

**REPORT OF**

**AN INVESTIGATION INTO THE DEATH OF ROBERT NICHOLS  
WHILE HOUSED AT THE CHITTENDEN REGIONAL CORRECTIONAL  
FACILITY ON FEBRUARY 5, 2005**

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## I. INTRODUCTION

This report presents the results of the investigation conducted by Vermont Protection & Advocacy, Inc. (VP&A), into the circumstances leading up to the death of Robert Nichols on February 5, 2005 while at the Chittenden Regional Correctional Facility (CRCF).

On February 4, 2005 at approximately 3:30 AM agents from the Department of Alcohol, Tobacco and Firearms brought Mr. Nichols to CRCF in South Burlington from the Vermont State Police barracks in Rutland. Mr. Nichols was lodged as a federal detainee. At approximately 9:00 AM Mr. Nichols was transferred from CRCF to court and subsequently returned at approximately 1:30 PM because he was suffering from opiate withdrawal symptoms and could not go before the Judge. Upon his return to CRCF Mr. Nichols was placed in the Alpha Unit (segregation) and put on 15-minute special observation checks, per a report by the Superintendent.

At approximately 7:00 PM a correctional officer noted that Mr. Nichols was “detoxing” off heroin. At approximately 7:15 PM a nurse met with Mr. Nichols and she noted that detoxification orders were subsequently approved by the physician. The records demonstrate that Mr. Nichols’ was not seen again by anyone from the medical department until approximately 5:54 AM on February 5, 2005, when he was found deceased in his cell.

## II. Background

### A. **Robert Nichols**

Mr. Nichols was a 44-year old obese man with a history of alcohol and drug addiction and treatment for depression and anxiety. Mr. Nichols was self-employed throughout most of his adult life. Mr. Nichols leaves behind his wife Eva, his three step-children, his mother, four sisters and one brother.

### B. **Chittenden Regional Correctional Facility**

CRCF is a minimum-security jail located in South Burlington, Vermont. A mixture of employees from the Department of Corrections, Paul Cotton LLC, and Prison Health Services provided mental health and medical care during the times relevant to this investigation. The Superintendent of this facility is Jay Simons.

## III. CIRCUMSTANCES

### A. **Sequence of Events Leading To Incarceration**

On February 1, 2005, Mr. Nichols was arrested for possession of cocaine in Lebanon, New Hampshire and was lodged at the Grafton County Jail. The New Hampshire Police had contacted Mrs. Nichols to tell her where he was and that she could pick him up the following day after his arraignment in Court. About an hour after this

first phone call the police called back to inform Mrs. Nichols that they were transporting Mr. Nichols to Dartmouth Hitchcock Medical Center in Lebanon for treatment because he was showing symptoms of withdrawal. Mr. Nichols spent about 8 hours at Dartmouth receiving treatment. Once stable, Mr. Nichols was released into the custody of the police. The discharge diagnosis from Dartmouth was heroin use and respiratory depression. Mr. Nichols was subsequently released on bail and returned home to Brandon, Vermont.

On February 3, 2005 the Drug Enforcement Agency along with the Vermont State Police conducted a search of Mr. Nichols' home at which time Mrs. Nichols informed the officer that Mr. Nichols would be in need assistance with the withdrawal due to drug use. The Vermont State Police arrested Mr. Nichols on firearm charges and brought him to the barracks in Rutland. Mrs. Nichols also went to the barracks and informed another officer that Mr. Nichols would need assistance when he began to withdraw.

#### **B. Sequence of Events at CRCF**

On February 4, 2005 at approximately 3:30 AM agents from the Department of Alcohol, Tobacco and Firearms brought Mr. Nichols to CRCF in South Burlington where he was lodged as a federal detainee. Mr. Nichols was placed in a cell in the booking area at which time he was placed on special observation status<sup>1</sup> per a report from the Superintendent.

At approximately 9:00 AM Mr. Nichols was transferred from CRCF to Federal Court in Burlington. Another federal prisoner being arraigned that day (referred to as Inmate #1) reported observing Mr. Nichols in the holding cell at court that day. He reported that Mr. Nichols appeared to have difficulty breathing, was vomiting, was soaked in sweat, and was having difficulty walking. Two Federal Marshall's arrived and took Mr. Nichols back to CRCF.

According to a memo written by Jay Simons, Mr. Nichols was returned to CRCF at approximately 1:30 PM because agents reported he was suffering from severe withdrawal symptoms and could not go before the Judge. At 2:55 PM Mr. Nichols was placed in the Alpha Unit (segregation) and placed on 15-minute checks.

