigation is not at all suggesting the corrections officers are "bad" employees or people lacking in compassion. They have difficult jobs and have made a commitment to keeping those on their watch safe and the community by extension. However it can understandably be a frustrating job which is why training is needed. A CO cannot be so reactive to a mentally ill inmate that she thinks he is "out to get" her and others. See **Attachment 1** documenting some of the observations and comments made by corrections staff.

Primarily, even the mental health unit staff seemed to work off of a punitive type of model. When asked whether writing DR's and locking someone in their cell might exacerbate their mental illness, Krulish stated that the default should be to let the CO write the "DR" and back off. To do otherwise, he said, would "handicap" Bravo in a way that would prevent the unit from running. He did not think the DR is possible to remove from the process.

FINDING: The DOC failed to provide meaningful access to services by failing to train its staff about persons with disabilities with the result that D.C. was treated in a punitive manner because of his disabilities.

[72] One CO said he could not recall any training outside the issue being mentioned when he was in the Academy. Another said she had sat in on some "meetings" attended by the Superintendent, MHU, LSU and caseworker but no actual training. One CO said the training she got was "shadowing" a more experienced officer. She said there is also an SFI directive to read and sign off on.

4. The DOC's acts of discrimination were by reason of D.C.'s disability.

The final element that D.C. must prove as part of his prima facie case, is that the DOC denied him meaningful access to services because of his disability. It seems clear that the DOC relied on the fact that D.C. was disabled in making its decisions with regard to the "services" he received and that these decisions denied him meaningful access to services and reasonable accommodations. Anything he said could be discounted because he might say something else the next day or hour. He was a poor reporter, he was inconsistent, he had difficulty advocating for himself. He could be dismissed as delusional, as fixated, as unreasonable, as forgetful.

His lack of good hygiene made him repulsive and unsympathetic to some people. His co-occurring disabilities were exasperating. Basically, there was not much that the facility felt it really had to do, both because he couldn't effectively complain (with the exception of his trazadone and sleep issues and wanting to get out of Alpha and out altogether) and because they perceived there was not much he would be susceptible to in a therapeutic sense. However the ADA regulations stated that inmates with disabilities "shall not" be placed in facilities "that do not offer the same programs as the facilities where they would otherwise be housed."[73] This described the lengthy placement in Alpha and the treatment in Bravo.

The DOC has not claimed that there were any systemic breakdowns[74] in services caused by some outside force such as T.S. Irene's impact on the DMH's delivery of services. As noted above, courts are often deferential to "prison administration"[75] and "[r]easonable accommodations must be evaluated in light of the importance of security issues and necessary measures.[76] Mr. Krulish did indeed cite security and safety issues with respect to placing D.C. in Alpha. He cited D.C.'s paranoia and safety and said he would have needed to "see more" before moving him. The problem for the DOC is that there is no documentation of any effort whatsoever to move D.C. out of Alpha quickly and Krulish could not be sure there was even an attempt at "intermittent visits." Another option which was not discussed, but would have been a possible reasonable accommodation, would have

[73] 28 C.F.R. §35.152(b)92)(iii).
[74] *See* Henrietta D. v. Bloomberg, 331 F.3d 261, 272-73 (2nd Cir. 2003).
[75] *See* Turner v. Safley, 482 U.S. 78, 84–85, (1987) (noting deference to administration regarding prison management is appropriate).
[76] *See* Pierce v. Cnty. of Orange, 526 F.3d 1190, 1217 (9th Cir.2008).

been to start him in Bravo, in a more "normal" cell and use an incentive system to grant him more freedom as safety concerns receded. At least he could have seen and heard and talked to others. He could have watched TV. He could have voiced an affirmative desire to participate and been given the option to do so.

