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SOMETIMES IT TAKES A TRAGEDY: HOW THE DEATH OF A
MENTALLY ILL INMATE MAY BECOME A CATALYST FOR
A NEW HORIZON OF MENTAL HEALTH REFORM IN
VIRGINIA

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ABSTRACT

This comment recounts a recent tragedy that occurred in the Commonwealth of Virginia that resulted from neglect of a mentally ill inmate in the state's correctional system. Mentally ill inmates have been long ignored by the Commonwealth as a result of lack of funds and resources available to correctional facilities. The General Assembly has considered legislation that would prevent stories like the one in this comment, but legislators delayed action and prioritized other matters. This comment calls upon the General Assembly to take these tragedies seriously and put mentally ill inmates on the agenda in 2018.

INTRODUCTION

On April 22, 2015, 24-year-old Jamycheal Mitchell was arrested and charged with petit larceny.¹ He was accused of stealing a two-liter Mountain Dew, a Snickers bar, and a Little Debbie Zebra Cake from a 7-Eleven in Portsmouth, Virginia. Collectively, the merchandise was worth a total of five dollars and five cents.² Mr. Mitchell, who was diagnosed in fourth grade as mildly intellectually disabled and in fifth grade as bipolar schizophrenic, believed his father owned the store and claimed the items were his.³ He would never be released from custody.⁴ Shortly before dawn on August 19, 2015, Jamycheal Mitchell was found dead in his jail cell.⁵ In the 101 days that he was incarcerated, he had lost more than forty pounds.⁶ Mr. Mitchell's tragic story not only revealed systemic flaws in Virginia's correctional system, it has also highlighted the subpar availability of mental health treatment in the Commonwealth. While the shocking circumstances surrounding this case have attracted widespread media attention, Mr. Mitchell is not the first mentally ill inmate to receive inadequate care or ex-

¹ Elliott C. McLaughlin, *Jailers Let Mentally Disabled Man Starve to Death, Lawsuit Says*, CNN (May 17, 2016, 11:39 PM), <http://www.cnn.com/2016/05/16/us/jamycheal-mitchell-hampton-roads-virginia-jail-lawsuit>.

² *Timeline: The Case of Jamycheal Mitchell*, WASH. POST, <https://www.washingtonpost.com/apps/g/page/local/timeline-the-case-of-jamycheal-mitchell/1833/>.

³ McLaughlin, *supra* note 1.

⁴ *Jailers Let Mentally Disabled Man Starve to Death, Lawsuit Says*, *supra* note 2.

⁵ *Id.*

⁶ Sarah Kleiner, *Details emerge about Jamycheal Mitchell's time in jail, but questions linger*, RICHMOND TIMES-DISPATCH (Apr. 1, 2016), http://www.richmond.com/news/local/crime/details-emerge-about-jamycheal-mitchell-s-time-in-jail-but/article_b57a216f-8062-50ef-a5a4-2185dccfda7e.html.

perience neglect.⁷ Unless significant reforms are enacted, he will not be the last.

Incomplete investigations from various government bodies revealed shocking circumstances surrounding Mr. Mitchell's incarceration and death, but no probe adequately explained exactly how Mr. Mitchell starved to death while in custody.⁸ State legislative responses aimed to identify and address each systemic failure that contributed to his death.⁹ While the General Assembly developed meaningful responses that might help prevent such tragic incidents from occurring in the future, not all were adopted and implemented.¹⁰ Those requiring taxpayer funds faced greater opposition due to a significant budget shortfall.¹¹ Legislators must continue to focus on developing meaningful mental health and criminal justice reform by prioritizing it within the budget if they are to adequately adopt measures that prevent this from happening again. The 2018 General Assembly must seek answers about Mr. Mitchell's treatment and confinement, develop responsible solutions that would have prevented Mr. Mitchell's death, and insist on passing legislation that will ensure the safety of those who are incarcerated or mentally ill within the Commonwealth.

⁷ Jean Casella and James Ridgeway, *Another Prisoner with Mental Illness Dies in Isolation*, SOLITARY WATCH (Sept. 21, 2010), <http://solitarywatch.com/2010/09/21/another-prisoner-with-mental-illness-dies-in-isolation/>; Pete Earley, *Another Mentally Ill Prisoner in Virginia Dies: State Officials Won't Answer Questions About It*, OFFICIAL WEBSITE OF PETE EARLEY (June 17, 2016), <http://www.petearley.com/2016/06/17/another-mentally-ill-prisoner-in-virginia-dies-state-officials-wont-answer-questions-about-it/>; Reed Williams, *Lawsuit Claims Prisoner Died Due to Neglect from Jail Employees*, RICHMOND TIMES-DISPATCH (Mar. 7, 2013), http://www.richmond.com/news/local/city-of-richmond/lawsuit-claims-prisoner-died-due-to-neglect-from-jail-employees/article_93490bdd-f16b-5b26-a2c8-26229a6a6624.html; see also Justin Jouvenal, *Man Accused of Stealing \$5 in Snacks Died in Jail as He Waited for Space at Mental Hospital*, WASH. POST (Sept. 29, 2015), https://www.washingtonpost.com/local/crime/man-accused-of-stealing-5-in-snacks-died-in-jail-as-he-waited-for-space-at-mental-hospital/2015/09/29/7ceac8a2-5aff-11e5-9757-e49273f05f65_story.html?utm_term=.a8f02ece22c6; Dahlia Lithwick, *Still No Answers*, SLATE (May 13, 2016, 5:59 PM), http://www.slate.com/articles/news_and_politics/jurisprudence/2016/05/what_happened_to_jamycheal_mitchell.html; Meg Wagner, *Virginia Jail Under Investigation Following Two Inmate Deaths*, NEW YORK DAILY NEWS (Dec. 13, 2016, 9:59 AM), <http://www.nydailynews.com/news/national/virginia-jail-investigation-inmate-deaths-article-1.2909209>.

