REPORT OF:

AN INVESTIGATION INTO THE CIRCUMSTANCES SURROUNDING THE DEATH OF LAWRENCE BESSETTE JR. ON MAY 22, 2003 AT THE NORTHERN STATE CORRECTIONAL FACILITY

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FINAL INVESTIGATIVE REPORT
February 12, 2004

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I. SUMMARY

This report presents the results of the investigation conducted by Vermont Protection & Advocacy, Inc. (VP&A), into the circumstances surrounding the suicide death of Lawrence Bessette Jr. on May 22, 2003, at the Northern State Correctional Facility in Newport, Vermont.

Since early in 2002, VP&A has been monitoring conditions facing Vermont's disabled inmates. The results of this investigation into the circumstances of Mr. Bessette's death are relevant to concerns raised by many prisoners, their family members, and advocates regarding the mental health treatment and environment facing Vermont inmates today.

This report details systemic failures on the part of two correctional facilities which together created circumstances that may have contributed to Mr. Bessette's suicide. This report focuses on specific rules, policies and protocols, issued by the Department, with authority over its contractors, which were violated during Mr. Bessette's short period of incarceration. These rules, policies and protocols are in place in order to protect inmates and assure their humane and appropriate treatment. When these rules, policies and protocols are violated or ignored, as they were in Mr. Bessette's case, the consequences are tragic.

VP&A intends this report to provide specific evidence of systemic failures which account for the environment and circumstances in which Mr. Bessette was not provided adequate mental health evaluation and treatment while incarcerated and subsequently committed suicide. Based on continued monitoring of conditions facing Vermont's disabled inmates, VP&A believes that the environment, circumstances, and weak enforcement of rules, policies and protocols affecting disabled inmates continues to be a source of serious risk to those inmates' well being. Recommendations are made at the conclusion of this report which, if implemented, VP&A believes will assist in preventing similar future suicides and other harm to Vermont's disabled inmate population.

On May 11, 2003, Mr. Bessette was transferred from the Chittenden Regional Correctional Facility (CRCF) in South Burlington, Vermont, to the Northern State Correctional Facility (NSCF) in Newport, Vermont. Mr. Bessette had been on 15-minute checks[1] quite frequently during his 12-day stay at CRCF. Once he was moved to NSCF, Mr. Bessette was placed on 15-minute checks by the shift supervisor for three days until seen by a mental health contractor, who removed him from the 15-minute checks on May 13, 2003.

[1] Department of Corrections Protocol 361.01.13 IV. Definitions, Special Suicide Watch *is a level of watch characterized by very close, nearly continuous, observation; documentation at 15 minute intervals.* Standard Suicide Watch *means physical checks at staggered or irregular intervals not to exceed every 15 minutes; documentation as observation occurs.*

On May 16, 2003, Mr. Bessette put in a sick slip[2] asking to see a mental health provider. On May 22, 2003 at 12:30pm, Mr. Bessette met with a mental health contractor who was employed by Matrix Health Systems. The mental health contractor noted at that time that Mr. Bessette was "stable." Mr. Bessette had requested medication to treat his symptoms, and was also referred by a mental health contractor to the psychiatrist for an evaluation, but received neither. On May 22, 2003, sometime between the hours of 3:07pm and 3:57pm, Mr. Bessette hung himself in his cell with his own belt. He was pronounced dead at North Country Hospital in Newport, Vermont at 4:44pm.

II. BACKGROUND

A. Mr. Bessette

Mr. Bessette was a 34-year-old white male who had a history of treatment for major depression and long-term substance abuse. Mr. Bessette had three children, two sons who resided with his former girlfriend of eight years, and one daughter who resided with another former girlfriend. According to records, Mr. Bessette considered attempting suicide in 2002 by hanging, however, he then began seeing a physician in the community and was put on medication. Mr. Bessette was lodged at CRCF on April 30, 2003, for violating probation.

According to Department of Correction's medical records, Mr. Bessette was diagnosed as being cocaine and alcohol dependent, and having an adjustment disorder with disturbance of conduct. Department records also noted a diagnosis requiring further evaluation to rule out antisocial personality disorder upon his April 30, 2003 admission to CRCF. Further evaluation revealed he was also suffering from depression

According to letters he had written to his family during this time, Mr. Bessette was despondent over the recent breakup with his girlfriend, who is also the mother of his two sons, and called her on several occasions while incarcerated trying to reunite, including on the day of his death. Mr. Bessette's roommate at NSCF stated that Mr. Bessette had told him that he was trying to get medicine from mental health and "…they basically told him, well we'll get around to it when we get around to it." Mr. Bessette also told his roommate earlier that morning that his girlfriend had left him.