D.C. plaintively and repeatedly voiced his despair at being locked up to Krulish, nursing, Trauth, COs and Granger, his caseworker. He wanted out of Alpha. Had the DOC quickly and consistently made genuine efforts to place him out of Alpha and had those efforts failed over and over, or started him in Bravo using the same methods, then perhaps they would have a stronger leg to stand on, but there is no evidence that they tried to do that.[77]

V. Conclusion

When all is said and done, it is abundantly clear that D.C. should never have been placed in a correctional facility at all, but as already discussed, there were no other viable option under the circumstances. He had not been in a correctional setting before and had never been locked in a cell for twenty-three (23) hours a day. It was not due to any action of the DOC (or the DMH) that he was there, but once there, the DOC had a legal duty to do more than just "stabilize" him and to do more than provide him with shelter and food. Class action suits have been based on less.

There are no truly malicious actors here, although the term "neglect" works and occasionally the modifier "benign" can be applied. While this investigation is not a clinician, it seems like staff should have explored the option of moving him to Bravo either immediately or within twenty-four (24) hours and made every effort to immediately acclimate him there. Nursing progress notes and CO shift reports do not paint a picture of a D.C. who was more stabilized in Alpha than he was day to

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[77] *See* 28 C.F.R.§ 35.150 Existing facilities section (b)(2) Methods: General. A public entity may comply with the requirements of this section through such means as redesign or acquisition of equipment, reassignment of services to accessible buildings, assignment of aides to beneficiaries, home visits, delivery of services at alternate accessible sites, alteration of existing facilities and construction of new facilities, use of accessible rolling stock or other conveyances, or any other methods that result in making its services, programs, or activities readily accessible to and usable by individuals with disabilities. A public entity is not required to make structural changes in existing facilities where other methods are effective in achieving compliance with this section. A public entity, in making alterations to existing buildings, shall meet the accessibility requirements of § 35.151. In choosing among available methods for meeting the requirements of this section, ***a public entity shall give priority to those methods that offer services, programs, and activities to qualified individuals with disabilities in the most integrated setting appropriate.***

day in Bravo. He seemed pretty much the same in a general sense. The DOC broke its own rules and assigned him to disciplinary segregation - they essentially punished him for being mentally ill.

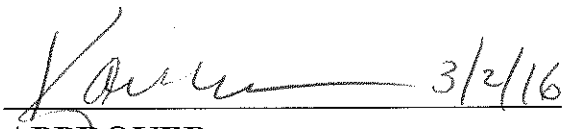
This investigation believes that D.C.'s lack of self-advocacy skills and lack of an advocate allowed the DOC/CCS staff to do the bare minimum, or less, with respect to services. Conversely, the lack of mental health services or monitoring and training of staff resulted in punitive measures – lock-ins, DR's and lack of access to services. D.C. in some respects is not amenable to class therapeutic treatment, however that is not a legal justification for providing him with so little and ignoring his requests for accommodation and pleas to be moved or for medication. The VFHPAA requires us to prevent, or at the very least honestly examine, any attempt to justify a lower level of care for persons in D.C.'s circumstances. In this instance, the DOC did not provide him the protections to which he was legally entitled.

RECOMMENDATIONS

1) This investigation makes a preliminary recommendation to the Human Rights Commission to find there are **reasonable grounds** to believe that the Department of Corrections discriminated against D.C. on the basis of his disability and violated the VFHPAA's "integration mandate" of 9 V.S.A. §4201(c)(2) and the general prohibition related to denial of access to services etc., codified at 9 V.S.A. §4201(c)(1).

2) This investigation makes a preliminary recommendation to the Human Rights Commission to find there are **no reasonable grounds** to believe that the Department of Mental Health discriminated against D.C. on the basis of his disability with respect to either the integration mandate or that it denied him access to services. Thus, there is no violation of either section of the VFHPAA.

Nelson M. Campbell
Administrative Law Examiner



APPROVED:
Karen L. Richards
Executive Director & Legal Counsel

ATTACHMENT 1

Alpha Unit Tracking Log, -Mental Health Checks for the 10 day period D.C.