⁸ Mike Gooding, *Lawmakers Push for Mental Health Reform in Virginia Jails*, WVEC (Jan. 19, 2017, 9:39 AM), <http://www.13newsnow.com/news/local/virginia/lawmakers-push-for-mental-health-reform-in-virginia-jails/387191783>.

⁹ See *id.*

¹⁰ Jordan Pascale, *Bill Aimed at Investigating Deaths, Mental Health Screenings in Virginia Jail Fails Because There's No Money*, VIRGINIAN-PILOT (Feb. 3, 2017), https://pilotonline.com/news/government/virginia/bill-aimed-at-investigating-deaths-mental-health-screenings-in-virginia/article_5f508440-3059-5c7e-af3a-39074e954c17.html.

¹¹ *Id.*

I. JAMYCHEAL MITCHELL'S STORY

After Mr. Mitchell's arrest, the magistrate set his original bond at \$3,000, but it was revoked for reasons not specified in court documents.¹² He was held in jail on a magistrate's order without bail after indicating that he suffered from mental health issues during his pretrial screening.¹³ His family was told he was being held without bail so he could receive treatment.¹⁴ Jamycheal Mitchell never received such treatment. Rather than being treated or even monitored, he was held in the restricted housing section of the jail where he was kept almost exclusively from interacting with the general population.¹⁵ Prior to his incarceration, a Portsmouth Department of Behavioral Healthcare Services employee took Mr. Mitchell to a clinic biweekly to receive an injection of psychotropic medications.¹⁶ In jail, Mr. Mitchell received "virtually no psychotropic medication."¹⁷

A. Medical Evaluations

Jamycheal Mitchell first received a medical screening on April 24, 2015, two days after his arrest, which revealed that his "thought process does not make sense" and that he was delusional.¹⁸ Subsequent medical evaluations consistently yielded similar results.¹⁹ On April 29, 2015, a Portsmouth judge ordered a competency evaluation for Mr. Mitchell to determine if he would be eligible for a mental health treatment diversion program instead of jail.²⁰ The following day, the evaluator reported Mr. Mitchell was disoriented, but made no observation of psychotic behavior, and further noted that Mr. Mitchell "refused to accept services from Portsmouth Behavioral Health Care Services," preferring to receive treatment in nearby Virginia Beach.²¹ He was moved from the Portsmouth City Jail to the Hampton Roads Regional Jail on May 11, 2015.²² Jail records from his transfer indi-

¹² *Jailers Let Mentally Disabled Man Starve to Death, Lawsuit Says*, *supra* note 2.

¹³ *Id.*

¹⁴ *Id.*

¹⁵ Kleiner, *supra* note 6.

¹⁶ McLaughlin, *supra* note 1.

¹⁷ *Id.*

¹⁸ *Id.* (describing that five days later Mr. Mitchell was screened again and labeled "very psychotic").

¹⁹ *See id.* (citing the April 29, 2015 report labeling Mitchell as "very psychotic" and the May 2015 report describing Mitchell as "continu[ing] to present as acutely psychotic."); *Jailers Let Mentally Disabled Man Starve to Death, Lawsuit Says*, *supra* note 2 (citing the April 30, 2015 evaluation that determined that Mitchell "was appropriate for [a mental health hospital] diversion [program] but refused to accept services").

²⁰ *Jailers Let Mentally Disabled Man Starve to Death, Lawsuit Says*, *supra* note 2.

²¹ *Id.*

²² McLaughlin, *supra* note 1.

cate he weighed 190 pounds.²³ His transfer file recommended monitoring him as a suicide precaution and noted that he required medical treatment, including administration of psychotropic medication.²⁴ On May 21, 2015, a judge ordered that Mr. Mitchell be sent as an incompetent defendant to Eastern State Hospital.²⁵ Eight days later, Mr. Mitchell remained at the jail, prompting the judge to reiterate the competency order.²⁶ He was never transferred.

On July 30, 2015, Mr. Mitchell was taken to the hospital for emergency care, where he was diagnosed with edema, hypoalbuminemia (low levels of a blood protein commonly resulting from malnutrition), and elevated transaminase (a possible indicator of liver damage).²⁷ He weighed 145 pounds.²⁸ The next day, a judge again reiterated the competency order, requiring he be sent to a mental health facility for treatment.²⁹ His family, concerned that he looked extremely thin and worried about his health, pleaded with the jail that he be transferred for medical care.³⁰ He was still never transferred. Instead, three weeks later, Jamycheal Mitchell was found dead in his jail cell.³¹ He weighed 144 pounds.³² A medical examiner ruled his death the result of “cardiac arrhythmia accompanying wasting syndrome of unknown etiology,” or extreme weight loss and heart problems, one perhaps causing the other.³³

B. Investigations

In the wake of Mr. Mitchell’s death, many questions were raised, some of which still linger today. Why was he in jail for over three months? Why was he even arrested and taken to jail for stealing \$5 worth of goods? Why was his bail revoked? Why was he not released to his family while awaiting

²³ Kleiner, *supra* note 6.