The records show that Mr. Nichols was not evaluated by medical staff upon his return from Court and before being placed in segregation.

At 7:00 PM the correctional officer on the Alpha Unit noted on the unit log that Mr. Nichols' was "detoxing" off heroin and further wrote, "keep an eye on him."

At approximately 7:00 PM another inmate (referred to as Inmate #2) in the unit

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<sup>1</sup> Vermont Department of Corrections, Suicide Prevention Protocol 361.01.13, VI. D. "Monitoring - Special Levels of Supervision, 3. Special Observation: A degree of observation reserved for the inmate who is actively suicidal, as demonstrated by threatening suicide, attempting suicide, developing suicidal plans or related behaviors. A. Inmates at this level must be observed by a designated staff member on a continuous, uninterrupted basis..."

reported hearing Mr. Nichols vomiting violently a few times in his cell. This inmate stated that he informed the correctional officer. This inmate reports that the correctional officer looked into Mr. Nichols cell door through the window and commented that he was “dope sick.” This inmate reported that later in the evening he again heard Mr. Nichols vomiting and again told the correctional officer Mr. Nichols was sick.

At 7:15 PM a nurse from the medical department documented that she received a call from the Alpha Unit asking that she come see Mr. Nichols because he was having withdrawal symptoms. At this time he was experiencing vomiting and tremors. The nurse documented that Mr. Nichols had a fever of 100.2 and slight tremors, and that he had vomited three times during the evening. The nurse noted that that she obtained “detox orders<sup>2</sup>” from physician.

At 9:00 PM an incoming inmate (referred to as Inmate #3) was placed in the same cell with Mr. Nichols in the Alpha Unit. This inmate reported that when he entered the cell Mr. Nichols was lying on the bottom bunk curled up in a ball with his face toward the wall. This inmate reported that from about 9:00 PM through 3:30 AM Mr. Nichols tossed and turned constantly. Then he reported that Mr. Nichols got up from his bunk four times during that period of time to vomit. This inmate stated that Mr. Nichols made an odd noise when he was breathing, like snoring and then catching his breath and waking up. At approximately 3:30 AM according to this inmate Mr. Nichols stopped tossing and turning and breathing strangely. He thought Mr. Nichols had finally gone to sleep. This inmate stated that throughout the night the correctional officer would shine his flashlight into the cell about once every hour and that no one ever opened the cell door for any reason between 9:00 PM and 6:00 AM on February 5, 2005.

At approximately 5:54 AM on February 5, 2005 a correctional officer opened the cell door to deliver the breakfast trays and discovered that Mr. Nichols was dead. The correctional officer’s incident reports states: “...*We both saw the above named resident on the bottom bunk, naked, discolored and eyes were open...I then said ‘he looks dead’ and called a “10-33 Medical Alpha Unit”...I had already observed Nichols as follows: A naked male laying on his back; defecation [sic] was obvious; blood had ‘pooled’ into the lower parts of the body touching the bunk and in his arm, which extended outward from the bunk; eyes open and non responsive; no chest movement indicative of breathing and body color. I had already touched the discolored foot (left) and noticed it to be cold. He was not responsive to touching of the arm nor his chest...*”

The nurse wrote in her incident report that Mr. Nichols appeared to have been deceased for about an hour.

An ambulance was called to the facility and Jay Simons was contacted. Subsequently the Vermont State Police were notified.

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<sup>2</sup> Physician Detox Orders: 1. Narcotic Detox Orders; (1). Ibuprophen 600-800mg, PO, BID, PRN x3D. (2) Immodium 2mg, PO BID, PRN x 3D. (3) Benadryl 25-50mg PO BID, PRN x 3D. (4) Phenergan 25mg, PO or PR BID, PRN x 3D. (5) Clonidine 0.1mg, PO BID PRN x 3 days (hold for systolic b/p <100).

#### IV. INVESTIGATION INTO THE DEATH OF MR. NICHOLS

VP&A's investigation included the following:

- ➔ Review of Mr. Nichol's Department of Correction's medical and mental health records.
- ➔ Review of Vermont Department of Correction's Protocols regarding medical and mental health treatment.
- ➔ Review of contract between Prison Health Services and State of Vermont, Department of Corrections.
- ➔ Review of records from the Dartmouth Hitchcock Medical Center.
- ➔ Review of records from Rutland Mental Health.
- ➔ Review of autopsy report from the Chief Medical Examiner's Office.
- ➔ Review of Department of Correction's records including but not limited to unit logs, special observation sheets and incident reports.
- ➔ Review of inmate interviews conducted by Prisoner's Rights and VP&A.

