Disability Rights Oregon

TO: Chair Prozanski, Vice-Chair Thatcher, & Members of the Senate Committee on Judiciary and Ballot Measure 110
FROM: Disability Rights Oregon (DRO)
DATE: February 9, 2021
RE: DRO 's Testimony in Support of Senate Bill 207 - Independent Corrections Ombudsman

Dear Chairs and Members of the Committee:

Disability Rights Oregon (DRO) submits this testimony in support of Senate Bill 207 and the funding for an Independent Corrections Ombudsman.

Since the very beginning of the COVID-19 pandemic, Disability Rights Oregon has received a steady stream of calls and letters from prisoners with disabilities about failure of corrections staff to keep them safe during the COVID-19 pandemic including but not limited to inappropriate use of personal protective equipment (PPE) and failure to use PPE potentially exposing both prisoners and staff, lack of access to timely medical care, and overuse of segregation or isolation to mitigate the spread of the virus regardless of the prisoners health. These complaints have been widespread, coming from nearly every correctional facility across the state.

Oregon Health Authority's data demonstrating COVID-19's disproportionate impact on individuals in congregate care with underlying conditions including several outbreaks in Oregon's prisons underscores the seriousness of our concerns regarding the safety of prisoners and the need for an independent ombudsman.

Disability Rights Oregon (DRO) also offers to serve in this critical role. DRO would bring a unique credibility and independence in this role as the statewide nonprofit that upholds the civil rights of 950,000 people with disabilities in Oregon to live, work, and engage in the community. For more than 40 years, we have served as Oregon's federally authorized and funded Protection & Advocacy System. DRO is committed to ensuring the civil rights of all people are protected and enforced, including in correctional settings. In recent years, DRO has actively maintained our presence in jails and prisons across Oregon. For example, in 2018, we issued a report about the use of police canines in jail to forcibly extract an inmate with a disability from his jail cell. *See enclosure*. This report led to the passage of SB 495 to limit the use of police canines for intimidation, control, or punishment of inmates. In 2019, DRO wrote another report detailing the failure to take reasonable steps to protect a prisoner who died from complications of influenza. *See enclosure.* Finally, DRO also worked with the Oregon Department of Corrections from 2016 through 2020 to improve management of adults in custody with serious mental illness. *See enclosure.*

Support of SB 207: if passed into law, SB 207 will make good on a promise made in 1977 to create an independent ombudsman (*see* ORS 423.400). Forty-four years later, this action is necessary to provide critical advocacy and save as many lives possible during a global pandemic. DRO submits this testimony today to applaud your leadership and support this bill to create an independent ombudsman.

DISABILITY RIGHTS OREGON

"You are going to get bitten":

Columbia County Jail's Use of Canines to Intimidate and Control Inmates

Disability Rights Oregon

Fall 2018

EXECUTIVE SUMMARY

Many jails use physical force to control inmates who are considered a safety risk. To protect both inmates and staff, sound correctional practice and law require corrections staff to adhere to several principles before using force including the following:[1]

- Use of force used only as last resort;
- Consider de-escalation and other interventions that address the behavior short of using force; and
- Use force in manner to minimize injury to both inmates and staff

Because the use of police canines to forcibly remove inmates from their cells runs counter to these principles, the practice is rare.[2] Only Oregon and five other states allow this practice. In Oregon, however, Columbia County Jail is the only jail that permits corrections staff to use canines to extract inmates from their cells. No other known country authorizes the use of dogs to attack inmates who do not voluntarily leave their cells.

Only Oregon and five other states allow this practice. In Oregon, however, Columbia County Jail is the only jail that permits corrections staff to use canines to extract inmates from their cells.

Last year, Columbia County Jail's use of a canine to forcibly control inmates was captured in a graphic video. Footage of the August 1, 2017, incident shows officers using a canine to first intimidate Mr. Christopher Bartlett, an inmate with mental illness.[3] The canine barks menacingly for several minutes in order to control Mr. Bartlett's behavior.

[1] Steve J. Martin, *Staff Use of Force in a Confinement Setting*, Vol. XXV No. 1, June-July 2013.

[2] Human Rights Watch's report "Cruel and Degrading: The Use of Dogs for Cell Extractions in U.S. Prisons, available at https://www.hrw.org/report/2006/10/09/cruel-and-degrading/use-dogs-cell-extractions-us-prisons

[3] Portland Tribune article dated December 3, 2017, includes the video footage and is available at http://portlandtribune.com/scs/83-news/380262-267222-sheriff-deems-dog-attack-on-jail-inmate-justifiable

After intimidation fails to persuade Mr. Bartlett to comply with orders, the canine is then unleashed to forcibly remove him from his cell. This incident graphically violates the principles that govern the use of force by jail staff.[4]

Mr. Bartlett with a canine on his back.

Inmates who experience mental illness may be disproportionately subjected to a canine attack. For example, officers may be more likely to subject inmates who experience mental illness to canines when attempting to forcibly remove them from their jail cells when the individual inmate fails to follow jail commands.

Officers who are not specifically trained in de-escalation techniques, crisis intervention, and other trauma informed interventions may wrongly believe inmates' lack of compliance is willful rather than connected to their disability.

> [I]nmates with mental illness may be at greater risk of physical harm once officers use canines to control them.

Moreover, inmates with mental illness may be at greater risk of physical harm once officers use canines to control them. The best way for an inmate to avoid being bitten by the canine is to submit and lie still. It may be much harder for inmates who are anxious, overexcited, or delusional to submit and avoid being bitten. Unsurprisingly, using a police canine to remove an inmate with mental illness from his cell is inconsistent with best practice standards.

Oregon state law is silent as to whether the use of canines in correctional facilities constitutes "physical force" or "physical punishment." During the 2019 legislative session, Disability Rights Oregon (DRO) will advocate for changes in the law to ban the use of canines for intimidation, control, or punishment of inmates.

In February 2018, Columbia County Prosecutor, Jeff Auxier, convened a grand jury to investigate the incident and sought DRO's guidance regarding which experts should testify.[5] The

[4] Mr. Bartlett has also filed a federal lawsuit against Columbia County available at http://media.oregonlive.com/pacific-northwest-news/other/ColCountycasesuit.pdf

[5] The entire Columbia County grand jury report may be found at http://media.oregonlive.com/pacific-northwest-news/other/ColumbiaCountydocs.pdf

grand jury was comprised of community members, not experts familiar with the health, safety, and civil rights of inmates. While concluding the jail "operated in a responsible and professional manner," the grand jury also issued several recommendations.

One recommendation noted the county's cost concerns but continued to urge the county to adopt a Corrections Enforcement Response Team.[6] This recommendation is consistent with testimony presented to the grand jury as a safe and effective way "to tailor uses of force" and "increase the safety of deputies and inmates." [7] The grand jury also recommended the county partner with a qualified mental health professional "to attempt to deescalate crisis situations before deputies use force."[8]

DRO encourages Columbia County to stop using canines for use of force in the jail. Instead, DRO will continue to urge Columbia County to explore proven de-escalation tactics consistent with national best practices, especially those most effective with and appropriate for prisoners with mental illnesses or other behavioral disabilities to promote the health and safety of all inmates, including those with disabilities.

[6] Notably, the grand jury reached a different conclusion then DRO, as well as the experts we consulted for this report. The grand jury instead found, "It is the conclusion of the panel that properly training and certified police canines can be a useful tool for corrections deputies when maintaining order inside of a jail facility." According to the information provided to DRO, the grand jury did not hear from any expert witnesses who endorsed using canines for cell extractions in jails or prisons, although some Columbia County employees endorsed the practice.

[7] *Id.* at 5.

[8] *Id.* at 6.

INTRODUCTION

> Disability Rights Oregon sincerely thanks Christopher Bartlett for the courage in sharing his story and information about his disability in this public report. The bias perpetuated against people with mental illness is profound. Yet, you had the strength to stand up for yourself and others like you who experience harm behind jail walls.

In our state and across the country, jails house a staggering number of individuals who experience mental illness. According to the Bureau of Justice Statistics, one out of every four jail inmates experiences "serious psychological distress."[9] Approximately 40% of inmates also report a history of mental illness.[10] While people with mental illness disproportionally represent jail inmates (raising questions of criminalization of mental illness), jails themselves are often ill equipped to respond to inmates whose behaviors relate to their disability requiring treatment rather than punishment.

As the federally designated Protection and Advocacy System for Oregonians with disabilities, Disability Rights Oregon (DRO) has the ability to access facilities that care for or confine people with disabilities. DRO's access authority is used to monitor facility conditions and to investigate concerns of abuse or neglect.[11] We have used this authority in several jails around the state, as well as written public reports to alert members of our community about our findings. The purpose of these reports is to improve the criminal justice system for Oregonians with disabilities.

In December 2017, DRO investigated an allegation that Christopher Bartlett, an inmate with mental illness held in the Columbia County Jail, was forcibly extracted from his cell using a police canine. DRO requested all of Mr. Bartlett's records regarding this incident including the police body camera footage, jail policies, mental health forms, evaluations and assessments, and written complaints. With his permission, DRO now shares our findings from these records in this report to illustrate the harm caused by this problematic practice.

[9] Bronson and Berzofsky, "Indicators of Mental Health Problems Reported by Prisoners and Jail Inmates, 2011-12, June 2017, U.S. Department of Justice Bureau of Justice Statistics, available at https://www.bjs.gov/content/pub/pdf/imhprpji1112.pdf

[10] *Id.*

[11] 42 U.S.C. § 10805(a)(4) (2012); 42 C.F.R. § 51.41(b),(c) (2016); Or. Rev. Stat. § 192.517 (2015).

To determine the scope of Columbia County's practice, DRO also conducted a public records request of all 36 counties in Oregon. The responsive records revealed that Columbia County Jail is the only jail in our state that permits a canine in use-of-force events.

DRO has two primary concerns about Columbia County Jail deploying canines in use of force events. First, canines are not specially trained to aid officers in forcibly removing inmates. This creates a safety risk for both inmates and corrections staff. Based on information provided to DRO by the Oregon Police Canine Association,[12] police canines are routinely trained for either detection (for drugs, bombs, or to find victims) or violent apprehension in the field to capture fleeing criminals who pose a risk, if uncaught, of creating a serious threat to the public. However, there is no specific training regarding using canines in use of force events in correctional settings.

Canines are not specially trained to aid officers in forcibly removing inmates. This creates a safety risk for both inmates and corrections staff.

Based on DRO's investigation and consultation with experts, using canines to forcibly remove inmates from their cells is not consistent with legal or best practice standards, which will be discussed in greater detail in these two sections below: "An Expert View of Canines and Best Correctional Practices" and "Clear Legal Standard for Use of Force and Inmates with Mental Illness".

[12] https://www.opca.com/

COLUMBIA COUNTY JAIL

August 2017 Incident at Columbia County Jail

Mr. Bartlett sitting on the curb before his arrest.

On July 18, 2017, Christopher Bartlett was arrested for charges related to alleged vandalism, disorderly conduct, and resisting arrest. This was not the first time Mr. Bartlett was arrested or taken to Columbia County Jail.