²⁴ See McLaughlin, *supra* note 1 (describing that further medical evaluations continued to reveal Mitchell’s medical illness. For example, on May 20, 2015, a doctor concluded in a psychological evaluation that Mr. Mitchell was “psychotic and manic” and had “grandiose ideas,” emphasizing that Mr. Mitchell “lacked the capacity to assist counsel in preparing a defense”).

²⁵ *Jailers Let Mentally Disabled Man Starve to Death, Lawsuit Says*, *supra* note 2.

²⁶ *Id.*

²⁷ McLaughlin, *supra* note 1.

²⁸ *Id.*

²⁹ *Jailers Let Mentally Disabled Man Starve to Death, Lawsuit Says*, *supra* note 2.

³⁰ *Id.*

³¹ *Id.*

³² *Id.*

³³ Sarah Kleiner, *McAuliffe: Spend \$5M on Mental Health, Not on Well-Heeled Commemoration*, RICHMOND TIMES-DISPATCH (Feb. 12, 2017), http://www.richmond.com/news/virginia/government-politics/mcauliffe-spend-m-on-mental-health-not-on-well-heeled/article_6f8bdd1d-bde8-54a9-8157-fddd06986da8.html.

transfer if it was going to take so long? Why was he held in the restrictive housing unit, where he was more isolated not only from the general population, but from human contact of any kind? Why was he not medicated while in jail? Why was he never transferred when it became clear he needed psychiatric help? What happened during the two and a half months between his transfer to the Hampton Roads jail and his arrival in the emergency room? Why was Jamycheal Mitchell so malnourished? How did this happen? How *could* this happen?

Prisons and jails may have become de facto housing facilities for much of America's mentally ill population, but this in particular case seems to have caught the attention of Virginians statewide.³⁴ Multiple agencies opened investigations into the circumstances surrounding Mr. Mitchell's death.³⁵ However, no report adequately explained what many Virginia state legislators wanted to know: How could a bipolar schizophrenic man suffering from delusions essentially waste away "while under what was supposed to be close supervision?"³⁶ The Virginia Office of the Inspector General (OIG), an agency created in 2012 to investigate fiscal waste and identify inefficiencies in state agencies, was widely assumed to take the lead into the investigation.³⁷ However, a lack of jurisdictional authority prohibited the agency from fully investigating the case.³⁸ The OIG reviewed some circumstances surrounding Mr. Mitchell's death, but never investigated the death itself, citing state statutes that prevented such an investigation.³⁹

The Hampton Roads Regional Jail conducted its own investigation into Mr. Mitchell's death.⁴⁰ However, no report will be made public.⁴¹ No jail staff members have been reprimanded, no one has been fired, and no poli-

³⁴ Jouvenal, *supra* note 7; Sarah Kleiner, *Mental Health Bills Drafted After Jamycheal Mitchell's Death Past First Hurdle*, RICHMOND TIMES-DISPATCH (Jan. 13, 2017), http://www.richmond.com/news/virginia/government-politics/general-assembly/article_872d56f7-8989-573d-80ad-d5371692b9b6.html; Michael Martz, *Va. House panel would empower investigation of jail deaths*, RICHMOND TIMES-DISPATCH (Feb. 21, 2017), http://www.richmond.com/news/virginia/government-politics/general-assembly/va-house-panel-would-empower-investigation-of-jail-deaths/article_0e2712ea-217a-50ed-8ec7-2fd48350f49b.html.

³⁵ Kleiner, *supra* note 33.

³⁶ Gooding, *supra* note 8.

³⁷ Jordan Pascale, *McAuliffe Outraged at House for Blocking Inspector General Appointment Over Jamycheal Mitchell Case*, VIRGINIAN-PILOT (Feb. 9, 2017), http://pilotonline.com/news/government/Virginia/mcauliffe-outraged-at-house-for-blocking-inspector-general-appointment-over/article_f50128c7-8580-59b4-998a-bbf18968a2f1.html.

³⁸ *Id.*

³⁹ *Id.*

⁴⁰ Kleiner, *supra* note 6.

⁴¹ Patrick Wilson & Gary A. Harki, *Here's Why 11 Agencies Haven't Criminally Investigated Jamycheal Mitchell's Death in Jail*, VIRGINIAN-PILOT (May 13, 2016), https://pilotonline.com/news/government/politics/virginia/here-s-why-agencies-haven-t-criminally-investigated-jamycheal-mitchell/article_33e39472-139d-5322-8a03-8d9557e65018.html.

cies have been changed in the wake of Mr. Mitchell's death.⁴² Virginia's Department of Behavioral Health and Developmental Services, the agency that oversees Eastern State Hospital, also conducted its own investigation in which it blamed clerical missteps for keeping Mr. Mitchell in jail rather than a mental hospital.⁴³ This report revealed that the judge's order to have Mr. Mitchell transferred to Eastern State Hospital, where he would have received mental health care, was never processed because it had been stuffed into a desk drawer by an "overwhelmed" hospital worker and was not found until after Mr. Mitchell's death.⁴⁴ An employee of the department also cited backlogs and the lack of available beds at Eastern State Hospital for preventing Mr. Mitchell's transfer.⁴⁵ However, one thing the OIG report did reveal was that "[n]ot only were there no backlogs," between May 21, when the first competency order was issued, and August 19, when Mr. Mitchell died, "there was only one day when all beds were full."⁴⁶