B. Northern State Correctional Facility

The NSCF is a medium-security prison located in Newport, Vermont. This facility has no mental health unit. Contracted employees of Matrix Health Systems and Correctional Medical Services (CMS) provided mental health and medical care during the time relevant to this investigation. There was another untimely death of an inmate in

[2] Sick slip is the process by which inmates submit a written request to be seen by medical staff or mental health staff. There is a 3 working day response requirement for the Department of Corrections once they receive a slip from an inmate. Department of Corrections Protocol 361.01.03 Mental Health Intake Assessment, V, C.

the month prior to Mr. Bessette's death[3]. That inmate died of an apparent overdose. Autopsy and police reports have not yet been released pending further investigation.

C. Chittenden Regional Correctional Facility

The CRCF is a medium-security jail located in South Burlington, Vermont. This facility has no mental health unit. Contracted employees of Matrix Health Systems and Correctional Medical Services (CMS) provided mental health and medical care during the times relevant to this investigation. This facility housed both male and female inmates at the time of Mr. Bessette's incarceration.

D. Vermont Protection & Advocacy, Inc.

Vermont Protection & Advocacy, Inc. (VP&A) is an independent, private non-profit agency mandated by federal law to provide advocacy services on behalf of people with disabilities to ensure their rights are protected. See Developmental Disabilities Assistance and Bill of Rights Act, 42 U.S.C. § 15001 et seq.; Protection and Advocacy for Individuals with Mental Illness Act, 42 U.S.C. § 10801 et seq; 42 C.F.R. Part 51 et seq.

Under this federal mandate, VP&A has the duty and authority to investigate allegations of abuse and/or neglect involving people with disabilities, if the incident is reported to VP&A, or if VP&A determines there is probable cause that an incident of abuse and/or neglect occurred. Id. VP&A has jurisdiction to conduct investigations of alleged abuse and/or neglect in the following settings: hospitals, nursing homes, community facilities, board and care homes, homeless shelters, and jails and prisons. 42 U.S.C. § 10802(3); 42 C.F.R. § 51.2.

III. CIRCUMSTANCES SURROUNDING THE DEATH OF MR. BESSETTE

A. Sequence of Events at CRCF

Mr. Bessette was lodged as a detainee at CRCF on April 30, 2003.

Mr. Bessette's first contact with a mental health provider after his April 30, 2003, lodging was with a mental health contractor on May 1, 2003 when that contractor completed a Mental Health Evaluation form and a Mental Status Evaluation form. That mental health contractor placed him on 15-minute checks on May 1, 2003, but it is not clear from reviewing the record if he was on Special Suicide Watch or Standard Suicide

[3] VP&A is investigating the untimely death of an inmate at NSCF that occurred a month prior to Mr. Bessette's death.

Watch.[4] The Mental Health Evaluation form indicates Mr. Bessette's prior history of treatment with his outside physician and being prescribed medication. The evaluation also notes Mr. Bessette had a 20 year history of cocaine addiction. The Diagnostic Impressions as noted on this evaluation by this mental mealth contractor were: Axis I: Cocaine dependence and alcohol dependence, adjustment disorder with disturbance of conduct. Axis II: rule out antisocial personality disorder. That same day the contractor completed a Mental Health Treatment Plan / Progress Report for Mr. Bessette, which noted to continue him on 15-minute checks with a target date of May 2, 2003.

Mr. Bessette was given an Initial Needs Survey[5] (INS) at CRCF on May 2, 2003 by a correctional officer. This INS included three (3) responses which are "…critical items for which immediate attention is warranted" and required notification of the Shift Supervisor.[6] The supervisor's action was noted below on the same form, which read, "Seen immediately by mental health, per mental health does not need to be on 15 minute checks."

Mr. Bessette met again with the mental health contractor on May 2, 2003, at which time the contractor discontinued the 15 minute checks, noting "Denies current thoughts/plans/intent to harm self or others…remove from 15 min. √'s [checks], inmate informed he can request mental health for supportive counseling if he so desired."

On May 5, 2003, the mental health contractor met with Mr. Bessette again. It was noted in his medical record, "Last night I had sort of a breakdown. I thought of hanging myself or cutting myself. I was crying uncontrollably…" The record then instructed, "remain on 15 minute √'s [checks] due to ongoing suicidal ideation/fragile state, refer to tx [treatment] team."