The arresting officer noted that Mr. Bartlett "rambled" and "accused us of stealing his heritage from him." The officer went on to note that Mr. Bartlett failed to follow multiple commands and, due to this failure, physical force was used to book him. The July 18, 2017, Columbia County booking form indicates a question mark as the response to the question, "Do you have any concerns about the prisoner's mental health?" After Mr. Bartlett was booked into jail, the arresting officer noted that Mr. Bartlett was placed in a safety cell to prevent him from harming himself.

On August 1, 2018, Columbia County Jail decided to move Mr. Bartlett from his current cell to another cell "due to his behavior in the jail." The county reports it "used standard recommended de-escalation methods in accordance with best practices for several hours before using force."

At approximately 1pm, five deputies and the canine got into position to forcibly remove Mr. Bartlett from his cell. While the canine was loudly barking and jumping, Mr. Bartlett was ordered to put his hands in the cuff port in his jail cell door. When Mr. Bartlett went to lay back down on his bed, he was told to comply or he was "going to get bitten." When he refused to follow commands, the canine was deployed. When the canine was released, the dog immediately bit Mr. Bartlett on the hip and right torso dragging him abruptly to the floor. The deputies then cuffed Mr. Bartlett while he was screamed in pain.

The deputies took Mr. Bartlett out of the jail cell and "pod" when they noted his injuries and sent him to the hospital for medical attention. The jail's August 2, 2017, progress note states Mr. Bartlett was injured during the attack including a wound due to "a dog bite on his R[ight] upper arm" and "old wound on knees open during use of force."

Mr. Bartlett has a Serious Mental Health Condition

Mr. Bartlett identifies as having serious mental illness. There were no records or assessments provided by the jail dated August 2nd, the day a canine was used to forcibly extract him from his cell, to verify or assess Mr. Bartlett's mental health on that particular day. However, at his July 18th booking, the question, "Do you have any concerns about the prisoner's mental health?" on the Columbia County booking form was answered with a question mark.

Mr. Bartlett's handwritten notes to jail staff also contain several potential indicators of delusion. One statement said, "U see I'm was directly related to Jesus Christ." Months later, this grandiose delusion was confirmed by a jail psychiatrist on October 13, 2017. This evaluation also notes that Mr. Bartlett experienced auditory hallucinations, was prescribed antipsychotic medication, and was diagnosed as "psychosis NOS, consider schizophrenic."

Auditory hallucinations and the resulting inability to determine whether what is being heard is coming from an internal or external source may be a clinical reason why a person experiencing psychosis is not able to follow or understand verbal commands.

It is unclear whether Mr. Bartlett's disability was factored in the decision to authorize the planned use of force or whether he could understand the verbal commands to place his hands in the cuff port. It is also unclear if there was a consultation with jail mental health prior to the planned cell extraction regarding the contraindicating mental health symptoms.

DRO agrees with the grand jury the Columbia County grand jury: the jail should partner with a qualified mental health professional to conduct an assessment and attempt to "deescalate crisis situations before deputies use force."[13]

[13] The Grand Jury report at page 6, available at http://media.oregonlive.com/pacific-northwest-news/other/ColumbiaCountydocs.pdf

Video Evidence Shows Use of Force Not Justified

Despite the grand jury's conclusion, DRO remains concerned that using a canine to forcibly remove Mr. Bartlett from his cell on August 1, 2017, was not justified.[14] First, the records provided by the jail appear to contain several inaccuracies. For example, the General Offense report from the August 1st use of force states:

"I watched Sergeant [redacted] and another deputy attempt to handcuff Bartlett, but Bartlett pulled his hands back inside the cell, Bartlett became irate and was not complying with commands."

These words are not consistent with the video footage. On the video, immediately prior to the canine attack, you can hear the voice of the Sergeant clearly stating that Mr. Bartlett went back to lay down on the mattress. There was no attempt to handcuff nor footage of Mr. Bartlett becoming "irate." Laying back down does not indicate becoming "irate" or being a risk to oneself or others which may justify use of force.

> It's imperative for the health and safety of everyone in jails that use of force be justified.

The canine officer also inaccurately states in his report that "I commanded him to the ground and he did not obey." Yet, the video shows the canine immediately taking Mr. Bartlett down upon entering cell and no command was given to get to the ground.

It's imperative for the health and safety of everyone in jails that use of force be justified. The video does not show that force was used as a last resort or that it was proportional to the resistance or the threat encountered. The discrepancy between the incident reports and the video suggests the use of force was not justified.

DRO remains concerned that Columbia County Jail stands behind its policy to use a canine in use of force events. Using canines to forcibly remove Mr. Bartlett from his cell was unnecessary. This is deeply troubling given that Mr. Bartlett was seriously injured and still has nightmares about the attack over a year later.

[14] Again, the grand jury impaneled by Columbia County, consisting of lay members of the community rather than experts, disagreed with DRO's assessment and concluded the jail "is operated in a responsible and professional manner." *Id.*

An Expert View of Canines and Best Correctional Practices

Steve J. Martin, a career corrections professional with over 45 years' experience and former expert for both the U.S. Department of Justice Civil Rights Division and the Department of Homeland Security Division of Civil Rights, has reviewed the footage of the Columbia County Jail extraction and issued the following expert opinion: [15]

Mr. Bartlett being taken down the K9

The use of physical force to control confined persons is a lamentable event in any operation of American prisons, jails, and juvenile facilities. Moreover, there are few elements of a confinement operation that can more quickly generate civil or criminal legal action than alleged instances of unnecessary staff use of force.

Because staff use of force necessarily involves risk of physical injury to both inmates and staff, it is also necessarily governed by sound correctional standards, policies, guidelines and decisions of the court system through application of the 8th and 14th Amendments to the U. S. Constitution. It is on these grounds I will address the efficacy of utilizing K-9s during the course of a cell extraction be it in prisons or jails.

Mr. Martin goes on to offer the following expert opinion regarding Mr. Bartlett's cell extraction:

> "Both sound correctional practice and the law consistently set out core principles governing staff use of force. They are as follows:
>
> - Force should be used as a last resort;
> - Force should be used in a manner to minimize injuries to both inmates and staff;
> - Force should cease when control has been established;
> - Force should never be used to punish or inflict wanton pain on a subject; and
> - Force should be proportional to the resistance or threat encountered.
>
> *The use of K-9s in a cell extraction violates each and every one of these core principles.*

[15] Mr. Steven J. Martin is also the author of Correctional Law Reporter, *Staff Use of Force in a Confinement Setting*, Vol. XXV No. 1, June-July 2013.

First, absent imminent threat of serious bodily injury or death, the use of K-9s, given all the modern day tactical options available to staff, should never be employed as a last resort. Second, because a K-9 is an animal whose behavior cannot be completely controlled, injuries cannot be minimized to the subject and may actually be exponentially increased because defensive resistance and panic by the subject can actually increase the K-9's attack.

Third, ceasing force once control is established may not be immediately accomplished after the K-9 engages the subject. Fourth, use of a K-9 to inflict injury under the guise of a less than precise control tactic may give rise to the claim of punishment and wanton infliction of pain. Finally, use of a biting dog, given the tremendous jaw strength of such an animal, is not proportional to the resistance or threat encountered absent the circumstances justifying lethal force.

While it is not unusual for K-9s to be used in a correctional setting for contraband detection, tracking, and escorting*, I am not aware of a single confinement operation that permits* K-9*s to be used in cell extractions*. I have reviewed policies that strictly prohibit their deployment to intervene or participate in a cell extraction. One such policy I reviewed includes a provision that K-9s on facility patrol shall never be deployed to intervene during a use of force between staff and inmates because this would place staff at risk of a bite from the K-9. In sum, an agency official who authorizes K-9s in cell extractions, subjects himself/herself and subordinates to needless liability claims and even criminal civil rights claims. Perhaps, most importantly, such a practice is antithetical to the first rule of correctional administrators, i.e., to provide a safe work environment for staff, civilians, and inmates. *The use of* K-9*s in cell extractions represent quite simply unacceptable risks of harm to both staff and inmates*."

Clear Legal Standard for Use of Force and Inmates with Mental Illness

Mr. Martin and other criminal justice experts advise against the use of canine in cell extractions - including forcible removing inmates with mental illness from their cells because those inmates are at greater risk of physical harm.

In order to avoid injury, an inmate being bitten by a dog must submit to the dog and lie still. Pulling away from a biting dog is likely to increase tissue damage and serious injury. Inmates with mental health conditions may be fearful, anxious, overexcited, or delusional, making them least likely to submit and most likely to pull away, thus suffering greater or potentially permanent injury. The harm caused to inmates serves as the legal basis for prohibiting the use of canines in jail use of force events.

This harm is especially problematic when there are other, safer ways to manage an inmate's behavior without resulting in a canine attack. For example, local experts included in Columbia County's grand jury investigation testified regarding other uses of force or de-escalation techniques rather than using canines. First, Sergeant Brandon White from Multnomah County testified about their Corrections Enforcement Response Team (CERT).

Noting Columbia County's cost concerns, the grand jury still recommended that county establish CERT to "increase the safety of deputies and inmates." Second, Gabe Gitnes from the Oregon Department of Corrections testified regarding the proven effectiveness in de-escalation techniques and the Department of Corrections "significant reduction in use of force incidents using these tools."[16] These local corrections practices outside of Columbia County are consistent with the national standards.

Mr. Bartlett being bitten by a CANINE.

The American Bar Association (ABA) Criminal Justice Standard clearly states, *"Canines should never be used for purposes of intimidation or control of a prisoner or prisoners."*[17] The ABA Criminal Justice Standard also cites to applicable 8th Amendment jurisprudence that forms a legal basis to reject using canines to respond to behaviors of inmates with disabilities as it is both cruel and unusual.

Instead, jail staff should first "determine whether the prisoner has any contraindicating medical conditions, including mental illness."[18] This includes when an inmate does not comply with commands potentially related to their disability. For example, an officer's wish to compel a prisoner's compliance with an order is insufficient to justify use of either electronic or chemical weaponry.[19]

[16] Columbia County Grand Jury Report, pages 5-6, available at http://media.oregonlive.com/pacific-northwest-news/other/ColumbiaCountydocs.pdf

[17] The ABA Criminal Justice Standard 23-5.8 Use of Chemical Agents, Electronic Weaponry, and Canines (the "ABA Criminal Justice Standard") available at https://www.americanbar.org/content/dam/aba/publications/criminal_justice_standards/Treatment_of_Prisoners.authcheckdam.pdf.

[18] *Id.* at 140-142.

[19] See, *e.g., Hickey v. Reeder*, 12 F.3d 754, 758-59 (8th Cir. 1993) (shooting a prisoner with a stun gun to make him clean his cell violated the Eighth Amendment).

Columbia County Jail records show no evidence that a clinical consultation was conducted to consider contraindications even though the cell extraction was planned and Mr. Bartlett's medical records clearly establish his disability. It is also unclear if jail corrections staff understood or considered whether Mr. Bartlett's refusal to comply was due to this disability and, in particular, his experience of hearing or seeing things that were not there.