How, then, is it possible that a man who presents as acutely psychotic was able to waste away, to essentially starve to death over a period of four months, while under supervision? Unfortunately, getting the answer of how exactly the justice system failed Mr. Mitchell is impeded by freedom of information laws, which provide considerable discretion for jail administrators to conceal records.⁴⁷ Because of this, much of what has been uncovered about the conditions of Mr. Mitchell's confinement have come through accounts from various inmates incarcerated with him at Hampton Roads Regional Jail.⁴⁸ Delegate Patrick Hope compared Mr. Mitchell's death to a plane crash: pilots often explain that such an incident is not attributable to

⁴² Kleiner, *supra* note 6.

⁴³ *Id.*

⁴⁴ Patricia Sullivan, *Death of Inmate Puts Inspector General's Job at Risk*, WASH. POST (Feb. 9, 2017), <http://www.standard.net/National/2017/02/10/Death-of-inmate-puts-inspector-general-s-job-at-risk>.

⁴⁵ McLaughlin, *supra* note 1.

⁴⁶ *Id.*

⁴⁷ Sarah Kleiner, *Jamycheal Mitchell's Family to Lawmakers: Fix Virginia's Mental Health System*, RICHMOND TIMES-DISPATCH (Jan. 18, 2017), http://www.richmond.com/news/virginia/jamycheal-mitchell-s-family-to-lawmakers-fix-virginia-s-mental/article_1409b0e3-b94d-556a-8517-8acc8ae129a7.html.

⁴⁸ *Id.*; Travis Fain, *Jamycheal Mitchell's Family: Please, Not Again*, DAILY PRESS (Jan. 18, 2017), <http://www.dailypress.com/news/politics/dp-nws-jamycheal-mitchell-20170118-story.html>; see McLaughlin, *supra* note 1 (describing that inmates alleged that guards did not feed Mr. Mitchell because he refused to return the trays from previous meals. When he did eat, according to inmate reports, "he ate voraciously." Other inmates alleged that Mitchell would sometimes request extra food because he was so famished. Not only were these requests denied, guards also sometimes deny him water. Occasionally he was denied food "for days at a time." At one point, he tried to flush his clothing down the toilet, and guards responded by taking his clothes, mattress, sheet, and blankets, leaving him with just a metal sheet for a bed. An inmate who was tasked with cleaning the cell after Mr. Mitchell died reported that it was smeared with urine and feces. Inmates also witnessed guards spraying a water bottle in Mr. Mitchell's face, kicking him, handcuffing him, and leaving him naked in the hallway, or punching and twisting his arm as he reached through the hole in his cell door for food).

any one thing, but rather to a cascade of many things that went wrong.⁴⁹ Given that there is likely no single precipitating factor that led to Mr. Mitchell's death, there also cannot be one quick or easy solution. There should, however, still be accountability for each and every decision that contributed to this "cascade of things that went wrong."⁵⁰ The jail is now facing a federal lawsuit, and the U.S. Department of Justice is examining the treatment of mentally ill inmates at the facility.⁵¹ However, it is simply too soon to predict the outcome of this lawsuit.

According to a 2017 Mental Health of America report, Virginia ranks among the bottom half of states in most categories that measure delivery of mental health care.⁵² The Commonwealth was ranked 38th in overall access to care, a holistic metric that aggregates fifteen factors including, but not limited to, the number of adult and youth residents with a mental illness, the degree to which their healthcare needs are met, their access to affordable insurance, and the mental health workforce availability.⁵³ Nationwide, an estimated 1.2 million inmates have some mental illness.⁵⁴ In June 2016, less than a year after Mr. Mitchell's death, Virginia's local and regional jails held 3,350 inmates with severe mental illness.⁵⁵ Three-fifths of those were concentrated in just twelve Virginia jails.⁵⁶ Jamycheal Mitchell's may have been a case where everything that could go wrong did, but these alarming statistics indicate that unless systemic reforms are adopted, the mentally ill will continue to struggle in dangerous conditions throughout the Commonwealth's prisons and jails.

II. LEGISLATIVE RESPONSE

Mental Health Services in the Twenty-First Century, a special Virginia joint subcommittee tasked with studying and improving the delivery of

⁴⁹ Jordan Pascale, *Jamycheal Mitchell's Family Comes to Richmond to Support Bills Addressing Jail, Mental Health Deficiencies*, VIRGINIAN-PILOT (Jan. 18, 2017), https://pilotonline.com/news/government/local/jamycheal-mitchell-s-family-comes-to-richmond-to-support-bills/article_4816362c-e23e-55a7-9efe-83884eb89cca.html.

⁵⁰ *Id.*

⁵¹ Peter Dujardin, *State's Sheriff's Deputies Get Training on Jail Deaths, Investigations*, DAILY PRESS (Aug. 15, 2017), <http://www.dailypress.com/news/crime/dp-nws-jail-death-training-20170815-story.html>.

⁵² Theresa Nguyen & Kelly Davis, Mental Health America, *The State of Mental Health in America 8* (2017), <https://www.mentalhealthamerica.net/sites/default/files/2017%20MH%20in%20America%20Full.pdf>.

