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Vermont Protection & Advocacy, Inc. Releases Death Investigation Reports Concerning the Deaths of Neil Prentiss and James Quigley while in the Custody of the Vermont Department of Corrections

Vermont Protection & Advocacy, Inc. (VP&A), in furtherance of our federal mandate to protect and advocate for the rights of individuals with disabilities, today releases two Death Investigation Reports concerning the outcome of its investigations into the circumstances surrounding the deaths of Mr. Neil Prentiss on November 22, 2002 and Mr. James Quigley on October 7, 2003. These two reports add to the information regarding these two individuals' deaths that was made public by the Marks/McLaughlin Report commissioned by the Governor earlier this year. While VP&A agrees with many of the conclusions found in the Marks/McLaughlin Report regarding the deaths of Mr. Prentiss and Mr. Quigley, these reports add more details about the policies and standards that were violated by the Department and contributed to the deaths of these individuals. VP&A's investigative reports provide additional and specific recommendations for positive change within the Department of Corrections to prevent future deaths of Vermont inmates.

VP&A's report on Mr. Prentiss' death describes the failure of the Department to assure Mr. Prentiss received adequate medical care while incarcerated. Although Mr. Prentiss died outside the correctional facility, the report makes clear that the lack of adequate medical care within the facility was an important contributing factor to his untimely death.

VP&A's report on Mr. Quigley's death details a variety of rules, policies and standards that were violated by Department of Corrections' staff. The violations include failure to respond to both Mr. Quigley's written requests for help and to the Department's own independent expert who alerted the Department months prior to Mr. Quigley's death about problems on the unit in which Mr. Quigley died.

VP&A releases these two reports at this time in order to assure that the public is aware of all the relevant facts relating to the circumstances of Mr. Prentiss' and Mr. Quigley's untimely deaths. In addition, VP&A intends that the release of these investigative reports will assist the public, professionals and policy makers to maintain a focus on the problem of medical and mental healthcare services to Vermont's inmates with disabilities.

The two investigative reports can be viewed and downloaded from the VP&A website, vtpa.org, in the public and press folder. Any questions or comments regarding these reports may be directed to Ed Paquin, Executive Director of VP&A , at the telephone number and address listed above.