#### V. FINDINGS AND CONCLUSIONS

VP&A's investigation found evidence that the Department of Corrections and Prison Health Services contracted staff minimized the seriousness of Mr. Nichol's medical condition upon his incarceration at CRCF and failed to follow procedures regarding treatment. Mr. Nichols was in the Vermont Department of Corrections' custody for less than two days when he died.

Jay Simons, Superintendent at CRCF, wrote in his summary of the event "... Upon review of Nichols' medical file, core file, and the A unit Special Observation Logs it appeared that all of this documentation was in order and all procedures had been followed in Nichols' case." VP&A disagrees with this statement for the following reasons:

##### A. **Lack of Timely Medical Care**

On February 4, 2005 at 4:44 am a correctional officer completed the Intake Medical Screening form on Mr. Nichols. Even though it is documented on the form that Mr. Nichols was currently suffering from withdrawal and had consumed about 80 bags of heroin within the past three days, medical staff was not called

immediately by the correctional officer to assess his condition. Instead, Mr. Nichols was placed in a cell in the booking unit until he was transferred to court at 9:00 AM.

Vermont Department of Corrections, Health Care Services (481), IX. Responsibilities, Admissions Officer/Supervisor, A. Upon admission an Intake Medical History will be recorded regarding each inmate prior to his/her being given living arrangements...B. Any abnormalities will be referred immediately to medical staff (i.e., any yes answer to Intake Medical History...C. Any evidence of or report the use of medication or drug by admittee is to be reported [to] medical services staff."

Vermont Department of Corrections, Management of Chemical Dependency and Withdrawal, Protocol 361.01.08, V. Protocol, A. Management of Inmates who are Intoxicated: (1) Inmates who are suspected to be experiencing symptoms of drug or alcohol withdrawal will be referred to the health care unit for evaluation of their symptoms. (2) Officer training shall include recognition of signs and symptoms of recent ingestion and the appropriate course of action to follow.

The records show that Mr. Nichols was not seen by a nurse until 7:15 PM on February 4, 2005, approximately 14 hours after the initial intake was completed. From review of his medical record it appears the nurse did contact the physician and obtained detoxification orders. The DOC records are unclear whether or not the detoxification medication regimen was started due to poor documentation by the nurse. However, the Chief Medical Examiner's Toxicology Report notes the presence of the medications used for detoxification as listed on the DOC "Physician Detox Orders" form. The nurse did not initial the Medication Administration Record (MAR) on this date or at anytime on February 5<sup>th</sup> to indicate that the medications were given to Mr. Nichols nor are there any medical progress note that reflects that the nurse provided Mr. Nichols with the medication and his response to the medications. Even though Mr. Nichols was experiencing withdrawal symptoms worthy of a detoxification order no one from the medical staff ever followed up on his care for the rest of the night. According to Mr. Nichols' records he was never evaluated by a physician. DOC policy states that he should have been "...kept under a high level of observation"<sup>3</sup> while going through withdrawal. The nurse and/or physician failed to contact a mental health provider to assist in the evaluation of Mr. Nichols as is also required by the contract between Prison Health Services and DOC. His records demonstrate that he was not seen by medical staff after the 7:15 PM visit until after he was found dead in his cell the following morning.

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<sup>3</sup> Vermont Department of Corrections, Management of Chemical Dependency and Withdrawal, Protocol 361.01.08, V. Protocol, 3. "Inmates displaying more severe levels of intoxication or withdrawal shall be kept under a high level of observation by qualified health professionals or health-trained correctional officers. A transfer to a licensed acute care facility should occur when and if it becomes necessary."

State of Vermont Standard Contract for Personal Services between the Department of Corrections and Prison Health Services, Inc., V. Administrative Services, G., b. Detoxification, *“Detoxification treatments shall include the DOC Mental Health Provider in inmate evaluation and, if necessary, treatment plan development. Individuals committed under the influence of alcohol or drugs will be kept under close observation. The nursing staff will utilize established nursing protocols to monitor intoxicated individuals during the detoxification period. If the individual indicates a history or exhibits signs of an intense detoxification period, a physician will evaluate the inmate to determine whether hospitalization for evaluation and treatment is appropriate.”*

State of Vermont Standard Contract for Personal Services between the Department of Corrections and Prison Health Services, Inc., V. Administrative Services, II. Health Care Services, A. Intake Screening, *“Contractor shall conduct a receiving screening on all new commitments (including transfers) immediately upon the inmate’s arrival at the DOC facility and before the inmate enters the general population of the facility. The screening shall be conducted by a qualified medical professional... .”*

National Commission on Correctional Health Care (NCCHC), Standards for Health Services in Prisons (2003), P-G-06 Intoxication and Withdrawal, Compliance Indicators, 5. Inmates experiencing severe, life-threatening intoxication (overdose) or withdrawal are transferred immediately to a licensed acute care facility. 6. Individuals at risk for progression to more severe levels of intoxication or withdrawal are kept under constant observation by qualified health care professionals or health-trained correctional staff, and whenever severe withdrawal symptoms are observed, a physician is consulted promptly.