⁵³ *Id.*

⁵⁴ *Id.*

⁵⁵ Kleiner, *supra* note 34.

⁵⁶ *Id.*

2018]

SOMETIMES IT TAKES A TRAGEDY

77

mental health services in the Commonwealth, investigated and proposed various solutions throughout the year leading up to the 2017 General Assembly session.⁵⁷ This committee focused on revealing each of the system failures responsible for Mr. Mitchell's death. However, given that the OIG investigation revealed little and the jail's own report was never released, answering these questions and uncovering exactly what went wrong became a challenge in itself.⁵⁸

The objective to remedy the many (some unknown) issues was further complicated by budgetary concerns.⁵⁹ Virginia faced a revenue shortfall of over \$1 billion, forcing state legislators to draft a new budget for 2017, effectively killing the potential of any bill with a financial impact statement attached.⁶⁰ Despite these difficulties, the General Assembly enacted some meaningful legislation that will protect inmates with mental illnesses. For example, among the more than one dozen bills proposed in the wake of Jamycheal Mitchell's death were some aimed at fostering transparency and increasing accountability for jails and prisons.⁶¹

A. Passed Bills

1. S.B. 1063 - Corrections, State Board of; membership, powers, and duties

According to the Virginia Department of Corrections, an estimated 226 people have died in Virginia's jails or while under jail supervision since 2012.⁶² Local and regional jails have largely been responsible for conducting their own investigations, essentially policing themselves yet wholly protected by freedom of information laws that allow them to conceal any reports generated from these internal investigations.⁶³ Senate Bill 1063, which adds subsection 69.1 to Code § 53.1, shifts investigative authority from each individual jail to the Board of Corrections, a nine-member group already tasked with overseeing local and regional jails (different from the

⁵⁷ Sarah Kleiner, *Mental Health Subcommittee Hopes to Take a Bite Out of Widespread Systemic Problems*, RICHMOND TIMES-DISPATCH (Jan. 7, 2017), http://www.richmond.com/news/local/mental-health-subcommittee-hopes-to-take-a-bite-out-of/article_06cea26e-bfb0-596c-9c29-3507ee3522fe.html.

⁵⁸ Wilson & Harki, *supra* note 41.

⁵⁹ See Michael Martz, *McAuliffe Budget Cuts Include 26 Layoffs, Set Stage for New Bid to Expand Medicaid*, RICHMOND TIMES-DISPATCH (Oct. 13, 2016), http://www.richmond.com/news/virginia/government-politics/generalassembly/mcauliffe-budget-cuts-include-layoffs-set-stage-for-new-bid/article_b57f7238-e21f-5514-990399d434195b25.html.

⁶⁰ *Id.*

⁶¹ See Pascale, *supra* note 49.

⁶² Sullivan, *supra* note 44.

⁶³ *Id.*

Department of Corrections, which oversees state prisons).⁶⁴ The Board, while previously not responsible for investigations, did already have some authority over local jails, including promulgating rules and regulations for the operation of local Virginia jails, as well as providing certification to ensure operation of such in compliance with the standards and regulations.⁶⁵ Some argued against transferring investigative authority to the Board, believing it lacked the resources or ability to conduct such intensive investigations, and likely would have failed to produce the very answers legislators sought in Mr. Mitchell's death.⁶⁶ To quell this concern, S.B. 1063 also amended Code § 53.1-2 to reclassify the qualifications required of Board members, ensuring that it has "(ii) one individual employed by a public mental health services agency . . . (iii) one individual with experience with overseeing a correctional facility's or mental health facility's compliance with applicable laws, rules, and regulations . . . and (viii) two individuals with experience in conducting criminal, civil, or death investigations."⁶⁷ The Board now has legal authority to issue subpoenas, conduct hearings (including taking sworn statements under oath), and order correction of any Virginia jail's failure to comply with established regulations.⁶⁸ However, the Board is still without power to bring criminal investigations, which must be initiated and conducted by law enforcement officials.⁶⁹ Brian Moran, the Virginia Secretary of Public Safety, emphasized that it was crucial the bill not merely authorize investigations, but also update the requirements of board members to include individuals with the experience and knowledge necessary to effectively lead such investigations.⁷⁰ Original drafts of this bill provided for two paid positions for investigators, but the final version only retained one investigative position.⁷¹

The bill requires the Board to prepare a detailed report of its findings, which is to be submitted to the Governor and the leaders of both the House

⁶⁴ S.B. 1063, 2017 Gen. Assemb., Reg. Sess., 2017 Va. Acts 759 (quoting amended VA. CODE ANN. § 53.1-2).

⁶⁵ Va. Code Ann. § 53.1-5.

⁶⁶ Martz, *supra* note 34.

⁶⁷ S.B. 1063, 2017 Gen. Assemb., Reg. Sess., 2017 Va. Acts 759 (quoting amended Va. Code Ann. § 53.1-2).

⁶⁸ Bill Bartel, *Questionable Jail Deaths in Future Expected to Get Closer Scrutiny Under New Virginia Law*, VIRGINIAN-PILOT (Jul. 25, 2017), https://pilotonline.com/news/government/politics/virginia/questionable-jail-deaths-in-future-expected-to-get-closer-scrutiny/article_b341bd49-8771-5ee0-9daf-a46b63cdd836.html.