> "Canines should never be used for purposes of intimidation or control of a prisoner or prisoners." The American Bar Association Criminal Justice Standard

Humane Treatment of Inmates with Disabilities

The Substance Abuse and Mental Health Services (SAMHSA) is the agency within the U.S. Department of Health and Human Services that leads public health efforts to advance the behavioral health of our communities.[20] SAMHSA continuously issues guidance to jails to ensure corrections staff provide trauma informed care and interventions.[21]

In particular, SAMHSA offers training to corrections staff so that they can avoid re-traumatizing individuals and offering more effective interventions for responding to inmates with mental illness.[22]

As a matter of public policy, we all have a shared interest in ensuring all people, including those with disabilities, are treated humanely while they are being held in jail. Ultimately, those who are charged with crimes do come back to our communities when they are found to be not guilty or when they have served their time.

We should all be invested in ensuring that our fellow Oregonians are not severely injured or prevented from fully re-integrating back into society simply because their disability may have made it more difficult to comply with jail rules.

[20] https://www.samhsa.gov/about-us

[21] SAMHSA Emerging Issues in Behavioral Health and the Criminal Justice System, available at https://www.samhsa.gov/criminal-juvenile-justice/behavioral-health-criminal-justice

[22] https://www.samhsa.gov/criminal-juvenile-justice/state-federal-collaborations

Instead, these individuals should have the same opportunity as all of us to be contributing members of society.

When DRO last spoke to Mr. Bartlett, he told us that while he had not been arrested again, he still has nightmares about a dog attacking him and the scars to prove it.

RECOMMENDATIONS

To protect inmates who experience mental health conditions and to maintain the safety and security of correctional facilities, DRO recommends the following:

1. Prohibit Using Canines for Cell Extraction Due to Risks of Harm

In the state of Oregon, there are no clear state or local training protocols for police canine and their involvement in correctional use of force events. For example, in the Columbia County General Offense report dated August 1, 2017, the canine officer notes that the canine used for the cell extraction is only certified for patrol as defined as "tracking area…article…building searching," as well as "narcotics detention."

DRO was provided the training records for the canine used to attack Mr. Bartlett. Based on the records, it appears that the canine received approximately 330 hours in training ranging from searching, tracking, agility, obedience, and aggression. The vast majority of these hours were spent training the canine on searching, tracking, and obedience. Notably, the canine received approximately 7 hours of training on "apprehension." The notes from the apprehension trainings also indicate that the canine had difficulty releasing its bite on command and frequently needed an electric collar to correct the poor behavior.

To address this gap in state law, in the 2019 legislative session, DRO will advocate for legislation that prohibits the use of canines in correctional facilities for the purpose of intimidation or control. We will also seek clarity regarding when a "use of physical force" for the purpose of intimidation or control is a type of "physical punishment."

2. Train Staff to Use Interventions More Appropriate to Respond to Inmates with Disabilities

There are several interventions and techniques better suited to respond to inmates with disabilities. When responding to a person whose disability may prevent them from following commands or procedures, correctional staff should carefully approach the use of force and be specifically trained in de-escalation techniques, crisis intervention, and other trauma informed interventions rather than resorting to physical force including using canine. Otherwise, inmates with mental illness or other disabilities may be disproportionally subject to acts of force when untrained officers wrongly believe the lack of compliance is willful rather than due to their disability.

Consistent with the testimony provided by Oregon Department of Corrections to the Columbia County grand jury, DRO continues to encourage the county to reach out to SAMSHA to obtain proven de-escalation training and related policies.

3. Ensure the Use of Force is Justified and Proper Reporting is Conducted

Any use of force must be justified and its use must be accurately and properly documented. Accurate reporting of such incidents allows for thoughtful and accurate debriefing. Without it, it's far more difficult to hold jail staff accountable or understand how jail staff can create a safe and appropriate jail environment.

CONCLUSION

The August 2017 use of a canine to remove Mr. Bartlett from his cell in the Columbia County Jail does not appear to be an isolated incident. Based on statements made to the media, DRO understands that former Sheriff Dickerson estimates “a canine deputy” has been used on inmates in the jail "about half a dozen times" since the police canine was deployed to the jail in November 2015.

In September 2018, DRO’s Legal Director, Emily Cooper, met with Columbia County jail officials and their attorneys to raise the same concerns addressed in this report. It is DRO’s understanding that the jail will remain the only county in the state of Oregon that allows canines to forcibly remove inmates from their cells.

DRO urges Columbia County to prohibit the use of canine for the purposes of intimidation or control of inmates whose disabilities may be the basis for their failure to comply with commands. More broadly, our viewing of the video in this case left the strong impression that the barking canine was used to terrorize the inmates into compliance. This should not be an acceptable strategy in a civilized society.

Jail is no place for people with mental illness. Our local communities need psychiatric crisis services, housing, and supports to keep people out of crisis. This will require new or shifted resources that can only be provided by public action.

DRO also calls for state legislators to adopt legislation to prohibit the use of canines in any use of force event in jail settings.

ACKNOWLEDGEMENTS

Written by Emily Cooper, Legal Director.

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Disability Rights Oregon is the Protection and Advocacy System for Oregon.

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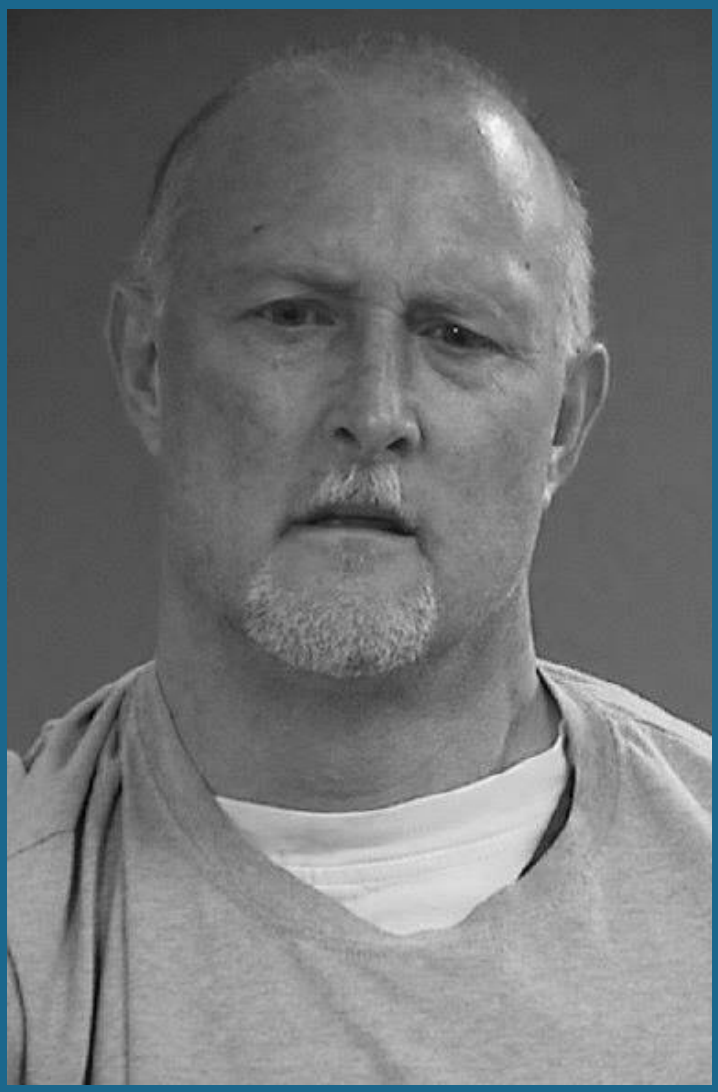
Independent Investigation of the Death of Michael Barton:

Mental Illness & Medical Neglect in an Oregon Prison



DRO | Disability Rights Oregon

Summer 2019

Introduction

In January of 2018, a 54-year old Oregon State Prison inmate with a long history of mental illness and obvious dementia caught the flu. Over the next month, Michael Barton[1] became sicker and sicker. By mid-January, multiple witnesses report that he was unable to walk or sit up. He eventually stopped eating and trays of uneaten food piled up on the floor. He could not get to the sink in his cell and believed that the water there was poisoning him.[2] The nurses who responded to his cell stood in the doorway and argued with him because they interpreted his irrational resistance to drinking the water in his cell as malingering or an obstinate refusal to follow medical advice. Despite multiple visits and tearful requests to be admitted to the medical infirmary where the physicians at the practice were supposed to care for inmates, he was continually returned to his cell. By early February, he became bedridden and unresponsive to anyone who tried to rouse him.

> [W]e have consistently found that many of the people who suffer most profoundly have mental health needs, cognitive disabilities, or other substantial healthcare needs.

On February 5, 2018, Mr. Barton lost consciousness while being wheeled to the infirmary. He was rushed to a Salem hospital. He arrived at the hospital without having regained consciousness. Four liters of infected pus and fluid were removed from his chest cavity to treat an infection causing a collapsed lung. On February 6, 2018, Mr. Barton died from organ failure resulting from a massive methicillin-resistant staphylococcus aureus (MRSA) infection.[3] Despite the availability and low cost of providing potentially life-saving treatment, Michael Barton did not receive that treatment.

He died because his mental illness and dementia led nursing and medical staff to ignore his true condition and dismiss his ever more desperate complaints and symptoms as manipulative malingering. After being contacted by multiple witnesses who were haunted by the circumstances that led to Mr. Barton's death, Disability Rights Oregon (DRO) conducted an investigation, reviewed his records, and interviewed additional witnesses. Below are the findings of our investigation.

1 Mr. Barton's family has authorized DRO to reveal his identity in this report. However, the individual witnesses who have provided information included in the report are referred to in a manner that is designed to conceal their identities as much as possible. Because the inmates referred to in this report are housed in an all-male institution, all witnesses will be referred to with male pronouns regardless of gender.

2 Between January 28 and February 5, he was seen by jail medical staff at least eight times and consistently begged to be admitted to the infirmary. Four of those medical contacts took place at his cell, but the nurses who responded failed to take his vitals or enter his cell.

3 MRSA is a common disease in hospitals, prisons, or other confined care facilities that is treatable with antibiotics.

For the past decade, Disability Rights Oregon has worked to improve the well-being of people with mental health conditions and disabilities who are ensnarled in the criminal justice system. We have visited jails and prisons across the state to monitor conditions and interview people with disabilities who are incarcerated in conditions that often destroy their mental and physical health. When possible, we have worked collaboratively with state agencies and county jails to improve conditions. Throughout our work, we have consistently found that many of the people who suffer most profoundly have mental health needs, cognitive disabilities, or other substantial healthcare needs.

This report continues that work. It reveals a cascade of systemic failures that led to the death of Mr. Barton, an individual who might still be alive but for well-known disabilities that impaired his ability to navigate the medical system that was responsible for his care at the Oregon State Penitentiary.

Disability Rights Oregon's investigation into Mr. Barton's death is supported by multiple eyewitness accounts and ODOC records.

Eyewitness Accounts

Approximately nine months after Mr. Barton's death, two individuals contacted DRO. Both were eyewitnesses to many of the events that preceded his death. One of those individuals is an Oregon Department of Corrections (ODOC) employee who was reluctant to complain about the system that employed him. He nevertheless contacted DRO because the death of Mr. Barton had haunted him until he could no longer remain silent about what he knew and had seen. He requested that we protect his identity as much as possible because he feared some sort of retaliation by colleagues stating that "you can't imagine what it's like to be blackballed here."