This mental health contractor stated in an interview with VP&A that she first discussed Mr. Bessette's condition at the treatment team meeting on May 6, 2003, and that at least one contracted psychiatrist was present at that meeting. The mental health contractor reports the response was that because Mr. Bessette came in with drugs in his system, it would be at least three weeks before the psychiatrist would evaluate him for

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[4] Department of Corrections, Protocol 361.01.13, Suicide Prevention, V. Policy, …*An inmate is particularly susceptible to becoming suicidal immediately upon admission to a facility (including transfers), when intoxicated from alcohol or other drugs at the time of admission…*VI. Protocol B. Communication/Referral, (3) *The Shift Supervisor shall ensure that appropriate correctional staff are properly informed of the status of each inmate placed on suicide watch and an Authorization for Suicide Watch and Suicide Watch Observation Log shall be completed for all inmates placed on suicide watch.*

[5] Department of Corrections, Mental Health Receiving Screening, Protocol 361.01.01 IV. Definitions, Initial Needs Survey *is a system of structured inquiry and observation designed to prevent newly arrived inmates who pose a health or safety threat to themselves or others from being admitted to the facility's general population, and to identify those newly admitted inmates in need of medical care.*

[6] Initial Needs Survey, Scoring and Action Sheet, #4 *If you checked any of the non-shaded boxes which contained a *, notify the Shift Supervisor immediately. These are critical items for which immediate attention is warranted.* Department of Corrections Protocol 361.01.01-A.

any type of medication to treat his symptoms.

On May 6, 2003, another mental health contractor at CRCF met with Mr. Bessette. It was noted in his medical record, "…apparent low risk for harm today…will see upon request…d/c [discontinue] 15's."

On May 7, 2003, Mr. Bessette was seen in the medical office as documented by a registered nurse who wrote the following in Mr. Bessette's CMS Interdisciplinary Progress Notes: "IM [inmate] seems depressed and talks about suicide but denies having a plan…call to CO [correctional officer] and IM put on 15 minute checks …[Psychiatrist] aware. To be seen tomorrow by MH [mental health]… ." There was no written referral[7] form for mental health in his medical record for this date.

On May 7, 2003, the registered nurse also completed an *Intake Mental Health Screening and Assessment* form. The following questions and answers are noted on the left hand side of this form: Suicide Potential Screening: 1. Arresting or transporting officer believes subject may be suicide risk – answered yes. 6. Has psychiatric history (psychotropic medication or treatment) – answered yes. 8. Expresses thoughts about killing self – answered yes. 11. Expresses feelings there is nothing to look forward to in the future (feelings of helplessness and hopelessness) – answered yes. 13. Appears overly anxious, afraid or angry – answered yes. On the right hand side of this same form, the following questions and answers are noted: Psychiatric Screening: 1. History of psychotropic meds – answered no. This notation is in direct conflict with the information provided in Question #6 on the left hand side of the form. There is a comment noted at the bottom of this form, apparently attributed to Mr. Bessette: "I just got taken away from my family I have nothing to live for."

On May 8, 2003 at 12:30pm, the original mental health contractor met with Mr. Bessette. It was noted in his medical record, "…inmate quite candid about suicidal thoughts, which he continues to describe as 'intense' when he's having them, but that they 'come and go'. Reports extremely depressed mood with frequent crying spells and fear about his impulsivity…continue on 15 min. √'s [checks]…will discuss case in tx [treatment] tm [team] ... ."

On May 8, 2003 at 4:00pm, Mr. Bessette was seen by a different registered nurse who noted the following in Mr. Bessette's CMS Interdisciplinary Progress Notes: "I/M [inmate] to HC [health center]. MH [mental health] gave paper from I/M stating he had 'chest pains, irregular heart beat'…consult with MH… regarding future tx [treatment] plan. Place on MD/NP[doctor/nurse practitioner] list for FU [follow up]." There was no written referral form in his medical record for mental health.

On May 9, 2003, the mental health contractor met with Mr. Bessette again. It was noted in his medical record, "I have suicidal thoughts about every ten minutes. I feel

[7] DOC Protocol 361.01.02 Referral for Mental Health Services, V., B. *Mental health referrals by staff members (1) Any staff member who believes that an inmate may be in need of mental health services shall complete a Mental Health Referral form.*

more and more depressed…". The note goes on to state, "will remain on 15 min. √'s [checks] given frequency and intensity of SI [suicidal ideation]…will refer Mr. Bessette to see [psychiatrist]5/13/03 to evaluate for antidepressants given severity of symptoms and due to sx's [symptoms] actually getting worse over time."

