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Press Release

June 22, 2010

Disability Rights Vermont (DRVT) announces its release of *An Investigation into the Death of Michael Crosby at the Chittenden Regional Correctional Facility on August 26, 2009.*

This report identifies individual and systemic problems that may have contributed to Mr. Crosby's untimely death less than twelve hours after being admitted into the correctional facility. The report also provides specific recommendations for changes in Department of Corrections' policy and practice that should be implemented immediately to prevent future similar tragedies. The investigative report and the response from the Department of Corrections can be found on:

www.vtpa.org/Investigative_reports.html.

DRVT is Vermont's protection and advocacy system for people with disabilities, federally empowered to investigate incidents of abuse and neglect and to protect their civil rights.

In this report DRVT identifies several critical areas of needed improvement in Department of Corrections' protocols and practices, including:

- Improving the process by which prisoners are identified as needing medical evaluation and treatment, particularly when there are issues of substance use and withdrawal. This must include referral to qualified medical providers when prisoners admit to have recently ingested illegal/non-prescribed substances or when the prisoners are noted to have signs of substance use upon admission.

DRVT is the protection and advocacy system for the State of Vermont.

Email at info@DisabilityRightsVT.org,

On the web: www.disabilityrightsvt.org

- Assuring that adequately qualified nursing staff, specifically Registered Nurses rather than Licensed Practical Nurses, are available at all shifts, including weekends, and that the nurses be required to actually provide and document assessment and treatment for incoming prisoners, rather than simply noting that the nurses were in a specific area of the facility at certain times.
- Implementing increased quality assurance to eliminate any perception on the part of DOC staff or contractors that violations of policies and procedures will go unnoticed and uncorrected, including the introduction of independent monitoring protocols by entities outside State government.

Also relevant to Mr. Crosby's death is the agreement reached between DRVT and the Department of Corrections creating new protocols for the Department's assessment and treatment of prisoners with withdrawal/detoxification needs. To view that agreement, please visit www.vtpa.org/Investigative_reports.html and click on [DRVT-DOC agreement on Detoxification-Withdrawal 11.05.09](#).

DRVT wishes to thank Mr. Crosby's family for their assistance in obtaining information about his death and for their permission to publish our report. DRVT hopes that the information contained in our investigative report will be useful to prevent similar future tragedies within the Department of Corrections.

For further information please call Ed Paquin or AJ Ruben at 1-800-834-7890.