The other was an inmate helper[4] who made a similar request noting that ODOC had retaliated against all inmate helpers by barring them from Oregon State Penitentiary (OSP)'s Behavioral Health Unit and Mental Health Infirmary following another inmate helper's report about conditions to the Statesman Journal.[5]

Following our receipt of the above-noted initial reports, DRO requested and reviewed relevant ODOC records pursuant to our authority under Protection and Advocacy for Individuals with Mental Illness Act of 1986 ("PAIMI Act").[6] Subsequently, DRO received information from three additional witnesses to circumstances and events related to Mr.

4 Inmates in Mr. Barton's unit are assisted by 4-8 inmate helpers. Some are "ADL workers" who assist with Adult Daily Living tasks such as toileting. The others are Inmate Peer Companions who have less specific support duties such as being someone to sit next to in a social activity.

5 He reports that this ban was eventually lifted for the MHI, but that inmate helpers were still barred from the BHU at the time of his contacts with DRO.

6 Protection and Advocacy for Individuals with Mental Illness Act of 1986 (the "PAIMI Act") provides for the protection of rights of individuals with mental illness, 42 U.S.C. § 10801 et seq. 42 CFR § 51.41 provides DRO access to ODOC records related to the circumstances that led to Mr. Barton's death.

Barton's condition and death. Those witnesses corroborated and/or expanded upon what we had learned previously.

Our review of the events leading to Mr. Barton's death is thus based on records provided by ODOC and the accounts of at least five witnesses. Importantly, there is little or no daylight between the accounts that we were able to piece together from the five witnesses. In addition, although the witness accounts provided important information that was not available to ODOC, those accounts were not contradicted by the records that ODOC provided to DRO.

Fears of Retaliation

Based on the concerns of the individuals who eventually provided information to DRO, we consider their willingness to speak with us heroic and will describe the information that they provided in a manner that will conceal their identities as much as possible. Our decision to mask the identities of these and other individuals who contributed to DRO's investigation does not reflect the accuracy of their fears about retaliation. Similarly, it does not reflect the extent to which those fears are attributable to actions by ODOC vs. actions by co-workers who might see complaints or questions about what may have occurred in the secretive world of prison as a violation of an unwritten code that punishes "snitches." More simply, we do not take a position on whether or not ODOC retaliates against complaining inmates and employees as an institution, but we know that people who live and work in Oregon prisons fear many informal types of retaliation by other ODOC employees.

DRO's Investigation of Michael Barton's Death

Michael Barton was sent to prison for a bank robbery in April of 2017. He arrived with a long history of serious mental illness. The videotaped robbery puzzled his lawyer and the police. He was arrested behind the bank building after he calmly walked away from the lobby carrying a bottle of Gatorade and a bright red bank bag of money. Although he held up a kitchen knife on his way out of the building, that was the first time that anyone saw it, apparently because he forgot to brandish it during the earlier phase of the robbery. The responding police officer wrote that he saw a man "walking south from the bank matching the suspect's description. I locked eyes with the male and he walked towards me. 'It was me.'"

> On one occasion, Mr. Barton pounded the sink in his cell out of frustration that he could not figure out how to turn off the running water faucet.

According to somewhat unclear records, it appears that Mr. Barton was transferred to a special unit at Oregon State Penitentiary (OSP) about five months after he began his sentence because he just couldn't handle the daily demands of mainline prison life. Over the next 17 months, his confusion led Oregon Department of Corrections (ODOC) and its Behavioral Health Services (BHS) department to provide him assistance from inmate helpers and mental health clinicians who repeatedly noted the seriousness of his mental health condition. It was even noted that he could not understand how to open the unlocked door of his cell. On one occasion, Mr. Barton pounded the sink in his cell out of frustration that he could not figure out how to turn off the running water faucet.

A Viral Illness

In January 2018, Mr. Barton started presenting symptoms of a viral illness consistent with the flu. During the remainder of the month, he was taken to the infirmary in a wheelchair pushed by inmate helpers on multiple occasions. He was seen by a number of nurses and medical providers who ignored his increasingly panicked requests to be admitted to the infirmary. On these occasions, he cried and begged to stay in the infirmary saying that he could not drink the water in his cell to take medications[7] because it made him dizzy. These pleas and the potential significance of Mr. Barton's illogical belief about the water in his cell were ignored or overridden by other concerns. One of those concerns was a fear of treating Mr. Barton in the small OSP infirmary where other patients might catch whatever he had.

7 On January 31, 2018, Doxycycline, an antibiotic was prescribed. Prior to that, Mr. Barton's condition was treated with acetaminophen and ibuprofen.

This was voiced by one of the providers who refused to admit Mr. Barton to the infirmary when stating, "I don't want him in my infirmary where he can make other people sick."

> On these occasions, he cried and begged to stay in the infirmary saying that he could not drink the water in his cell to take medications because it made him dizzy.

The medical staff at OSP repeatedly misinterpreted Mr. Barton's obvious inability to understand or follow their instructions (e.g. drink fluids and leave your bunk slowly) as malingering and/or refusal to take medication. Multiple witnesses reported to DRO that as his condition deteriorated, Mr. Barton became too weak to leave his bunk to get water from the sink a few feet away. Meanwhile, Correctional Officers (COs) continued to do their rounds and nurses checked in on Mr. Barton without entering his cell to physically assess him or take vitals. From their vantage point at the doorway, they did not recognize his semi-comatose state or see his swollen and discolored limbs underneath a blanket that was wrapped tightly around his emaciated body.

> [A]n inmate helper asked the Corrections Officers on duty to open Mr. Barton's cell so that he (the helper) could give Mr. Barton some water. The request was refused by a Corrections Officer who answered that, "if he is able to go to the bathroom, he can get his own water."

During the same roughly two-week period, Mr. Barton was seen every day by inmate helpers and other witnesses who observed that his limbs were visibly swollen and that his skin was becoming increasingly dusky gray. On one occasion, an inmate helper asked the COs on duty to open Mr. Barton's cell so that he (the helper) could give Mr. Barton some water. The request was refused by a CO who answered that, "if he is able to go to the bathroom, he can get his own water."

On February 4, 2018, multiple witnesses saw meal trays lying untouched on the floor of Mr. Barton's cell and realized that he had not left his bunk for days. One of those witnesses insisted that a nurse come to evaluate Mr. Barton's obviously serious condition. The nurse who eventually responded refused to enter the cell or take vitals. The same witness eventually entered the cell and lifted Mr. Barton's head to give him a sip of water so that he could swallow what witnesses assume was an antibiotic pill that the nurse passed in from outside of the cell. The witness was so alarmed that he made a series of requests to Security and Medical hoping to convince someone that Mr. Barton needed urgent medical attention.

> One of those witnesses insisted that a nurse come to evaluate Mr. Barton's obviously serious condition. The nurse who eventually responded refused to enter the cell or take vitals.

The repeated response was that a nurse had seen Mr. Barton and that his condition could wait until an appointment at the OSP infirmary on the following morning. However, records and witness accounts make it clear that the nurse's assessment of Mr. Barton's condition did not include a physical examination. Many hours later, the same individual ended his efforts without being able to convince anyone that Mr. Barton was in a condition that could not wait until morning.

Weeks after Becoming Ill, Mr. Barton Loses Consciousness

On the next morning (February 5, 2018), Mr. Barton's inmate helper came to pick him up with a wheelchair for his scheduled trip to the infirmary. When Mr. Barton failed to respond from his bed, the inmate helper pushed aside the uneaten meal trays on the floor and went to Mr. Barton's bunk. He saw that Mr. Barton's limbs were even more swollen than before and that his skin was a frighteningly lifeless shade of gray. Because Mr. Barton could not sit up, the inmate helper had to lift him as deadweight into the chair. By the time they were a few feet out of the cell and on their way to the infirmary, Mr. Barton's head flopped to one side. He lost consciousness and his bladder emptied down his leg. The inmate helper screamed for help. Security staff responded with a "Man Down" code.

> The inmate helper had to lift him as deadweight into the chair. By the time they were a few feet out of the cell and on their way to the infirmary, Mr. Barton's head flopped to one side. He lost consciousness and his bladder emptied down his leg.

Mr. Barton never regained consciousness. Once hospitalized in Salem, he was diagnosed with a significant infection. Four liters of MRSA-infected fluid were surgically removed from his chest cavity. Following the surgery, he went into multi-system organ failure. Treatment was ultimately ended. Mr. Barton was pronounced dead at 7:31 p.m. on February 6, 2018.

Mr. Barton's family learned of his death through a Facebook posting authored by a friend of Mr. Barton's which stated "Michael Barton RIP." When a family member contacted the author of the posting, he was told that the friend believed that Mr. Barton had died of heart attack while in custody. Mr. Barton's family did not become aware of the circumstances surrounding his death until DRO succeeded in contacting them in June of2019.

A Detailed Portrait of Neglect

DRO's investigation of the circumstances that led to Mr. Barton's death led us to conclude that he died because of negligence.[8] One medical provider after another failed to consider the impact of his mental illness and obvious dementia when called to assess his medical condition and complaints. A review of ODOC records further suggests that these failures and their increasingly negative effects on the medical and mental healthcare that was provided to Mr. Barton began many months before he died.

One witness who contacted DRO observed Mr. Barton shortly before his death on two occasions about a week apart. Another saw Mr. Barton almost daily for the entire seventeen months during which Mr. Barton lived in OSP's Intermediate Care Housing unit. Both witnesses therefore saw Mr. Barton during the period that began approximately one or two weeks before his death when he (Barton) became too ill to leave his cell under his own power.

The consistent accounts of these two individuals and the others who contacted us later described an alarming decline in Mr. Barton's health. His worsening symptoms were met with indifference and/or hostility by nurses who dismissed his increasingly urgent and incoherent complaints. Where others saw a medical crisis, the nurses who refused to enter Mr. Barton's cell and failed to perform a physical examination or measure vital signs saw a chronic and troublesome complainer whose condition was not their problem.

Too Ill to Get out of Bed

A nurse responded to Mr. Barton's cell about a week before his death, probably on January 31 or February 1. According to multiple witness accounts, this happened only after one of the witnesses made repeated requests for medical attention after observing that Mr. Barton seemed very ill, was unable to get out of his bunk, and was coughing up sputum. The same individual further reported that the nurse who eventually responded refused to enter Mr. Barton's cell in order to take vitals or administer medications that he (the witness) believed to be antibiotics.[9] When spoken to about the apparent seriousness of Mr. Barton's condition and need for a setting where he could get water without needing to get out of bed, the nurse responded that if he (Mr. Barton) couldn't be bothered to get himself water or meds, "that would be too bad for him and that he was a known faker and complainer."

Subsequently and while the nurse watched, one of the reporting individuals entered the cell to hold up Mr. Barton's head so that he could drink a sip of water and swallow the medication. He did not see Mr. Barton again until February 4, 2018, one day before he died.