On May 11, 2003, a licensed practical nurse completed a *Health Services Transfer Form* for Mr. Bessette pending his transfer to NSCF. The nurse indicated the following answers to relevant questions on the transfer form: Mental health special concerns: None; Mental health history: None; Follow up care: left blank; Pending consults/appointments: left blank; Mental Health Roster? Answered 'no'; Cleared by mental health for intra-system transfer: left blank; Date of last mental health assessment: 5/6/03 [incorrect date].

Mr. Bessette was transferred from CRCF to NSCF on May 11, 2003.

The original mental health contractor from CRCF stated in an interview with VP&A that on May 12, 2003, she called the psychiatrist again with her concerns regarding Mr. Bessette's signs of depression and was told to raise her concerns at the next treatment team meeting.

On May 13, 2003, the treatment team met at CRCF, at which time the mental health contractor was notified that Mr. Bessette had been transferred to Newport.

B. **Sequence of Events at NSCF**

On May 11, 2003, a registered nurse at NSCF, completed the *Health Services Reception Form* which noted the following answer to one question: 3) Referrals: (d) Mental Health – circled "no."

On May 11, 2003, a correctional officer, completed the *Initial Needs Survey* on Mr. Bessette. This survey contained three responses that are "…critical items for which immediate attention is warranted" and require notification of the Shift Supervisor. The Shift Supervisor did sign off under "Shift Supervisor Action" putting Mr. Bessette on 15 minute checks on this same date. *See footnotes 5 and 6.*

Also on May 11, 2003, the correctional officer completed an *Intake Medical Screening* form for Mr. Bessette. Mental health was marked with a question mark.

On May 13, 2003, a mental health contractor met with Mr. Bessette. It was noted in his medical record, "…pt currently placed on 15 √'s [checks] for high INS [Initial Needs Survey]…'Have thoughts of suicide but I have my boys.' Pt. denies any plan or intent, yet, reports sporadic thoughts. Pt. seeking medication for depressive sx's [symptoms]. Pt. reports sleep disturbance, emotional instability, and irritability…(+) [positive] (illegible) cocaine user with sporadic SI [suicidal ideation] thoughts. Hx [history] of suicide under the influence. Reports depression sx's but this could be

secondary to cocaine use. Stable, low risk of self-harm. Send for records[8], 30 √'s [minute checks] for 24 hr then d/c [discontinue]." Even though this mental health contractor noted to send for Mr. Bessette's outside records, there is no documentation or signed release indicating the records had been requested, as is required by protocol.[9] Mr. Bessette was housed in the Delta Bravo (DB) unit at NSCF.

The mental health contractor did not schedule Mr. Bessette at that time for medication evaluation to treat his depressive symptoms, even though Mr. Bessette was requesting medication, and his prior mental health records from CRCF indicate that the previous mental health contractor was referring him to the psychiatrist for medication evaluation. Nor was a scheduled appointment made for Mr. Bessette to meet with the psychiatrist even though the previous mental health contractor made the referral at CRCF for a May 13, 2003 appointment with the psychiatrist.

On May 16, 2003, Mr. Bessette submitted a sick slip to see someone in mental health. The slip read, "I am having a breakdown and I need to talk to a counselor." Mr. Bessette was not seen until May 22, 2003 (5 working days). S*ee footnote 2*.

On May 22, 2003 at 12:30pm, Mr. Bessette was seen by the mental health contractor. It was noted in his medical record, "'I just needed to talk with someone'…Pt reports his attorney suggested VOP [violation of probation] 60 days sentence. Pt. reports this is good news, optimistic about the offer…Pt with narcissistic traits and substance abuse. Reports futuristic thinking, hopeful about release and spending time with his wife and children. No need to ascertain records due to pt. increased affect, outlook and possible release in 60 days. Stable, not SI/HI [suicidal ideation/homicidal ideation]. See upon request."

On May 22, 2003, sometime between 3:07pm and 3:57pm, Mr. Bessette hung himself with his own belt from the top bunk in his cell. His roommate found him at 3:57.

May 22, 2003 at approximately 4:20pm, Mr. Bessette was transported to the North Country Hospital via Newport Ambulance. He was pronounced dead at 4:44pm.

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[8] Department of Corrections Protocol 361.01.03 Mental Health Intake Assessment, V. E. *If an inmate has a history of mental health treatment, the inmate's signed authorization for release of information from previous providers shall be secured at the time of the mental health intake assessment…The original signed authorization(s) shall be forwarded to the provider(s) and copies of the authorizations shall be filed in the inmate's medical chart.*

[9] Department of Corrections Protocol 361.01.07 Continuity of Care for Medical/Mental Health Services A. 1. b. *If an inmate has a condition for which previous health records would be helpful in providing continuity of care, the inmate will be asked to sign a Release of Information form…'* and 2. B. 1. c.(2) *The mental health staff member shall submit the form to the administrative staff who will then send for the requested information by mail, fax, etc.* and (5) *Documentation of these actions shall be noted in the inmate's mental health chart.*

IV. INVESTIGATIONS INTO THE DEATH OF MR. BESSETTE

A. Vermont Department of Corrections

The Vermont Department of Corrections conducted an internal investigation into the death of Mr. Bessette. Their report indicates that all procedures were followed and that staff handled the incident accordingly.