⁶⁹ *Id.* ("They are not prosecutors," [Spokesman for Governor McAuliffe, Brian] Coy said. "This is basically to drive future policy decisions.").

⁷⁰ Dujardin, *supra* note 51.

⁷¹ Tyler Hammel, *McAuliffe Seeks Funding for Mental Health Screenings in Jails*, CAPITAL NEWS SERVICE (Feb. 19, 2017, 6:00 PM), <http://wric.com/2017/02/19/mcauliffe-seeks-funding-for-mental-health-screenings-in-jails>.

and Senate, but makes no mention of publishing or releasing the findings to the public.⁷² While passing another bill related to mental health is a positive step, S.B. 1063 stops short of ensuring transparency into jail investigations.⁷³ The Department may intend to make results public, but there is no explicit requirement to do so written into the statute. Bruce Crusier, Executive Director of Mental Health America of Virginia, is concerned this lack of transparency is exactly what prevented the release of details that would have revealed what actually happened to Mr. Mitchell.⁷⁴ Without transparency, there will be no accountability; and without accountability, another mentally ill inmate could suffer the same fate as Mr. Mitchell.

Ronaldo Myers, the New Hampton Roads Regional Jail Superintendent who took over after Mr. Mitchell's death, emphasized to his staff the need for transparency in a recent training.⁷⁵ He further stressed the importance of conducting detailed investigations, pointing out that every piece of evidence needs to be reviewed, no matter if that process becomes cumbersome and tedious.⁷⁶ Seven people have died in Virginia jails between February 25, when S.B. 1063 was passed by the General Assembly, and July 1, when funding for an investigator became available.⁷⁷ Two of these seven inmates died while incarcerated in Hampton Roads, the same jail where Mr. Mitchell died.⁷⁸ While the story of Jamycheal Mitchell's death has received heavy media coverage, these seven additional deaths highlight that his story is not unique and underscore the importance of improved transparency and independent investigative authority.

2. H.B. 2184 - Inmates; inpatient psychiatric hospital admission

Code § 19.2-169.6 governs the process for transferring inmates in correctional facilities to psychiatric hospitals.⁷⁹ Occasionally, inmates are identified for mental health screenings to determine if they are better suited for an

⁷² S.B. 1063, 2017 Gen. Assemb., Reg. Sess., 2017 Va. Acts 759; Martz, *supra* note 34; *see also* Kleiner, *supra* note 34.

⁷³ *See* Kleiner, *supra* note 34 ("We need to be sure[. . .]that when they do a report that it be easily available to the public and that it be placed on the department's website.").

⁷⁴ *See id.*

⁷⁵ Dujardin, *supra* note 51. ("Jails always have had a closed-door mentality. [. . .] So we have to open the door and say, 'OK, this is what happened.'").

⁷⁶ *See id.* ("Just because an officer said he made rounds every 15 minutes doesn't mean he made rounds every 15 minutes.").

⁷⁷ Associated Press, *Board of Corrections Heightens Scrutiny of Jail Deaths*, U.S. NEWS (May 18, 2017, 12:31 PM), <https://www.usnews.com/news/best-states/virginia/articles/2017-05-18/board-of-corrections-heightens-scrutiny-of-jail-deaths>.

⁷⁸ *Id.*

⁷⁹ VA. CODE ANN. § 19.2-169.6(I) (2017).

inpatient psychiatric hospital.⁸⁰ However, under the original Code § 19.2-169.6, the jail that housed them was not required to ensure they ever received that screening. House Bill 2184 increases accountability of jails by ensuring that inmates for whom a petition for inpatient psychiatric hospital admission has been filed receive the required preadmission screening.⁸¹ Code § 19.2-169.6(I) now requires jail administrators to contact the appropriate community services board or behavioral health authority and advise that department of the need for preadmission screening.⁸² If there is no response or the preadmission screening is never completed, the jail administrator is required to contact the director or other senior management at that department.⁸³ This provision merely imposes a requirement for jail administrators to take reasonable steps to ensure contact was made to both the agency and the Director, and is alone insufficient to ensure that evaluation and admission actually occur.⁸⁴

While forcing jails to take a proactive role in improving inmate access to necessary resources will benefit those it incarcerates, there must also be a mechanism to ensure that inmates who require admission to inpatient mental health facilities actually receive the necessary evaluation to warrant admission. Without such a mechanism, inmates who desperately require admission to a mental health facility may never obtain the help they need.

3. H.B. 1996 - Incompetent defendants; psychiatric treatment

House Bill 1996 addresses part of the remaining gap between jails and healthcare providers to help ensure these inmates actually receive the medical care ordered.⁸⁵ Code § 19.2-169.2, which instructs courts to order treatment for incompetent defendants to restore competency, now also requires that such defendant be transferred and accepted by the hospital as soon as practicable, which must be no longer than ten days from the court's order for inpatient hospital treatment.

On May 21, a judge ordered that Jamycheal Mitchell be transferred to an inpatient hospital facility to undergo treatment.⁸⁶ Eight days later he re-

⁸⁰ *Id.*

⁸¹ H.B. 2184, Gen. Assemb., Reg. Sess. (Va. 2017).

⁸² VA. CODE ANN. § 19.2-169.6(I) (2017).