The NCCHC also reads (page 105): *“As a precaution, severe withdrawal syndromes must never be managed outside of a hospital. Deaths from acute intoxication or severe withdrawal have occurred in correctional institutions. In deciding the level of symptoms that can be managed safely at the facility, the responsible physician must take into account the level of medical supervision that is available at all times.”*

## **B. Informed Consent**

There was no informed consent form signed by Mr. Nichols in his Department of Corrections medical record.

State of Vermont Standard Contract for Personal Services between the Department of Corrections and Prison Health Services, Inc., II. Health Care Services, D. Informed Consent, *“The Contractor shall ensure that a patient’s informed consent is obtained prior to all examinations, treatments and procedures... .”*



### C. Special Observation Status

When Mr. Nichol's was found in his cell on February 5, it appeared obvious to those present that he had died. According to DOC protocol, when an inmate is placed on special observation status they are supposed to be "...*observed by a designated staff member on a continuous, uninterrupted basis.*" (See Footnote 1). According to the records there was no continuous observation of Mr. Nichols, only 15-minute checks. VP&A questions the thoroughness of the "15-minute special observation checks" that are documented as having been done by the correctional officer on duty. From review of all the incident reports submitted the consensus was that Mr. Nichols' had been deceased for a period of time and that he was found to be lying on his back, naked and had skin discoloration. VP&A fails to see how the correctional officer conducting the checks did not notice Mr. Nichols' condition at some point in the hour before he was found. The Special Confinement Report reads that at all the check intervals throughout the night (with the exception of one at 1:45 AM where it is noted that Mr. Nichols was "sitting on bunk") the correctional officer noted that Mr. Nichols "appeared asleep" even though his roommate reported he was up a lot throughout the night and had vomited approximately four times. The officer documented that he completed checks at 4:45 AM, 5:00, 5:15 and 5:30. It does not appear that the officer conducted the required 5:45 check. Mr. Nichols was found at approximately 5:54 AM while officers were delivering breakfast trays.

## VI. SUMMARY

Mr. Nichols death may have been prevented if the correctional staff and Prison Health Care contracted providers followed prescribed policies and had provided the appropriate standard of care. Had they taken a more active role in assuring he was receiving adequate medical care and follow up this tragedy may have been avoided. Had Mr. Nichols been in a medical facility receiving supervised medical care while he went through withdrawal instead of in a segregation cell where at best he received cursory window assessments the outcome could have been different. The Department was aware that Mr. Nichols was very sick upon arriving at CRCF. VP&A strongly recommends that the Department and Prison Health Services look more closely at how they assess and provide for detoxification of inmates so as to avoid any future tragedies. The lack of medical care and oversight in this case is very disturbing especially given the fact that Prison Health Services assumed the contract for medical care for the Vermont Department of Corrections on February 1, 2005 and within the first week Mr. Nichols died. The failure to follow policies, as documented in this report, was certainly a factor in Mr. Nichols death. The DOC was made aware that outside advocates and members of the public had serious concerns about Prison Health Services being awarded the contract given their history of neglectful care of inmates around the United States.

## VII. **RECOMMENDATIONS**

Based on its findings and conclusions, VP&A recommends that the following actions be initiated by staff and all contracted providers at all the correctional facilities in Vermont:

1. **Verifiable and ongoing staff training in recognizing and reporting behaviors that are potentially life threatening for the individual experiencing them.**
2. **Assure, through repeated testing, that policies, directives, and procedures are taught to all staff and contracted employees and that these rules are followed consistently.**
3. **Staff and contracted providers who violated policies or standards of care should be disciplined or terminated depending on the severity of violation.**
4. **The Department should provide Mr. Nichols family with an apology and a monetary settlement for failing to adhere to all their own policies in this case.**
5. **In the future facility personnel should complete a thorough review and compare the records to the Department's procedures before issuing a statement that staff followed all procedures.**
6. **The Department should strictly monitor the care provided by Prison Health Services and consider changing the manner by which medical care is provided within the Vermont system, i.e., making it a not-for-profit venture.**
7. **The Department should have an outside consultant review this case and issue a public report on the findings.**

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