State Board of Local and Regional Jails

Calendar Year 2022

Annual Report of

Jail Death Reviews,

Audits, and Inspections

November 16, 2023

CONTENTS

Roles and Responsibilities of the Board 2
Purpose 2
Data Sources 2
Jail Death Review Process 3
Death Review Findings 6
Jail Audits and Inspections 7
Conclusion 13
Appendix A, Cause-of-Death Statistics 13
Appendix B, 2022 Deaths by Facility 14

ROLES AND RESPONSIBILITIES OF THE BOARD

The State Board of Local and Regional Jails is established in Article 2 (§ 53.1-2 *et seq*.) of Chapter 1 of Title 53.1. The Board is comprised of eleven members, with specific areas of expertise, appointed by the Governor.

The State Board of Local and Regional Jails is authorized to: establish operational and fiscal standards governing the operation of local and regional correctional facilities; establish minimum standards for health care services in local, regional, and community correctional facilities and procedures for enforcing such minimum standards; develop and implement policies and procedures for the review of the death of any inmate that the board determines warrants review that occurs in any local, regional, or community correctional facility; and establish minimum standards for the construction, equipment, administration, and operation of local correctional facilities and lockups. Compliance documentation for jails is provided in the Virginia Administrative Code 6VAC15, Chapter 40.

PURPOSE

The State Board of Local and Regional Jails (the Board) is statutorily obligated to report to the General Assembly and the Governor annually on the results of jail audits and inspections, as well as the circumstances surrounding the deaths of inmates in the custody of local correctional facilities. This report provides the detailed information required in § 53.1-5. and § 53.1-69.1.

DATA SOURCES

The information provided in this report comes from three primary sources:

- Facility Reports
- Investigative Reports
- Reports of Audits and Inspections

Following the death of an inmate, each facility is responsible for reporting the death and providing information relevant to the inmate's death. Thereafter, the Board's jail death investigators begin their analysis by obtaining and reviewing the following:

- Intake Records
- Medical/Mental Health Records
- Inmate Requests, Complaints, Grievances
- Inspection Notes
- Jail Reports, Records, Logs
- Inmate Records
- Video Footage

- Medical Examiner Reports
- Staff Interviews
- Witness Interviews
- Autopsy reports
- Third-party investigations, interviews, documents (locality, federal) when applicable
- Triennial Audits and Annual Life, Health, Safety Inspections

After obtaining and reviewing the aforementioned information, the death investigator compiles an investigative report to provide to the Jail Review Committee.

JAIL DEATH REVIEW PROCESS

The Board of Local and Regional Jails is responsible for reviewing the death of any inmate who was incarcerated in a local or regional jail at the time of their death to determine whether the circumstances surrounding the death violated the Board's minimum standards pursuant to § 53.1-69.1.

Review Process

1. The first step in the death review process is facility notification of the death to the Board's jail death investigators within 24 hours of the death. Notifications must be made using the designated Report of Inmate Death form.

2. Upon receiving notification of an inmate death, the assigned jail death investigator requests an Autopsy Report from the Medical Examiner's Office via the Department of Correction's Special Investigations Unit.

3. The Death Investigator then contacts the facility head to request and review any/all relevant information including:

    a. Medical/Mental Health Records
    b. Intake Records
    c. Inmate Requests, Complaints, Grievances
    d. Inspection Notes
    e. Jail Reports, Records, Logs
    f. Inmate Records
    g. Video Footage
    h. Medical Examiner Reports
    i. Staff Interviews
    j. Witness Interviews
    k. Autopsy reports
    l. Third-party investigations, interviews, documents (locality, federal) when applicable

m. Certification Audits, Inspections
n. Any other documentation the jail death investigator deems relevant to their investigation

4. After the case investigation is complete, the jail death investigator prepares a detailed report and schedules an initial case discussion with the Board's Executive Director.

5. The Executive Director then places the completed case(s) on the agenda for the Jail Review Committee.

6. Following a thorough review of all relevant facts and circumstances surrounding each death, the Jail Review Committee will make one of the following case recommendations to the Full Board:

    a. Close the case with a finding that no evidence was revealed that indicated that the facility was out of compliance with the regulations promulgated by the Board;

    b. Close the case with a finding that the evidence indicated that the facility was out of compliance with the regulations; however, the facility had taken sufficient corrective actions such that no further measures were necessary; or

    c. Recommend that the Board proceed with adjudication under the Administrative Process Act, Article 3 (§2.2-4018 *et seq*.).