8 DRO has reason to believe that Mr. Barton's death may actually be the result of deliberate indifference, but declines to focus on that distinction at the current time.

9 Multiple witnesses reported to DRO that it was common for nurses to refuse to enter cells in the ICH and elsewhere at OSP.

At least two witnesses reported to DRO that they observed multiple trays of uneaten food on the floor of Mr. Barton's cell during the evening of February 4, 2018. They saw this as an obvious indication that he had not left his bunk for more than a day. They additionally recall that at one of them insisted that "this man has to see a doctor" when he was finally able to summon a nurse to Mr. Barton's cell.

Nurses Ignore Critical Signs of Medical Emergency

Both of these witnesses additionally recalled a second occasion in which one of them eventually helped Mr. Barton raise his head and take a sip of water to swallow his medication because a nurse again refused to enter the cell. The responding nurse again took no vitals and did not perform even the most rudimentary physical examination. Nevertheless, the nurse assessed that Mr. Barton's condition could wait until an infirmary appointment scheduled for the following morning. Both witnesses report that the nurse remarked that, "he will be okay. Just make sure he has liquids." When one or both of them insisted that Mr. Barton needed urgent medical attention, the nurse responded that "He has an appointment tomorrow morning, and he will be fine till then." Subsequent calls to medical providers about the necessity of getting Mr. Barton to the infirmary immediately were unsuccessful.

A Physician Is Reluctant to Request a Dementia Assessment

One of the witnesses who contacted DRO is an ODOC employee who reported that he knew Mr. Barton well and routinely checked in on him during daily walks through the ICH.

He shared a widely held opinion that Mr. Barton had some form of dementia, likely the result of alcohol-induced brain damage. He believed that a prescribing physician whose caseload included Mr. Barton held the same opinion, but had not ordered a neurological evaluation to confirm the diagnosis. He (the reporting witness) and his colleagues believed that the same physician was reluctant to take that step because of historical resistance to ordering what were perceived to be "extra" tests and tasks by nurses and other medical providers who resented being asked to do things such as put in or implement orders that were not in the electronic medical record. Similarly, he believed that nurses and other medical staff also resented what they saw as a mental health prescriber "leaving his lane" and interfering with matters that were not his job.

His opinion was based on first-hand and consistent observation. He explained that Mr. Barton was usually friendly and outgoing during their almost daily encounters. During these encounters, he typically tried to help Mr. Barton understand the unit schedule and address other related problems. These included a persistent difficulty with understanding when the cell door was supposed to be locked how to open it when it was unlocked. For that reason, he often checked in with Mr. Barton at 6 p.m., a time when Mr. Barton was

permitted to venture out of his cell because the tier was open. However, Mr. Barton was consistently unable to leave his cell without help to open the door following a reminder that it was unlocked.

Too Weak to Drink from a Glass, Too Weak to Stand

The same individual reported to DRO that at some point during the weeks before his death, Mr. Barton became too weak to drink out of a glass because he could not lift up his head without help.[10] During the week leading to up to the 2018 Super Bowl, this individual reports that Mr. Barton was in his cell or in the infirmary on every occasion when he (the witness) was in the unit. He reports that Mr. Barton seemed very ill and unable to take care of even his most basic needs.

According to the same individual, there were many other indications of the seriousness of Mr. Barton's situation. One was that he was sleeping during the day, a departure from his normal pattern. He did not come out for open ward and responded to staff only after they attempted to rouse him several times. Also, even though the unit was typically warm, he reports that Mr. Barton was constantly shivering and under his blanket.[11] When Mr. Barton was asked if he had eaten (something that was reportedly not being tracked by staff), he mumbled incomprehensibly. With one exception that occurred shortly before Mr. Barton died, the same individual reports that he did not see Mr. Barton out of his bed during the week before his death.

That exception occurred on either February 3 or 4 when he saw Mr. Barton's return to the Intermediate Care Housing unit (ICH) from a trip to the infirmary. Mr. Barton was very thin. His skin was pale and gray and he appeared to be very weak. The witness watched as Mr. Barton was transferred from an infirmary wheel chair to another wheelchair that stayed in the unit because both chairs were too wide to pass through the doorway. Mr. Barton was moaning and tearful as he labored to get out of the first chair so that he could be transferred across the threshold to the second and reenter the unit. Mr. Barton had a hard time getting up and maintaining a standing position. He managed to do so only by holding onto the bars at the entrance to the unit and was crying. He repeated over and over that "I can't walk. I need help. I can't stand." Mr. Barton's legs shook under the strain of standing long enough to switch wheelchairs.

10 Although he might have been able to drink if provided with a straw or water bottle that did not require tipping, straws were not allowed in cells and the appropriate sort of water bottles were only available to inmates who, unlike Mr. Barton, had money to pay for them through OSP's commissary program.

11 Constant shivering and chills are signs of a bacterial infection.

An ODOC Employee's Request to Have Mr. Barton Readmitted to Infirmary is Denied

This individual was so disturbed by the above scene and his belief that Mr. Barton should not have been discharged from the infirmary that he called to request that Mr. Barton be immediately readmitted. He was told by the responding nurse that he "just needs to rest." Similarly, he reports that much of the correctional and nursing staff assumed that Mr. Barton was just complaining and being melodramatic. Even so, one of the COs who was there at the same time reportedly complained that a CO should not be expected to help an inmate walk because it was clear that anyone who needed that level of help belonged in the infirmary.[12]

12 COs are generally wary of laying hands on inmates without specific instructions or orders to do so.

ODOC'S Response to Mr. Barton's Death

The above-noted witness returned to work a few days later and learned of Mr. Barton's death from a supervisor in what he described as a "hush hush way." He reports that on previous occasions, he and other staff were informed of inmate deaths by email. In this case, that did not happen. Staff learned of Mr. Barton's death only by informal means.

During the week or two that followed Mr. Barton's death, the same individual heard a number of nurses exchange rumors about its cause. These included a suspected impact of liver disease and the related belief that Mr. Barton's condition should have been treated by the infirmary staff as "more acute" because he was immunologically compromised because of his liver disease. Some nurses believed, but did not seem to know, that MRSA was a lethal factor that may have been a predictable result for an individual with a depleted immune response. Some nurses believed that Mr. Barton should have been kept in the infirmary and others thought he should not have been there because he was too much of a risk to other patients. After the above-noted flurry of rumors and theories about the cause of death, the nurses who worked at the unit avoided mentioning Mr. Barton.

He reports that on previous occasions, he and other staff were informed of inmate deaths by email. In this case, that did not happen and staff learned of Mr. Barton's death only by informal means.

The Symptoms of a Complainer

The above account suggests that the nurses had little or no real knowledge about Mr. Barton's condition or medical history. Perhaps that explains why none of them questioned why he was not hospitalized sooner or discussed how their own conduct and attitudes might have been factors in his death.

On the other hand, Mr. Barton's death deeply disturbed many of the other people who worked in his unit. Based on his recollection of informal conversations that followed Mr. Barton's death, one of the witnesses who contacted DRO believes that the entire BHS team shares his own belief that Mr. Barton needed to be in the infirmary and that his death was probably avoidable. He also recalled seeing a CO break into quiet tears upon learning of Mr. Barton's death.

ODOC's Investigation Paints an Incomplete Picture

ODOC's review of the circumstances that led to Mr. Barton's death was supported by a thorough review of records. It confirmed significant shortcomings of the care that was provided to Mr. Barton, but did not conclude that his death was the result of negligence or neglect. As previously noted, however, ODOC's review was completed without the valuable accounts of the witnesses who provided additional information to DRO. For that reason, we believe that ODOC has not fully identified the changes in policy and practice that will be necessary to avoid similar tragedies in the future.

> Mr. Barton died because of negligence that occurred when one medical provider after another failed to consider the impact of his mental illness and obvious dementia when determining treatment for his condition and symptoms.

Following the medical examiner's decision not to do an autopsy, the ODOC's Chief Medical Officer concluded that the clinical cause of Mr. Barton's death was:

> "Influenza B, leading to secondary MRSA pneumonia (nasal Carrier), leading to MRSA empyema, leading to sepsis, leading to severe septic shock, leading to cardiopulmonary arrests, leading to anorexic brain and multisystem injury, leading to multisystem failure with severe anoxic brain injury. Altogether leading to death."

In other words, Mr. Barton died of a MRSA infection and subsequent complications that occurred after he caught the flu.

However, DRO's investigation of the circumstances that led to his death lead us to conclude that Mr. Barton died because of negligence that occurred when one medical provider after another failed to consider the impact of his mental illness and obvious dementia when determining treatment for his condition and symptoms. Although many of these failures took place during the last days of Mr. Barton's life, it is important to understand and consider who Mr. Barton was when assessing the quality of his medical care and its relationship to his disabilities.

Placed in Housing for People with Mental Illness & Intellectual Disabilities

As a starting point, it is significant that he lived in OSP's Intermediate Care Housing unit. The ICH is a specialized housing unit designed for individuals who are unable to successfully navigate daily prison life because of mental illness and developmental disabilities. Records do not clarify the reason for Mr. Barton's placement in the ICH, but it

is critical to understand that ODOC knew that he was an individual with a history of mental illness who had exhibited significant signs of dementia when he was moved there from another ODOC prison in September of 2017.

A History of Mental Illness

ODOC records also confirm that Mr. Barton entered the Oregon Correctional Intake Center on April 27, 2017 with a history of Serious Mental Illness following his conviction for Eluding Police.[13] At the time of his death and during at least the 17 months that preceded it, he also exhibited significant signs of dementia.

Those signs were continually reported in fifteen Behavioral Health Services (BHS) Progress notes that began on September 13, 2017 and ended on January 17, 2018. These notes were created by Qualified Mental Health Professionals (QMHPs.) QMHPs implement mental health treatment plans and otherwise support inmates with mental illness and other conditions that significantly impact cognitive levels and the ability of those inmates to navigate the demands of life in prison.

Mr. Barton's first (September 13, 2017) BHS progress note explains, "Although Mr. Barton has a mood disorder diagnosis, he appeared to be having symptoms of forgetfulness and confusion most associated with Dementia or Alzheimer's." It concludes with a description of Mr. Barton's progress in a treatment plan that is based on his acceptance of packaged units of Dialectical Behavioral Therapy (DBT.) The questionable effectiveness of DBT for an individual who may be suffering from Dementia is not discussed.

Obvious Signs of Dementia: Difficulty Opening Unlocked Cell Door & Other Simple Tasks

Eight of the fifteen BHS Progress Notes sent to DRO specifically support witness accounts that describe Mr. Barton's inability to open the door of his cell when it is unlocked. A November 14, 2017 BHS Progress Note also documents that peer companions reported that "One time during the day he could not get the water in his sink to turn off and he got so frustrated he began crying and hitting the sink."

The final January 17, 2018 BHS progress note is typical of those that preceded it. It notes that Mr. Barton "continues to be confused about how to open his cell door. He becomes easily frustrated over simple tasks" before assessing that "Mr. Barton has remained the same and progress is slow. His symptoms resemble Dementia and learning to open his cell door and other simple daily tasks are a struggle for him." It concludes by naming the latest DBT packet that Mr. Barton has "accepted" without noting whether or not he read or otherwise learned anything useful from it.