- 1/24- 2ndS-Very needed [sic] repeats himself and speaks to thin air; asked if I could call a cab

- 1/24-3dS-Soiled clothes and blanket – urine – complained of not feeling well says urination is accident-stated "many times that he needs to make an emergency phone call to home and would like his work boots;" 3d shift can not [sic] let him make phone calls, meds,

- 1/25-3dS-Ate meal took rec **better behaved** today took meds"

- 1/25-3d-S-Soiled himself. "Claims he is not getting medication that prevents this; [D.C.] seems to think he is being housed in a clinical mental health facility and is having a difficult time understanding that he is [in] a significantly more ridge [sic] environment i.e. asking if there is coffee or soda and snacks available during rec times or [understanding] that security staff are not nursing staff as well."

- 1/25-1stS-"Much more polite& respectful but quite needy. Had to be reminded to remain clothed...complaint with instructions to dress appropriately. Also had a few short vocal outbursts."

- 1/26-2ndS-Quiet most of shift. Somewhat needy. Asked me how to get in touch with Navy recruiter, states he would like to join the Navy upon his release."

- 1/27-2ndS-"Seems to be confused about why he is here. Asks for food quite often (as well as meds)....Cell inspected without issue. Ate dinner."

- 1/27-3dS- "Sitting on bunk the entire 4 hours, at times rocking back and forth with his blanket over his head."

- 1/28-3dS- "Some random outbursts. Complained he was cold. Requested extra blankets approximately 38 times. Request denied as he had 2 issued."

- 1/29-1stS-"Continues to ask to talk to Bill [Krulish] and make a call to his sister." [he was escorted to make the call by his caseworker]

- 1/30-2dS- "Very Quiet day. No issues or outbursts."

- 1/30-3dS- "Slight outbursts, where he yelled for help and occasionally knocking at door, awake most of the night, slept sitting up."

- 2/1-1stS- "Took Rec. Room inspected at 0629. Finally laying down on his bed napping. Previous shifts I have not seen him getting any sleep. No issues."

- 2/1-2ndS-"Very polite with staff all shift long."

Alpha Unit End of Shift Reports (EOSR) – Some of the EOSR were the same entries as the mental health checks; included are one's that were different

- 1/28-1stS – "Complaining of open wounds on his arms and legs. After looking at his arms I see no signs of open wounds. Seems to be slowly losing touch with reality and whats [sic] going on around him."

- 1/29-?- "Ate both meals and took rec had several outburst through the day."

- 2/3-1stS- "Claims he has open wounds all over his body, shows me his arms saying the 'open wounds' really hurt. It appears he has no open wounds what so ever [sic]."

BRAVO:

- 2/4/-2ndS – In from Alpha\...1st time in prison/He will need a lot of help/…Happy to be out of Alpha/He will need to shower as well

- 2/5-1stS-Napping/TV/Dayroom on/off/…Appears lost at times…Needs a lot of help/Helped him sweep up popcorn in his cell/He has more popcorn/Polite/Seems ok."

- 2/6-1stS-"Quiet in cell/on checks/Seems lost & confused/ He needs A LOT OF HELP/..Linens had blood on them/...His leg are swollen & Nurse Martha aware & open sores on his legs/...Not doing so well in unit/Thinks he is getting out after talking with his sister Ellen back to Brattleboro/Peeing on floor/Seems fine

- 2/6-2ndS – **Issued a DR for refusing to shower**/"He said he is going to decline the shower because he thinks the cold will make him sick.

- 2/7-2ndS- "Is concerned that he may be 'an inmate serving life.' I told him I think he is just here waiting for a bed and he said 'why do I need a bed?'"

- 2/9-1stS – "Meals in unit/Quiet in cell/Napping/TV/Dayroom on/off. Wrote on cell wall "I will get him to clean it or he will be issued a DR."

- 2/9-2ndS- "doesn't understand why he is here..advised me he didn't have any charges started to get upset about being here for no reason and I advised him to talk to caseworker tomorrow." **Got another DR for refusing to shower**.

- 2/9/-3Ds-He asked to shower, CO said OK after chow. "Seems confused by this environment."