7. If the case is closed, the assigned jail death investigator prepares a letter detailing the findings of the Committee's review. The letter is then reviewed and signed by the Chairman of the Board and submitted to the Governor, the Speaker of the House of Delegates, and the President pro tempore of the Senate in accordance with *Code of Virginia* §53.1-69.1, subsection D.

Mental Health Issues

More than one in four (more than 25%) of deaths in our jails are suicides. Assuming the correctness of the adage that suicide is an irrational act, this data then underscores the seriousness of the mental health crisis in our jails. This issue was recently addressed by Sheriff Karl Leonard of Chesterfield County. According to Leonard, an estimated 70% of Chesterfield's inmate population is composed of people with mental health issues. Additionally, he claims nearly 30% of the county's inmates have serious mental illnesses. "While we do our best to help [those] in need, we are not properly equipped, staffed, trained, or funded to be a mental institution," Leonard said. "And housing them in a jail is not the best course of action for them and only serves to exasperate an already tenuous situation… This needs to change, and it needs to change quick." The Board far too frequently reviews deaths in which the jail failed to properly recognize or obtain timely and appropriate treatment for an inmate suffering a mental health crisis.

DEATH REVIEW FINDINGS

Jail Deaths Reviewed in 2022

The Board of Local and Regional Jails' Jail Death Review Committee met 12 times during the 2022 calendar year. A total of 68 jail deaths were reviewed and in 18 instances facilities were determined to be out of compliance with the Minimum Standards for Jails and Lockups.

Deficiencies were identified as follows:

- **In one jail death, the facility was determined to be out of compliance with standard 6VAC15-40-110. Serious Incident Reports** – A report setting forth in detail the pertinent facts of deaths, discharging of firearms, erroneous releases, escapes, fires requiring evacuation of inmates, hostage situations, and recapture of escapees shall be reported to the Local Facilities Supervisor of the Compliance and Accreditation Unit, Department of Corrections (DOC), or designee. The initial report shall be made within 24 hours and a full report submitted at the end of the investigation.

- **In three jail deaths, the facility was determined to be out of compliance with 6VAC15-40-360. Twenty-four-hour emergency medical and mental health care** - Written policy, procedure, and practice shall provide 24-hour emergency medical and mental health care availability.

- **In one jail death, the facility was determined to be out of compliance with 6VAC15-40-370. Receiving and medical screening of inmates** - Written policy, procedure, and practice shall provide that receiving and medical screening be performed on all inmates upon admission to the facility. The medical screening shall: 1. Specify screening for current illnesses, health problems and conditions, and past history of communicable diseases; 2. Specify screening for current symptoms regarding the inmate's mental health, dental problems, allergies, present medications, special dietary requirements, and symptoms of venereal disease; 3. Include inquiry into past and present drug and alcohol abuse, mental health status, depression, suicidal tendencies, and skin condition; 4. For female inmates, include inquiry into possible pregnancy or gynecological problems; and 5. All inmates shall receive a tuberculosis (TB) skin test within seven days of admission to the facility.

- **In one jail death, the facility was determined to be out of compliance with 6VAC15-40-400. Management of pharmaceuticals** - Written procedures for the management of pharmaceuticals shall be established and approved by the medical authority or pharmacist, if applicable. Written policy, procedure, and practice shall provide for the proper management of pharmaceuticals, including receipt, storage, dispensing, and distribution of drugs. These procedures shall be reviewed every 12 months by the medical authority or pharmacist. Such reviews shall be documented.

- **In twelve jail deaths, the facility was determined to be out of compliance with 6VAC15-40-1045. Supervision of Inmates -** All inmate housing areas shall be inspected a minimum of twice per hour at random intervals between inspections. All inspections and unusual incidents shall be documented. No obstructions shall be placed in the bars or windows that would prevent the ability of staff to view inmates or the entire housing area.

Corrective Actions Taken by Facilities

- Enhanced policies and procedures, revised to address violations (e.g., expedite processes for calling 911 in case of a medical emergency).
- Additional training for staff (e.g., formal re-training of staff on safety procedures).
- Additional security staff to monitor inmates in mental health.
- Enhanced supervision (e.g., additional staff to observe inmates, additional checks for those with mental illnesses).
- Accountability of staff and administration.
- Enhanced medical care (e.g., hiring additional nurses).
- Replacement of health care contracted providers.
- Adequate assessment of offender medical and behavioral health needs (e.g., hiring additional mental health professionals to ensure proper screening, evaluations, and treatment).
- Administrative and clinical mortality reviews.
- Continuous Quality Improvement Program in health care services.
- Incorporation of internal audits by supervisory and administrative staff to ensure compliance with the Minimum Standards for Jails and Lockups.
- Routing roll-call reviews of the enhanced policies/procedures and standards.