"One time during the day he could not get the water in his sink to turn off and he got so frustrated he began crying and hitting the sink."

13 A charge that he pled to after his curious 2016 effort to rob a bank

Bank Robbery Hatched to Pay for Psychotropic Medication

Accounts of Mr. Barton's robbery also suggest that he may well have been suffering from symptoms of mental illness and/or dementia when he walked into the bank in 2016. The newspaper account of the robbery noted that Mr. Barton he was captured without incident while walking away from the bank.[14]

When DRO contacted his defense attorney about Mr. Barton, she remembered Mr. Barton and his case well. According to this attorney, the robbery occurred while Mr. Barton may have been homeless, but was socializing with men who lived in a group home for individuals with mental illness. Mr. Barton told her that he decided to rob a bank because he had run out of psychotropic medications and had no money to pay for more. In his account to her, it apparently never occurred to him that this might not be a good plan or the best way to access medication. She described the videotaped robbery as an event that suggested a highly impaired sense of practical reality in which Mr. Barton walked into the bank and waited politely and without concern while bank employees were collecting money and contacting the police. She further described how he walked out of the bank with little apparent understanding that he would be pursued while holding a red bank bag full of money.

14 https://mailtribune.com/news/crime-courts-emergencies/medford-police-nab-bank-robbery-suspect-within-minutes

ODOC Investigation

Although ODOC's investigation of Mr. Barton's death was not informed by the eyewitness accounts that were provided to DRO, it clearly reveals that the prison failed to provide him adequate medical care. It also acknowledges a nursing culture in which some nurses have become indifferent to the needs and symptoms of patients with psychiatric and developmental disabilities.

Despite Mr. Barton's history of serious mental illness, ODOC Medical Manager Dave Brown's February 19, 2019 Death Report indicates that Mr. Barton was not initially placed in special housing or identified as an individual who needed significant mental health services when he became an ODOC prisoner. However, the same report indicates, "Mr. Barton transferred from DRCI [Deer Ridge Correctional Institute] to OSP, where he was housed in the Intermediate Care Housing (ICH) for continuity of his mental healthcare needs. It is unclear the extent of the mental health change that prompted this move other than some increased confusion noted on the intake BHS chart note at OSP on 09/03/16."

A number of ODOC records indicate that the above-noted "increased confusion" should have been profoundly concerning. As noted earlier, following his transfer to ICH and for many months prior to his death, Mr. Barton was repeatedly described as frustrated and angry about being unable to leave his cell when it was unlocked because he could not fathom how to operate the door mechanism. A further indication of dementia or another serious impairment of his ability to understand or accomplish everyday tasks was ODOC's decision to assign him inmate helpers who helped Mr. Barton get to appointments and respond to the mundane demands of life in prison.

Mr. Barton Repeatedly Asks to Remain in the Infirmary

Brown's report makes no mention of this history or repeated requests by ODOC employees and inmates for medical attention during the last days of December 2017.[15] The report does indicate that Mr. Barton was seen cell-side at 4:30 a.m. on January 31, 2018 before "he was brought to the clinic for further assessment" and his vitals were again taken. His pulse oximeter[16] (pulse ox) reading of 93%[17] continued to register under the lower normal threshold of 95%, but he was observed to be "communicating without difficulty and had no coughing or sputum while in the clinic." Brown also reports that Mr. Barton "repeatedly requested to stay in the infirmary" and that "he was able to eat and drink without concern." It does not document whether he had any ability to leave his bed to eat or drink. Brown notes that Mr. Barton was returned to his cell and that his "chart did not indicate why INF admit was not recommended."

15 DRO has no understanding of whether this information was known by the report's author.

16 Pulse Oximeter readings measure the level of oxygen in a person's bloodstream.

17 Pulse oximeter readings below 95% typically activate an alarm, but the available records do not indicate whether this occurred or, if it did occur, that the alarm was turned off.

The Last Two Weeks of Mr. Barton's Life

Brown reports that Mr. Barton was again "seen in the clinic by a provider at 15:30" on the same day, approximately eleven hours later. In Brown's report, there is no indication of whether Mr. Barton was able to walk to the clinic unaided, required the assistance of his assigned inmate helper, or arrived in a wheel chair pushed by the helper. (However, multiple witnesses who contacted DRO confirmed that Mr. Barton was unable to leave his cell on foot for approximately the last two weeks of his life.) His pulse ox was measured at the somewhat concerning level of 95% and his heart rate had risen to 110.[18] [19]

According to Brown's report, Mr. Barton's blood pressure (107/65) was noted to be "only 20 points below baseline" and his appearance was described as "not toxic." A medical provider diagnosed lobar pneumonia and prescribed Doxycycline (an antibiotic) for 10 days. Brown further notes that Mr. Barton reported that he could not drink or eat in his cell because drinking the water there made him dizzy. He then begged to remain in the infirmary where he could eat and drink without leaving bed or drinking water that (he believed) made him dizzy. The provider attempted to explain that the dizziness was a result of sitting up too quickly rather than drinking the water in his cell, but Mr. Barton's request was denied and he was instead advised to sit up slowly to avoid dizziness when he returned to his cell.

February 3

The next entry in Brown's report is dated February 3, 2018 at 9:45 a.m. It describes Mr. Barton's next contact with a nurse. In that contact, there is again no mention of the fact that Mr. Barton arrived at the infirmary in a wheelchair with the aid of his helper. Mr. Barton complained of continued dizziness and "not feeling well." He also told the nurse that he had not "revived [sic] his meds in a day." According to the report, the nurse consulted Mr. Barton's medical record and disputed the accuracy of his account, apparently without probing whether Mr. Barton had no access to the medication, had been unable to take it, or was disoriented to the extent that he could not remember taking the medication. His pulse ox was up to 97%, but his heart rate continued to be above normal at 104.

A second entry on February 3, 2018 at 8:30 p.m. describes the first of a series of a cell-side encounters that followed Mr. Barton's visit to the infirmary earlier that day. In each of these encounters, it is clear that nurses who bring medication or otherwise respond to Mr. Barton's cell refuse to enter the cell, touch him, take vitals, or perform any sort of physical examination or assessment that could not be completed from the doorway.

During the 8:30 encounter, Mr. Barton "refused to sit or stand for his evening medication" for fifteen minutes of a nurse's requests for him to comply during which "he responded with a raised voice." The same note goes on to say that Mr. Barton continued to refuse

18 100 beats per minute is generally considered to be the upper limit of normal.

19 Normal pulse oximeter readings usually range from 95 to 100 percent. Values under 90 percent are considered low. Values under 60 mm Hg usually indicate the need for supplemental oxygen.

requests to sit or stand up when the nurse returned and that therefore, "medication was not administered." The record includes no account of what Mr. Barton may have been saying in a raised voice or if he gave a reason for refusing to sit or stand for his medication. The patient was not physically examined or assessed. No vitals were taken.

February 4

On February 4, 2018 at 7:00 a.m, Mr. Barton is described as having "refused to sit up for his meds without officer's assistance." It goes on to say that "Officer was able to assist and MR.[sic] Barton took his meds. Nurse educated Mr. Barton on proper hydration, Mr. Barton said he was unable."

There is no mention of uneaten meal trays on the floor of Mr. Barton's cell in this or any of the medical and nursing notes of February 3 or February 4, 2018.

A similar encounter took place at 7:00 am on the next day, February 4, 2018. In that encounter, Mr. Barton is again described as having "refused to sit up for meds without assistance." Although the nurse noted that "he was alert and oriented X3 with clear speech," the nurse did not indicate what Mr. Barton might have been saying. Medication was not administered and was to be "held until an ADL worker[20] is available to assist with sitting Mr. Barton up."[21]

February 5

The next entry in Brown's report is dated February 5, 2018 at 11:30 a.m., the time when "Staff report to the unit for man down."[22] The entry goes on to say, "staff found MR. (sic) Barton in a wheelchair in distress."

ODOC's Physician Review

ODOC Physician Reed Paulson's February 7, 2018 Mortality Case Review includes observations and issues that add to the picture already provided by ODOC's separate aforementioned death report and the accounts of the witnesses who contacted DRO.

It documents that Mr. Barton had history of mental illness and was administered

20 An "ADL worker" is an Adult Daily Living worker, one of two types of inmate helpers who worked in the ICH.

21 Previously noted witness accounts of the same encounters provides important missing context. According to those accounts, it was apparent that Mr. Barton was unable to get out of bed to access water and unable to take a pill without someone to lift his head while holding a glass of water on multiple occasions. Continued nurse requests for Mr. Barton to stand or sit up were necessary only because of the adamant refusal of nurses to enter Mr. Barton's cell or provide any assistance to him beyond offering medication from a distance. Mr. Barton seemed unable to understand or respond to any efforts to educate him on proper hydration while he was dizzy and too ill to sit up.

22 "Man Down" is a term used in most correctional facilities to announce a medical emergency requiring immediate response by security and medical personnel.

psychotropic medications for Bipolar Disorder by Behavioral Health Services (BHS) during at least some period of his custody in ODOC. Dr. Paulson explains the assignment of an inmate helper to Mr. Barton in July of 2017 as a response to "forgetfulness felt secondary to brain injury from substance abuse."

Dr. Paulson questioned the adequacy of eight (out of fourteen) aspects of Mr. Barton's medical treatment. He did so by rating those eight aspects at level four in a rating system that ranges from one to five where one denotes excellent care and five means that medical care does not meet the Community Standard of care. Within that five-point system, the next lowest rating of four describes care that "may not meet" the Community Standard of medical care.

In simpler terms, he concluded that the care provided in the following eight categories "may not meet" the necessary community standard of care:

- Preventive measures taken,
- Staff response appropriate,
- Level of Housing/care appropriate.
- Diagnosis timely,
- Diagnosis accurate,
- Preventive measures taken,
- Staff response appropriate, and
- Level of housing /care appropriate.

Dr. Paulson's review also reached a number of conclusions that support those of DRO's investigation:

> "Multiple visits with multiple staff and abnormal vital signs after the diagnosis of pneumonia represented opportunities for more and earlier intervention that may have prevented the terminal event. Orthostatic vital signs were never done."
>
> "Refusal to get up in the final 2 days in cell may have been misinterpreted inability to get up. Patient's mental illness may have been a confusing or distracting factor."
>
> "Staff safety concerns may have made entering the cell, in the last 3 days, for physical evaluation difficult and RN staff apprehensive."
>
> "Earlier admit to the infirmary may have made monitoring of condition easier and opportunities for earlier intervention possible. However, the facility is extremely ill-constructed for admitting influenza patients for monitoring, as we have multiple immunocompromised and/or medically fragile patients at all times. This creates an understandable hesitation in staff."

Dr. Paulson concluded his review with recommendations that included measures to facilitate in-cell medical evaluation and the following:

> "Increase RN and Provider staff to appropriate levels to reduce unnecessary mental fatigue and numbing. It is clearly demonstrated in this case that the fault does not lie in one person's mistake, but rather highlights system failure that has affected many staff."