⁸³ *Id.*

⁸⁴ H.B. 2184, 2017 Gen. Assemb., Reg. Sess. (Va. 2017) (requiring only that the appropriate community services board or behavior health authority be notified of the need for preadmission screening and that contact be made with senior management at the community services board or behavioral health authority if preadmission screening is not completed, and not actually requiring that screening take place or imposing liability in such cases).

⁸⁵ H.B. 1996, 2017 Gen. Assemb., Reg. Sess. (Va. 2017).

⁸⁶ *Jailers Let Mentally Disabled Man Starve to Death, Lawsuit Says*, *supra* note 2.

2018]

SOMETIMES IT TAKES A TRAGEDY

81

mained in the jail, prompting a judge to reiterate the transfer.⁸⁷ He still was never transferred for treatment.⁸⁸ Again on June 11, a doctor indicated that he remained psychotic, but was still never transferred for treatment.⁸⁹ The H.B. 1996 addition to Code § 19.2-169.2 would have protected Mr. Mitchell by increasing the communication between jail and hospital to help ensure he would have been transferred in time to receive the medical attention he required.⁹⁰

B. Failed Bills

While some of the mental health bills introduced in response to Jamecheal Mitchell's death passed, others aimed specifically at addressing deficiencies in treatment for mentally ill individuals failed.⁹¹ Given the tight budget, Senator Creigh Deeds, the chair of the Mental Health Services in the Twenty-First Century subcommittee, has urged other state lawmakers "to be realistic that [bills to improve access to mental health care and jail reform] are long-term goals" that will not fix the problem overnight.⁹² Nevertheless, Virginia Governor Terry McAuliffe pushed for more reforms now, calling mental health reform one of his "highest priorities"⁹³ and allotting \$4.2 million from his December 2016 budget proposal for mental health screenings and assessments in jails.⁹⁴ However, rather than approve Governor McAuliffe's proposal to use the money for mental health screenings, the Virginia House and Senate allocated this money toward a commemoration of the 400th anniversary of the founding of the House of Burgess at Jamestown and arrival of the first enslaved Africans in the English colonies.⁹⁵ With no funds left in the budget, the legislature was forced to table two bills that, if passed, could have significantly improved access to mental health care.⁹⁶ Mental health screenings and assessments of new in-

⁸⁷ *Id.*

⁸⁸ *Id.*

⁸⁹ McLaughlin, *supra* note 1.

⁹⁰ H.B. 1996, 2017 Gen. Assemb., Reg. Sess. (Va. 2017).

⁹¹ Pascale, *supra* note 49.

⁹² Kleiner, *supra* note 57.

⁹³ Letter from Terence McAuliffe, Gov. of Va., to Va. Gen. Assemb. Budget Conferees, in *Gov. McAuliffe Calls for Additional Funding for Mental Health Services in Jails*, WTKR (Feb. 19, 2017, 4:36 PM), <http://wtkr.com/2017/02/19/gov-mcauliffe-calls-for-additional-funding-for-mental-health-services-in-jails/>.

⁹⁴ Kleiner, *supra* note 33.

⁹⁵ *Id.*; Hammel, *supra* note 71.

⁹⁶ *Mental Health Screening and Assessment Bills Fail to Advance*, VA. ASS'N. OF COUNTIES (Feb. 22, 2017), <http://www.vaco.org/mental-health-screening-assessment-bills-fail-advance/>.

mates are critical to ensure the safety of the inmates and those supervising them, and “one way or another, [screenings] need to be addressed.”⁹⁷

1. S.B. 1064 - Mental health awareness training; law enforcement, firefighters, etc.

Jamycheal’s mother, Sonia Adams, and his aunt, Roxanne Adams, articulated that one of their primary concerns is that arresting and correctional officers receive better mental health training.⁹⁸ In response, Senator Deeds proposed S.B. 1064, which would have required law-enforcement officers, firefighters, and emergency medical personnel to participate in a mental health awareness program every two years.⁹⁹ The program would have provided training to help responders better understand and recognize signs and symptoms of various mental illnesses and stressors, and how to appropriately respond to aggressive behaviors including domestic violence and harassment.¹⁰⁰ Virginia already spends \$600,000 per year to provide Mental Health First Aid (MHFA), and the costs associated with this bill could be passed on to local agencies.¹⁰¹ The bill passed the Senate 40-0, but was left in House Courts of Justice committee.¹⁰² An earlier Senate version of the bill was assigned to the Committee on Finance, which developed an amended version that stripped out funding, leading some to believe that legislators “don’t seem to be prioritizing the problem.”¹⁰³

2. S.B. 1442 - Prisoners; mental health screening at local correctional facilities

Senator Deeds also introduced S.B. 1442, which would have required that every local and regional jail screen each individual admitted to the jail for mental illness within seventy-two hours of his or her intake.¹⁰⁴ While this bill would have cost an estimated \$4.2 million annually, the budget the

⁹⁷ See Bartel, *supra* note 68.

⁹⁸ Pascale, *supra* note 49.

⁹⁹ S.B. 1064, 2017 Gen. Assemb., Reg. Sess. (Va. 2017).

¹⁰⁰ See *id.* (describing the program provided at VA. CODE ANN. § 37.2-312.3).