JAIL AUDITS AND INSPECTIONS

Audit and Inspection Process

Currently, three full time regulatory compliance inspectors conduct annual life, health, and safety inspections and triennial certification audits of local and regional jails and lockups. Their inspections and audits determine compliance with the Minimum Standards for Jails and Lockups, 6VAC15-40. If a deficiency is noted, the facility is required to submit a plan of correction to address the deficiency. The inspectors conduct a follow-up onsite visit to the facility to ensure that corrective actions have been taken.

Audit and Inspections Results

The tables on the following pages detail the jail and lockup audit and inspection results and any deficiencies noted during the inspection or audit. The deficiencies column identifies the specific section of the Virginia Administrative Code that was determined to be out of compliance with the Minimum Standards. The specific section number is noted in the table, however, all refer to 6VAC15, Chapter 40.

During the audits and inspections conducted in 2022, the most frequent deficiency cited was 6VAC15-40-1100 Fire Safety Inspection. This standard requires facilities to have a state or local fire safety inspection conducted every 12 months. Localities that do not enforce the Virginia Statewide Fire Prevention Code shall have the inspection performed by the State Fire Marshal's Office. Written reports of the fire safety inspection shall be on file with the facility administrator. 9 facilities were found to be deficient in this area.

The second most frequent cited deficiency was 6VAC15-40-545, which addresses inmate food service workers. This standard requires that written policy, procedure, and practice shall ensure that a visual medical examination of each inmate assigned to food service occurs no more than 30 days prior to assignment and quarterly thereafter. It also states that each inmate food service worker shall be given a TB skin test prior to food service assignment. 7 facilities were found to be deficient in this area.

2022 Audit and Inspection Findings:

FACILITY	AUDIT/INSP	MONTH	DEFICIENCIES
ACCOMACK COUNTY	INSPECTION	December	No deficiencies observed
ALBEMARLE/CHARLOTTESVILLE RJ	INSPECTION	September	545
ALEXANDRIA DETENTION CENTER	INSPECTION	November	No deficiencies observed
ALLEGHANY REGIONAL	INSPECTION	December	No deficiencies observed
ARLINGTON COUNTY	INSPECTION	May	370, 420, 545, 1030
BLACKSTONE TOWN LOCKUP	AUDIT	October	1380
BOTETOURT-CRAIG COUNTY	INSPECTION	June	1030
BRISTOL CITY (Closed June 30, 2022)			
BRRJ - AMHERST	INSPECTION	June	No deficiencies observed
BRRJ – BEDFORD (Closed Temp.)			
BRRJ – CAMPBELL (Closed Temp.)			
BRRJ - HALIFAX	INSPECTION	September	No deficiencies observed
BRRJ - LYNCHBURG	AUDIT	May	No deficiencies observed
CAROLINE DET. CENTER ICE	INSPECTION	August	No deficiencies observed
CARROLL COUNTY LOCKUP	INSPECTION	August	No deficiencies observed
CENTRAL VIRGINIA REGIONAL	INSPECTION	March	No deficiencies observed
CHARLOTTE COUNTY	AUDIT	June	395, 980, 985
CHESAPEAKE CITY	INSPECTION	September	545,560
CHESTERFIELD COUNTY	INSPECTION	June	400, 950
CULPEPER COUNTY	AUDIT	March	No deficiencies observed
DANVILLE CITY	AUDIT	June	545, 980, 1045
DANVILLE CITY ADC	AUDIT	April	No deficiencies observed
DINWIDDIE COUNTY LOCKUP	INSPECTION	February	No deficiencies observed
EASTERN SHORE REGIONAL	INSPECTION	December	No deficiencies observed
ESSEX COUNTY LOCKUP	AUDIT	February	No deficiencies observed