Additional ODOC Reviews

ODOC provided an additional high-level evaluation of the care that Mr. Barton received in the form of a single hand-written and unsigned page that references the Chief Medical Officer's (CMO) report and therefore suggests that the CMO reports to its author.

> "[W]e did not recognize that this patient was critically ill"

This report notes that "there appear to be a few quality of care issues" before stating that "it seems as though we did not recognize that this patient was critically ill and we struggled with his compliance regarding Doxycycline." The author continues by noting that "his mental illness may have confounded staff's ability to assess his illness, but he had abnormal vital signs that were not acted upon." The author of the report also seems to doubt the accuracy of records that document missed doses of medication: "He only missed one day according to the MARs hmmm."

The same report concludes with the following statement: "Finally, the CMO's report is concerning but it differs in fundamental opinion component to that of the MSM.?? NEED more discussion." We agree and hope that any such discussion leads to meaningful action and reform.

Two ODOC e-mails also raise concerns about the care that Mr. Barton received before his death.

One is a cryptic February 9, 2018 email exchange that seems to endorse the failure of the nursing staff. In a response to some sort of contact or question that was not provided to DRO, an ODOC employee responds, "Ironic you say so considering it's their job to already know this stuff."

The second is a February 12, 2018 e-mail from ODOC Medical Services Manager Carrie Coffey to ODOC Medical Administrator Aimee Hughes.

> [ODOC Medical Services Manager] Coffey concludes by saying that "I am going to do a case review with staff to ensure that we learn from this complicated case" based on the below-listed bullet-pointed concerns:
>
> • "29th: why wasn't a quicker appointment made on the 29th Change in BP's from baseline
> • Investigation from nurses on intake from ICH Security
> • Not being allowed to enter cell to assist patient
> • Cognitive status of patient impairing an accurate subjective health status of patient".

Conclusion

Although DRO shares ODOC's opinion[23] that Mr. Barton's death was attributable to a system failure, we do not agree with the idea that no fault should be attributed to individual actors. Indeed, it is our belief that the conduct of the nurses who responded to Mr. Barton's cell during the last days of his life was surely negligent, if not deliberately indifferent, to the harms that ended his life.

The root causes of that negligent conduct may involve many interrelated and hard-to-quantify factors such as basic competence, poor training, poor supervision, too many administrative demands, staffing ratios, nurse recruitment and retention, and inadequate pay scales. However, the witnesses who contacted us about Mr. Barton universally believed that the nurses who were supposed to care for him were indifferent to his condition. The same reporters described a nurse culture that is rife with resentment about the "extra" difficulties and effort that are demanded when caring for patients whose mental illness and developmental disabilities limit the ability of those patients to understand questions and follow instructions.[24]

DRO shares that assessment and believes that there will be other Michael Bartons unless ODOC changes a culture that allows its nurses to see patients with cognitive and mental health disabilities as less than human.

In simplistic terms, Michael Barton died of a treatable disease that was not recognized and effectively treated by ODOC doctors and nurses. In that sense, because the gravity of his condition was obvious to anyone who bothered to look at him, he died due to negligence on the part of those providers and the system of care within which they worked.

However, because ODOC's nurses and doctors are the only source of healthcare for the thousands of individuals who are behind ODOC bars,[25] it is important to assess their performance in light of a specialized environment that is far different from the one we encounter outside of those bars. Although we may be dissatisfied with many aspects of the healthcare system in our country, if we are not happy with the competence or attitude of a nurse or doctor who is providing us with healthcare, we have at least some ability to go elsewhere or lodge a complaint to get the medical care we need.

That is not the case for prisoners in general. It is even less so the case for the large percentage of ODOC prisoners who, like Michael Barton, have disabilities that limit their ability to understand their environment or effectively communicate with doctors and

23 As stated by Dr. Paulson.

24 It is important to consider the impact of this attitude on the individuals who live in a specialized housing where a high percentage of the residents have been unable survive in general population because of mental illness and/or developmental disabilities

25 Outside care is provided to ODOC inmates under some circumstances, but as a rule, that is a rare occurrence.

nurses. That difference is even more true and acutely important in a specialized housing unit like the Intermediate Care Housing unit where Mr. Barton lived because of disabilities that rendered him unable to open an unlocked cell door.

To be sure, providing adequate medical care to an individual like Mr. Barton in a prison environment presents difficulties that require a heightened level of expertise and attention. Our investigation reveals that neither was available to him in the ICH. Instead, it exposes a medical culture, particularly among the nurses who failed to even examine a man whose condition alarmed many people; that should concern all of us.

At best, that culture tolerated a consistent failure to recognize or account for the impact of Mr. Barton's mental illness and dementia on his ability to communicate and understand his situation. Medical providers either did not care or did not understand that he could not competently respond to routine questions and instructions. At worst, it fostered a callous disregard for his welfare by the people who were supposed to care for him. In the insular environment of prison, Mr. Barton's death makes it clear that such a culture can be lethal.

As stated in an earlier portion of this report, DRO is not in a position to evaluate and weigh the relative importance of many factors that may have contributed to the creation of such a culture. We can and do say, however, that such an analysis, along with a subsequent implementation of effective steps to change that culture, is the legal and moral duty of the Oregon Department of Corrections.

Recommendations

DRO makes the following recommendations to ODOC.

Hire Independent Prison Health Expert

ODOC should consult with DRO to identify an independent prison health expert with successful experience in systemic reform of healthcare systems in correctional settings and extensive knowledge of the impact of mental illness and/or developmental disabilities on the ability of inmates to access medical care.

Evaluate Investigations into Mr. Barton's Death

ODOC should contract with the above-described independent prison health to ensure that this expert will review the investigations of Mr. Barton's death that were conducted by DRO and ODOC.

Identify Root Causes and Implement Necessary Changes

Based on the input and opinion of the independent prison health expert, ODOC should:

A. Identify the root causes, including but not limited to, the hiring and supervision of ODOC nurses that contributed to Mr. Barton's death;

B. Assess the impact of the current nursing culture on the medical care that is provided to inmates with mental illness and/or developmental disabilities; and

C. Identify and implement changes in policies and practices that would reduce or eliminate the above-noted root causes and negative aspects of nursing culture.

Facilitate the Independent Assessment of the Quality of Healthcare for Inmates with Mental Illness and/or Developmental Disabilities

ODOC should empower the independent prison health expert to review records, staffing levels, policies, and practices that impact the quality and consistency of medical care provided to inmates with mental illness and/or developmental disabilities. ODOC should also empower the expert to speak confidentially with inmates, ODOC administrators, staff,

contractors, and employees to discuss the quality of medical care provided to inmates with mental illness and/or developmental disabilities.

Facilitate the Independent Investigation of Retaliation on Medical Care for Inmates with Mental Illness and/or Developmental Disabilities

ODOC should empower the independent prison health expert to identify the significance of and basis for fear of retaliation by inmates and staff who complain about ODOC medical care provided to inmates with mental illness and/or developmental disabilities.

Provide the Independent Expert with any needed Assistance needed to Issue a Report on Medical Care Provided to Inmates with Mental Illness and/or Developmental Disabilities

Within one year, the independent prison health expert should issue a two-fold public report and ODOC should accept that report as a basis for further action. The report should contain both findings about the level of medical care provided to inmates with mental illness and/or developmental disabilities and recommendations supported by measurable objectives within a specified timeframe that will reduce or eliminate ineffective and disparately delivered healthcare for inmates with mental illness and/or developmental disabilities.

Adopt and implement the Recommendations of the Independent Expert

ODOC administrators and employees should work with the independent prison health expert to implement and troubleshoot the recommendations contained in the report described above for one year following the publication of the report.

Publicly Release the Independent Expert's Evaluation of ODOC's Success in Improving Medical Care for Inmates with Mental Illness and/or Developmental Disabilities after One Year

At the conclusion of the above-noted year, ODOC should publicly release the independent prison health expert's final report that describes 1) the effectiveness of ODOC's efforts to increase the quality of medical care provided to inmates with mental illness and/or developmental disabilities; and 2) any additional reforms that will be needed to ensure that inmates with mental illness and/or developmental disabilities receive effective medical care while in ODOC custody.

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Booking photo on front cover credit: Medford police

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Disability Rights Oregon is the Protection and Advocacy Agency for Oregon.

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Four Years Later:
Oregon Prison Overhauls Treatment of Inmates with Serious Mental Illness

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Learn more about our work to reform the criminal justice system in Oregon at: droregon.org/mental-health-rights-project.

Executive Summary

In 2016, Disability Rights Oregon (DRO) and the Oregon Department of Corrections (ODOC) signed a Memorandum of Understanding (MOU) that was aimed at improving conditions in the Behavioral Health Unit (BHU) at Oregon's only maximum security prison, the Oregon State Penitentiary. By signing that agreement, DRO and ODOC began a four-year[1] collaborative effort to transform the BHU from a dark, dangerous, and hopeless place into a more humane environment where both inmates with serious mental illness and staff who work with them could feel safe, and where inmates could leave their cells to receive mental health treatment.

Between January 8, 2016 and January 15, 2020, DRO monitored ODOC's progress toward achieving agreed upon benchmarks and found ODOC achieved the major goals of the MOU. As of January 2020:

- For much of 2019, the final year of the MOU, BHU inmates spent an average of more than 20 hours per week out of their cells.
- Most BHU inmates no longer stayed in the BHU for years at time.
- Approximately five to eight inmates per quarter were transferred to less restrictive units.
- Of the "long-term" inmates (i.e., men who have been in BHU for more than 18 months) approximately one per quarter were transferred to a less restrictive housing unit.
- Incidents of extreme self-harm and traumatic cell extractions that were once common in the BHU were rare by January 2020.
- BHU inmates received more effective mental health treatment in a new building with a level of dignity and confidentiality that was impossible earlier.

[1] The MOU expired on January 15, 2020. While the publication of this report was delayed due to the COVID-19 public health threat, the report is based on information gathered prior to January 15, 2020.

Background

On May 1, 2015, Disability Rights Oregon (DRO) issued "Behind the Eleventh Door," a report that documented a yearlong investigation of conditions in the Behavioral Health Unit (BHU) at the Oregon State Penitentiary (OSP). The report identified a culture at the OSP "that promotes unnecessary violence and retaliation by correctional staff" that resulted in Oregon inmates with severe mental illness being "routinely tasered, pepper-sprayed, isolated, and denied access to adequate mental health care." DRO concluded that the BHU had devolved into a hopeless and dysfunctional program where roughly 40 of the most severely mentally ill individuals in Oregon prisons spent 23 hours or more a day in tiny, stifling cells.

The report identified causes and made several recommendations for changes that would be necessary to restore the unit to its intended purpose: to provide effective mental health treatment in a humane and safe environment.

DRO's Investigation Led to a MOU to Improve the BHU

On January 8, 2016, DRO and the ODOC signed a Memorandum of Understanding (MOU) that was designed to resolve concerns collaboratively without litigation. The purpose of the MOU was to improve conditions within the four-year period of the agreement.

Specifically, DRO expected the agreement would deliver:

- more effective mental healthcare,
- a drop in the use of force against inmates, and
- a decrease in incidents of self-harm and attempted suicide.