- 2/10-2ndS- "In the dayroom talking a lot with other inmates/...gets upset when I don't answer his question about why he is here."

- 2/15-2ndS – "Upset about still being here"

- 2/17-1stS- "Asked to meet with Bill K. & it was passed on." (notes show Trauth came on 2/19. No evidence Krulish appeared.

- 2/20-1stS – **"HE got himself locked in due to not attending a meeting after being told he needed to come out & still he refused so Float 2 removed his TV and locked him in until 4pm**. He

believes he is being poorly treated & making false allegations towards staff even saying I cut him and saying I was going to get fired because he is a sick man & he doesn't believe he should be here. Watcg [sic] yourselves around him/...Foul mood/He also had money sent in facility & told no more & it will be considered contraband and be taken & not put in his account."

- 2/23-1stS – **"Staff be careful around him he is looking to SUE US"**

- 2/23-3Ds – "Submitted grievance about his meds, and requesting he be released into the community."

- 2/24-1stS – "He joined group this AM/**He lied to staff about not eating and he got approved to go eat w/unit only to find out that he ate per Float 2 Smith so now he is back in & locked in cell with no TV and A Major A 12 issued**.

- 2/24-2ndS-"Pro-Social in the dayroom/overheard him talking ...about the A-12 he earned today stated he doesn't remember eating/ate chow in the unit...went to get his coat came out of his cell **I gave him a look and I/went back into his cell."**

- 2/26-1stS- "He still has a lot of sores all over his body/**He got locked in w/no TV & kept knocking on/off & told to stop"**

- 2/26-2ndS- **Claims to have taken a shower on first shift but it was not marked off...has not been marked off for shower in 3 days. DR issued.**

- 2/26-3Ds- "Feels he is being mistreated and might want to get his lawyer involved."

- 2/27-1stS-**"I went over his minor DR for not showering & he tried again to lie about taking a shower so thank U CO Aldridge and he got 2 nights ELI w/no TV/**Still complaining he is not getting all of his meds."

- 2/28-1stS- I/M is so confused about the phone system…He's looking for help and the other I/M are frustrated with him and don't want to help him. He is very agitated over this."

- 3/1/-2ndS – **"Major DR issued for shower day."**

- 3/2-1stS – **Dayroom on/off/See sanction sheet/…He hates DOC & giving us a lot of trouble."**

STATE OF VERMONT
HUMAN RIGHTS COMMISSION

"D.C.", Complainant	)	
	)	
	)	
v.	)	VHRC Complaint No. PA15-0007
	)	
	)	
Vermont Agency of Human Services, Vermont Department of Mental Health and Department of Corrections, Respondents	)	

FINAL DETERMINATION

Pursuant to 9 V.S.A. 4554, the Vermont Human Rights Commission enters the following Order:

1. The following vote was taken on a motion to find that there are reasonable grounds to believe that the Department of Corrections, the Respondents, illegally discriminated against "D.C.", the Complainant, on the basis of his disability in violation of Vermont's Fair Housing and Public Accommodations Act.

Mary Marzec-Gerrior, Chair	For ✓	Against __	Absent__	Recused __
Nathan Besio	For ✓	Against __	Absent __	Recused __
Mary Brodsky	For ✓	Against __	Absent __	Recused __
Donald Vickers	For ✓	Against __	Absent __	Recused __
Dawn Ellis	For ✓	Against __	Absent __	Recused __

Entry: ✓ Reasonable Grounds __ Motion failed

Dated at Barre, Vermont, this 24th, day of March 2016.

BY: VERMONT HUMAN RIGHTS COMMISSION

Mary Marzec-Gerrior, Chair

Nathan Besio

Mary Brodsky

Donald Vickers

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STATE OF VERMONT
HUMAN RIGHTS COMMISSION

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Entry: ___ No Reasonable Grounds ✓ Motion failed

Dated at Barre, Vermont, this 24th, day of March 2016.

BY: VERMONT HUMAN RIGHTS COMMISSION

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