FACILITY	AUDIT/INSP	MONTH	DEFICIENCIES
FAIRFAX COUNTY ADC	INSPECTION		150, 440
FARMVILLE DET. CENTER ICE	INSPECTION	October	No deficiencies observed
FAUQUIER COUNTY	AUDIT	June	No deficiencies observed
FLOYD COUNTY LOCKUP	INSPECTION	April	No deficiencies observed
FLUVANNA COUNTY LOCKUP	INSPECTION	May	No deficiencies observed
FRANKLIN COUNTY	INSPECTION	April	No deficiencies observed
GALAX CITY LOCKUP	AUDIT	October	1100
GLOUCESTER COUNTY	INSPECTION	January	545, 1100
GRAYSON COUNTY LOCKUP	INSPECTION	April	1100
GREENE COUNTY LOCKUP	AUDIT	February	No deficiencies observed
HAMPTON CITY (Closed Temp.)			
HAMPTON CITY CC	INSPECTION	September	440, 1100
HAMPTON ROADS REGIONAL	CONSENT AGREEMENT/INSPECTION	December	1045
HENRICO COUNTY EAST	INSPECTION	December	545
HENRICO COUNTY WEST	INSPECTION	November	950
HENRY COUNTY	MOCK-AUDIT	October	120, 155, 290, 370, 395, 400, 545, 690, 910, 940, 945, 950, 1045, 1080
HIGHLAND COUNTY LOCKUP	INSPECTION	March	No deficiencies observed
LANCASTER COUNTY	INSPECTION	January	940
LOUDOUN COUNTY	INSPECTION	August	No deficiencies observed
MADISON COUNTY LOCKUP	INSPECTION	February	No deficiencies observed
MARTINSVILLE CITY JAIL AND ANNEX	INSPECTION	April	No deficiencies observed
MEHERRIN RIVER REGIONAL ALBERTA	AUDIT	July	No deficiencies observed
MEHERRIN RIVER REGIONAL BOYDTON (Closed Temp.)			
MIDDLE PENINSULA REGIONAL	INSPECTION	March	395
MIDDLE RIVER REG. JAIL	AUDIT	April	540
MONTGOMERY COUNTY	INSPECTION	June	370
NEW RIVER VALLEY REGIONAL	INSPECTION	November	950, 1045
NEWPORT NEWS CITY	INSPECTION	November	395, 545, 945
NORFOLK CITY	AUDIT	July	980, 990, 1030, 1045, 1100
NORTHERN NECK REGIONAL	INSPECTION	February	945, 950
NORTHWESTERN REGIONAL	INSPECTION	August	395

FACILITY	AUDIT/INSP	MONTH	DEFICIENCIES
PAGE COUNTY	INSPECTION	April	No deficiencies observed
PAMUNKEY REGIONAL	INSPECTION	January	393, 400, 440, 450, 1080
PATRICK COUNTY	INSPECTION	April	400, 440, 1100
PIEDMONT REGIONAL	AUDIT	August	No deficiencies observed
PITTSYLVANIA COUNTY	INSPECTION	February	390, 405
PORTSMOUTH CITY JAIL AND ANNEX	AUDIT	February	No deficiencies observed
PRINCE WM/MANASSAS RADC	AUDIT	March	No deficiencies observed
RAPPAHANNOCK REGIONAL	AUDIT	June	110, 560, 950
RICHMOND CITY	INSPECTION	September	No deficiencies observed
RIVERSIDE REGIONAL	CONSENT AGREEMENT/INSPECTION	December	393, 420, 450, 545, 1080
ROANOKE CITY	INSPECTION	May	No deficiencies observed
ROANOKE COUNTY	INSPECTION	April	395
ROCKBRIDGE REGIONAL	AUDIT	March	No deficiencies observed
ROCKINGHAM/HARRISONBURG REGIONAL JAIL	AUDIT	September	No deficiencies observed
RSW REGIONAL JAIL	AUDIT	February	No deficiencies observed
SMITHFIELD LOCKUP	AUDIT	October	No deficiencies observed
SOUTHAMPTON COUNTY JAIL AND ANNEX	INSPECTION	May	No deficiencies observed
SOUTHSIDE REGIONAL	INSPECTION	May	No deficiencies observed
SURRY COUNTY LOCKUP	AUDIT	September	No deficiencies observed
SUSSEX COUNTY	INSPECTION	February	No deficiencies observed
SWVRJA-ABINGDON	INSPECTION	October	1045, 1100
SWVRJA-DUFFIELD	INSPECTION	September	395, 940
SWVRJA-HAYSI	INSPECTION	August	No deficiencies observed
SWVRJA-TAZEWELL	AUDIT	April	No deficiencies observed
VIRGINIA BEACH CORRECTIONAL	AUDIT	October	393, 400, 440, 450, 1030, 1080, 1100
VIRGINIA BEACH LOCKUP #2	AUDIT	October	No deficiencies observed
VIRGINIA BEACH LOCKUP #3	INSPECTION	July	No deficiencies observed
VIRGINIA PENINSULA REGIONAL	AUDIT	January	No deficiencies observed
WESTERN TIDEWATER REGIONAL	INSPECTION	August	No deficiencies observed
WESTERN VA REGIONAL	INSPECTION	April	No deficiencies observed
WYTHE COUNTY LOCKUP	INSPECTION	August	No deficiencies observed