The MOU's concrete, measurable benchmarks were stand-ins for the broader goal of creating a safer and more hopeful environment for inmates and staff.

The MOU created a process where DRO engaged in regular data reviews with ODOC leadership and made evidence-based recommendations to ODOC decision makers. The process developed under the MOU proved critically important for improving conditions at the BHU.

Results: Improved Conditions for Inmates with Serious Mental Illness

Increased Time Out of the Cell

The most important of those achievements is that inmates housed in the BHU spent more time out of their cells in therapeutic programming and interaction with others. It is well established that prolonged isolation only exacerbates mental illness and can result in serious harm and unsafe conditions. As of January 2020, the unit's average amount of time that inmates spent out of their cell each week exceeded the crucially important 20-hour per week goal of the MOU. Moreover, this level of improvement was consistently true for three of the final four quarters the MOU was in effect.

Long-Term BHU Inmates Transferred to less Restrictive Housing

Changes in the unit culture have meant that most inmates no longer stayed in the BHU for years at a time while their mental health needs are ignored and allowed to worsen. Instead, men who had lived in the unit for years without leaving their cells gradually learned that it was safe and worthwhile to do so. It is perhaps for that reason that a steady stream of BHU inmates, typically five to eight per quarter, were able to transfer to other less restrictive housing even though the average length of stay in the unit was not substantially reduced. About one inmate per quarter of what ODOC calls "long-term" inmates (i.e., men who have been in the BHU for more than a year and a half) have also transferred to less restrictive housing units during the four-year term of the MOU.[2]

Decline in Use of Force

Prior to DRO's 2015 investigation, inmates regularly reported forced cell extractions conducted by heavily armored cell extraction teams and cleanup crews tasked with mopping up pools of blood. In short, cell extractions are highly traumatizing for both staff and inmates. This report finds the use of force by Corrections Officers (COs) in the form of cell extractions—a regular occurrence in 2015—was infrequent in the BHU as of January 2020.

Decline in Incidents of Serious Self-Harm Behavior and Suicide

In 2015, incidents of serious self-harm occurred frequently, traumatizing both staff and inmates. By the end 2019, incidents of serious self-harm were less frequent in the BHU. If

[2] In 2016, ODOC issued its first quarterly report on its progress toward the goals of the MOU. The report indicated that the average length of stay for the nine inmates who were moved to less restrictive units during the quarter was 343 days. The average length of stay for all BHU residents was 250 days during that same quarter. ODOC's final quarterly report was issued in January of 2020. The report indicated that the average length of stay for long-term residents was 384 days and that the average length of stay for all residents was 307 days.

the MOU accomplished nothing else, these changes would be significant and worth the effort expended to achieve them.

Better Trained Staff and Increased Clinical Capability

In 2016, the shortage of Qualified Mental Health Practitioners (QMHPs) was so dire that a staff vacation or resignation would result in prolonged delays for inmates attempting to access behavioral health services. Since 2015, the number of QMHPs assigned to the BHU has increased significantly. As of January 2020, there was more redundancy in the clinical staffing of the unit so that a QMHP could take a vacation or resign without significantly delaying the provision of behavioral health services. Another critical improvement was the Department's hiring of a long–needed skilled psychiatrist to oversee the work of the QMHPs.[3]

DRO's 2015 investigation identified a destructive imbalance of power between security and clinical staff that allowed for security staff to inappropriately influence clinical treatment on the unit. DRO finds that over the four years of the MOU, ODOC was thoughtful in selecting COs who work in the BHU, which largely repaired the imbalance that DRO found. This meant better treatment plans and more effective collaboration between the COs and QMHPs who worked together rather than in opposition to one another.

ODOC credibly reports that turnover and resistance to BHU assignments have both decreased between 2015 and 2020. ODOC has reported to DRO that many COs and clinicians view working in the BHU as a desirable assignment where COs have the opportunity to work with better trained and supportive colleagues who share a goal of creating and maintaining a healthy environment for inmates and staff alike.

Built-to-Suit Space for Behavior Health Treatment

In 2016, inmates did not have access to a clinically appropriate space for behavioral health treatment. Further, what treatment spaces existed were not confidential, which exacerbated the challenges faced by QMHPs and inmates. At the conclusion of the MOU, inmates in the BHU were able to access more effective and confidential behavioral health treatment in a new treatment building. The new building is a great improvement that partially mitigates the problems caused by a living environment that was originally designed and built as a place of punishment.

Conclusions on the MOU's Success

This report marks the formal endpoint of the MOU.[4] In conclusion, ODOC has reached

[3] ODOC has contracted with this psychiatrist, but fully expects that the position will become a permanent one.

[4] The end of the MOU does not mark the end of a largely collaborative process that the MOU brought into being. In December 2019, ODOC agreed to continue providing DRO with data after the expiration of the MOU

or exceeded most of the target goals. More importantly, it has improved conditions for more than one hundred people who live and work in the BHU, and achieved these results in a manner that appears to be sustainable. It is hard to quantify what it means for BHU inmates to be able to live in a place where forced cell extractions, self-injurious behavior, and attempted suicide are no longer a common sight. The importance of these indicators of improvement at the BHU cannot be overstated, particularly having reached or exceeded the 20 hours per week of out of cell time during most of the past year.

Despite these improvements, unit inmates still spend a substantial number of hours in their cells with little to do and no social interaction, which is counter-therapeutic for people with serious mental illness.[5]

The COVID pandemic has made regular on-site visits to the BHU impossible, but DRO will continue to monitor progress within the BHU by other means. DRO maintains an active monitoring process for conditions within correctional facilities, with special focus on the ongoing isolation of prisoners with mental illness.

that will allow us to monitor its progress toward increased time out of cells and other important measures of conditions in the BHU.

[5] There are now TV's in most or all BHU cells although too many of them may not be functional at any given time. TVs are no substitute for out-of-cell social interaction and treatment, but they are an improvement over endless hours of nothing but three walls and a Lexan-covered doorway to the hellish environment that was the BHU in 2015.

Recommendations for Ongoing Improvement

The BHU is a small unit within the ODOC medical system, which is one of many components within Oregon's corrections system. DRO's federal mandates stretch beyond the agreement with ODOC. Under DRO's federal mandates, we recommend the following.

Continue Improvements in the Larger Healthcare System of ODOC

DRO recommends the Department view the improvements in the BHU as a foundation upon which additional improvements should be built throughout the healthcare system of ODOC.

This recommendation is acutely relevant to a Mental Health Unit (MHU) that houses nearly 100 individuals with serious mental illness at Two Rivers Correctional Institution (TRCI) in Umatilla. Within the ODOC system, MHUs house people with mental illness, but provide a lower level of treatment than the BHU.

TRCI is responsible for the welfare of roughly 1,700 to 1,800 incarcerated Oregonians, including many who deserve, and urgently require, effective mental health treatment. Following the 2015 publication of "Behind the Eleventh Door," DRO received a fairly sustained series of letters and calls about the MHU at TRCI. As was the case for the BHU, those letters and calls come from both inmates and staff members. They consistently describe recurring problems that suggest a poor match between the staff who work within the MHU and the clinical needs of inmates. In addition, DRO continues to receive complaints about an imbalance of power between clinical and security staff—a problem similar to the one found by DRO in the BHU in 2015. Those concerns have been confirmed by multiple visits by DRO to monitor the conditions and treatment of people with mental illness at TRCI.

Because of DRO's advocacy, ODOC has taken some action to reduce some of the most serious concerns at TRCI. However, it is clear that much needs to change if TRCI's MHU is going to meet the needs of people with mental illness housed in that unit.

Stop the Solitary Confinement of People with Disabilities

In 2016, the Vera Institute of Justice[6] made a series of recommendations to ODOC.[7] One of those recommendations that is still neither adopted nor implemented is especially relevant to incarcerated individuals with serious mental illness and other disabilities:

> "Prohibiting placing adults in custody with serious mental illness, severe developmental disability, or neurodegenerative diseases in any form of extremely isolating segregation."

While ODOC has shifted away from using the term "solitary confinement," isolation includes any setting, by any name, where a detainee rarely has meaningful contact with others. DRO finds the practice has continued under other names.[8] The use of solitary confinement throughout ODOC is especially problematic for individuals whose behaviors are the result of inadequate behavioral health treatment or poorly understood developmental disabilities.

DRO urges ODOC to systematically track solitary confinement—regardless of what it is called or the reason that it was imposed—and take immediate actions to end its use for people with mental illness and people with disabilities.

Continue ODOC's Current Efforts to Improve the Culture and Recognize the Humanity of Incarcerated People

ODOC has aggressively investigated the operation of other penal systems to consider how it might create what it now refers to as a more "humanized and normalized" system

[6] The Vera Institute of Justice (Vera) is an organization whose overall mission is "To drive change. To urgently build and improve justice systems that ensure fairness, promote safety, and strengthen communities." Under that broad umbrella, it has conducted a number of initiatives devoted to its area of work called "Bringing Dignity to Life Behind Bars," by, among other things, reducing the use of solitary confinement. It was in this context that Vera, with funding from the U.S. Department of Justice Bureau of Justice Assistance, launched the Safe Alternatives to Segregation Initiative in 2015. It was through this initiative that Vera partnered with Oregon Department of Corrections (ODOC) to assess ODOC's segregation policies and practices, analyze outcomes of that use, and provide recommendations for safely reducing the use of segregation and enhancing the use of alternative strategies.

[7] A copy of the Vera report and recommendations can be found here: https://news.streetroots.org/sites/default/files/Final_Report_ODOC-Vera_Safe_Alternatives_to_Segregation_Initiative_Oct20....pdf. See pages 4 to 5.

[8] Solitary confinement, or what inmates universally call "the hole," is generally understood to be the isolation of an individual in a cell for more than 22 hours per day, especially for long periods of time. ODOC effectively imposes solitary confinement under many names that include Administrative Segregation, Cell Ins, Suicide Watch, Loss of Privileges (LOPs). See also Nat'l Comm'n on Correctional Health Care, Position Statement on Solitary Confinement (Isolation), at https://www.ncchc.org/solitary-confinement (defining isolation).

where both staff and the individuals who are incarcerated within it are able to lead more productive and dignified lives. To that end, ODOC has participated in reciprocal visits with Norway, a country whose penal system is the envy of the world for many reasons, not the least of which is a recidivism rate that is only a fraction of what is typical in the United States and most other developed countries. ODOC's initiative to adopt at least some of the Norwegian practices is in early stages, but shows some progress according to indirect measures of effectiveness that include correctional staff wellness surveys, work absence, and staff turnover data. It is our hope that ODOC will expand this effort, but focus on more quantifiable data that capture the wellness of inmates in addition to staff.

Systemic Improvement Needed to Divert People with Mental Illness Away from Prison

DRO continues to believe that prisons are inappropriate environments for individuals with serious mental illness because they are ill-equipped to safely meet those individuals' needs. The acuity of their needs demands an environment where clinical concerns can be fully addressed in a setting suited to that purpose, including community-based options that are tailored to meet the needs of an individual. Even with improvements, prisons are ill-suited for this purpose. We hope that alternative models will be pursued by the Oregon State Legislature.

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