¹⁰¹ VA. DEP’T. OF PLANNING & BUDGET, 2017 FISCAL IMPACT STATEMENT OF S.B. 1064, 2017 Gen. Assemb., Reg. Sess. (Va. 2017), <https://lis.virginia.gov/cgi-bin/legp604.exe?171+oth+SB1064F122+PDF> (last visited Sept. 29, 2017).

¹⁰² S.B. 1064, 2017 Gen. Assemb., Reg. Sess. (Va. 2017), <https://lis.virginia.gov/cgi-bin/legp604.exe?171+sum+SB1064> (last visited Sept. 29, 2017) (detailing the bill’s history).

¹⁰³ Kleiner, *supra* note 34 (quoting Mira Signer, then Executive Director of the National Alliance on Mental Illness of Virginia).

¹⁰⁴ S.B. 1442, 2017 Gen. Assemb., Reg. Sess. (Va. 2017) (proposed amendment of VA. CODE ANN. § 9.1-102(53)).

Governor introduced included funding for its approval.¹⁰⁵ Yet again, the House and Senate allocated these resources elsewhere.¹⁰⁶ The bill died in the House Committee on Appropriations.¹⁰⁷

The committee also crafted a bill to develop a standardized screening process for mental illness across all local and regional jails to increase accountability, and another that would create transportation systems for mental health patients, reducing their reliance on law enforcement as the primary option.¹⁰⁸ However, given Virginia's billion dollar budget shortfall, legislation requiring additional state funding proved nearly impossible to approve this year.¹⁰⁹ Despite this, included in this year's revised budget is language requiring the State Compensation Board to examine the cost of implementing screening and assessment of inmates at intake, a ray of hope that more changes may be on the horizon.¹¹⁰

C. 2018 Calls to Action

It is unfair to criticize the General Assembly's inability to pass all of the key legislation in a reduced session when facing a budget shortfall. The 2018 General Assembly will be tasked with developing a new budget, one that must not only improve administrative transparency and corrections accountability, but also facilitate access to mental health care statewide.¹¹¹ Joe Flores, Deputy Secretary of Health and Human Resources called the budget "a reflection of our priorities."¹¹² Some bills that serve these objectives were passed in the 2017 session, but the issues that led to Mr. Mitchell's death have not been fully resolved.¹¹³ Given the time the legislature has had to carefully develop meaningful and comprehensive solutions, as well as its ability to craft a new budget prioritizing mental health services, the 2018 General Assembly must be able to develop and authorize significant mental health and criminal justice reforms. Mere satisfaction with the job done so

¹⁰⁵ VA. DEP'T. OF PLANNING & BUDGET, 2017 FISCAL IMPACT STATEMENT OF S.B. 1442, 2017 Gen. Assemb., Reg. Sess. (Va. 2017) <http://lis.virginia.gov/cgi-bin/legp604.exe?171+oth+SB1442F122+PDF> (last visited Sept. 29, 2017).

¹⁰⁶ Kleiner, *supra* note 33.

¹⁰⁷ S.B. 1442, 2017 Gen. Assemb., Reg. Sess. (Va. 2017), <http://lis.virginia.gov/cgi-bin/legp604.exe?171+sum+SB1442> (last visited Sept. 29, 2017) (detailing the bill's history).

¹⁰⁸ See Kleiner, *supra* note 57.

¹⁰⁹ Pascale, *supra* note 49.

¹¹⁰ H.B. 1500, 2017 Gen. Assemb., Reg. Sess. (Va. 2017) (codified at VA. CODE ANN. § 53.1-84); see also GOVERNOR'S RECOMMENDATIONS FOR H.B. 1500, 2017 Gen. Assemb., Reg. Sess. (Va. 2017).

¹¹¹ See generally *The Basics of Virginia General Assembly*, ARC OF VIRGINIA, <https://thearcofva.org/advocacy/the-basics-of-virginia-general-assembly/> (last visited Oct. 12, 2017) (explaining that the Virginia General Assembly has a biennial budget system).

¹¹² Kleiner, *supra* note 33.

¹¹³ See Pascale, *supra* note 49.

far is unacceptable. Refusing to introduce, pass, and enact effective legislation to achieve the goals outlined above would be nothing short of a failure. It would portend the certainty that Jamycheal Mitchell will not be the last tragic victim of alarming systemic gaps and a glaring lack of accountability.

III. CONCLUSION

The shocking and tragic death of Jamycheal Mitchell should be an exceedingly rare occurrence, one that gains such significant media attention solely because of the fact that it simply never happens. Unfortunately, this tragedy only exposed significant systemic problems within Virginia's correctional system that pose a threat to all inmates, especially those suffering from mental health issues. The frequency of inmate deaths within Virginia's jails will continue unabated until jailers are held accountable for their treatment of the mentally ill. The legislature must be willing and able to respond through carefully developed initiatives aimed specifically at increasing corrections accountability, enhancing mental health screening and training for law enforcement officers, and increasing access to mental health treatment. The legislature's success in passing meaningful legislation and designating funding for studies and pilot programs are encouraging indicators that significant reforms may be on the horizon. Jamycheal Mitchell's death could serve as a catalyst for a re-envisioned correctional system that emphasizes recognizing and treating the mentally ill, or it could merely be forgotten as just another in a string of inmate deaths. Which it becomes depends entirely upon whether the 2018 Virginia General Assembly prioritizes corrections accountability and improved access to mental health services for those in the Commonwealth.

2018]

SOMETIMES IT TAKES A TRAGEDY

85