Definitions of the deficiencies cited in the 2022 Audit and Inspections findings are listed below. Comprehensive regulations for compliance with Minimum Standards for Jails and Lockups is available on the Commonwealth of Virginia Regulatory Town Hall website https://townhall.virginia.gov/, regulation chapter 6VAC15-40,

Deficiencies cited in 2022:

110 serious incident reports
120 classification
150 inmate exercise
155 access to recreational activities
290 provisions of reading materials
370 receiving and medical screening of inmates
390 training and competency of staff (CPR/First Aid)
393 universal precautions
395 management of sharps
400 management of pharmaceuticals
405 automatic external defibrillator (AED)
420 transfer summaries of medical records
440 medical care provided by personnel other than physician
450 suicide prevention and intervention plan
540 standards for food service equipment and personnel
545 standards for inmate food service workers
560 meals prepared, delivered and served under direct supervision
690 approved items visitors may bring to facility
910 searches of facilities and inmates
940 culinary items
945 tools
950 flammable, toxic and caustic materials
980 restraint equipment
985 restraint of pregnant offenders
990 administrative segregation
1030 assessments of inmates in disciplinary detention and administrative segregation
1045 supervision of inmates
1080 emergency plans and fire drills
1100 fire safety inspections
1380 fire safety inspections

Conclusion

The Board of Local and Regional Jails (the Board) is responsible for developing and establishing operation and fiscal standards governing local and regional correctional facilities. The Board is also charged with offering recommendations for changes to those standards resulting from the findings of inspections, audits, and reviews. Of particular concern, based on the 2022 findings, are the health and mental health needs of inmates. These areas will be of particular focus in the Board's revision of its standards (6VAC15-40), which is now underway.

Appendix A

Cause-of-Death Statistics

CAUSE	**2018**	**2019**	**2020**	**2021**	**2022**	**Total by Cause 2018-2022**
Natural Causes	28	27	22	40	31	148
Suicides	9	10	11	25	20	75
Accidental Drug Overdoses	6	2	0	10	14	32
Homicides	0	0	0	2	1	3
Undetermined	1	2	7	1	2	13
Total by Year	44	41	40	78	68	271

Appendix B

2022 Deaths by Facility

FACILITY DEATHS	2021	2022
Accomack County Jail	1	0
Albemarle-Charlottesville Regional Jail	0	1
Alexandria Detention Center	1	1
Arlington County Detention Center	1	1
Blue Ridge Regional Jail Authority – Amherst	0	2
Blue Ridge Regional Jail Authority – Halifax	0	1
Blue Ridge Regional Jail Authority – Lynchburg	1	3
Botetourt-Craig Regional Jail	0	1
Bristol City	1	0
Central Virginia Regional Jail	1	0
Charlotte County Jail	0	1
Chesapeake Correctional Center	3	1
Chesterfield County Jail	3	0
Danville Adult Detention Center	0	1
Danville City Jail	0	1
Fairfax County Adult Detention Center	2	3
Fauquier County Adult Detention Center	0	1
Hampton City Jail	3	1
Hampton Roads Regional Jail	4	1
Henrico County Jail West	2	3
Henrico County Jail Home Electronic Monitoring	1	0
Henry County Jail	1	2
Loudoun County Jail	2	0
Middle River Regional Jail	1	0
Montgomery County Jail	1	1
New River Valley Regional Jail	2	2
Newport News City Jail	4	0
Norfolk City Jail	1	2
Northwestern Regional Adult Detention Center	2	3
Page County Jail	1	0
Page County Home Electronic Monitoring	1	0
Pamunkey Regional Jail	1	2
Piedmont Regional Jail	2	0
Portsmouth/Chesapeake Correction Center	0	1
Portsmouth City Jail	1	1
Prince William County-Manassas Adult Detention Center	2	1
Rappahannock Regional Jail	2	3
Richmond City Jail	0	3
Riverside Regional Jail	7	4
Rappahannock-Shenandoah-Warren Regional Jail	1	2
Rockingham-Harrisonburg Regional Jail	4	0

Southwest Virginia Regional Jail Authority – Abingdon	3	4
Southwest Virginia Regional Jail Authority – Duffield	3	3
Southwest Virginia Regional Jail Authority – Haysi	2	1
Southwest Virginia Regional Jail Authority – Tazewell	1	1
Virginia Beach Correctional Center	5	3
Virginia Peninsula Regional Jail	1	0
Western Tidewater Regional Jail	0	1
Western Virginia Regional Jail	3	5