B. Vermont State Police

The Vermont State Police conducted an investigation into the death of Mr. Bessette on May 22, 2003. Upon review of the scene of the death, interviews with witnesses and Department of Correction's staff and the assistant medical examiner, the Vermont State Police concluded that Mr. Bessette had committed suicide by hanging. The police report did not address to what extent the Department of Corrections and its contractors complied with policies relevant to Mr. Bessette's care and treatment prior to his death.

C. State of Vermont Chief Medical Examiners Office

The State of Vermont Chief Medical Examiner's Office conducted an investigation into the death of Mr. Bessette The Assistant Medical Examiner in this case was present during the interviews of witnesses with the Vermont State Police, conducted a scene investigation, and photographed the body of Mr. Bessette at the hospital before it was released to the Medical Examiner. It was concluded to be a suicide by hanging.

D. Vermont Protection & Advocacy, Inc.

VP&A first learned of Mr. Bessette's death as a result of a news article in a local paper. On May 30, 2003, VP&A opened its own investigation, which included the following:

- ➔ Review of Mr. Bessette's medical and mental health record onsite at NSCF and later review of a copy of his file.
- ➔ Review of Vermont Department of Correction's Protocols regarding medical and mental health treatment.
- ➔ Review of Vermont Department of Correction's Report of the Untimely Death of Lawrence Bessette.
- ➔ Review of the Vermont State Police investigation report and supporting documents; interview with Vermont State Police detective in Derby.
- ➔ Review of the Chief Medical Examiner's autopsy report.

- ➔ Review of records from the North Country Hospital Emergency Room.
- ➔ Interview with the family of Mr. Bessette
- ➔ Review of personal letters written by Mr. Bessette to his family.
- ➔ Review of Mr. Bessette's medical records from outside physician.
- ➔ Interview with former Matrix Clinician who treated Mr. Bessette
- ➔ Review of records from Newport Ambulance Service.

V. FINDINGS AND CONCLUSIONS

VP&A's investigation found no evidence to suggest that Mr. Bessette's death was anything other than a suicide. This was also the conclusion of investigations conducted by the Vermont State Police, the Vermont Department of Corrections, and the Chief Medical Examiner's Office.

VP&A's investigation did find evidence that the Department of Corrections and its contracted agents, Matrix Health Systems and Correctional Medical Services, provided severely substandard mental health and medical care to Mr. Bessette. Mr. Bessette was in the Vermont Department of Corrections' custody for 23 days with no psychiatric evaluation or medication, despite repeated requests for help and admissions he was having suicidal thoughts and was feeling depressed. Numerous failures to abide by rules, policies and protocols on the part of a variety of staff may have contributed to Mr. Bessette's untimely death. These failures on the part of the Department of Corrections and its contractors could only have occurred in an environment that did not require strict adherence to policies and quality assurance in the provision of mental health treatment. The following sections, A-F, detail the specific violations VP&A uncovered during its investigations and the impact of the violations on Mr. Bessette's death.

A. Outside Records Request

No effort was made to obtain Mr. Bessette's outside medical records by mental health contractors at CRCF even though he reported that he had received treatment on the outside, including medications. The mental health contractor in Newport noted his intention to request Mr. Bessette's outside records initially, but then decided against it after the second visit with Mr. Bessette because Mr. Bessette seemed to be "stable." VP&A obtained copies of Mr. Bessette's medical records from his outside physician and the following significant findings were made:

(1) As far back as 1997, Mr. Bessette was being treated with Neurontin and Wellbutrin for a suspected mood disorder. In October of 1997 it was

noted "c/o [complaint of] wicked depression…admits to suicidal thoughts…notes anger, intense mood swings…depression".

(2) On November 27, 2002, Mr. Bessette went to the doctor because he was "…feeling down all the time…having voice tell him to hurt self, took rope/made into noose to hang self…major depressive episode, severe with psychotic features. Candidate for antidepressants. F/u 12/3/02."

(3) On December 4, 2002, "Will start with mood stabilizer. Neurontin 300mg…patient will recheck in one week at which time an SSRI [Selective Serotonin Reuptake Inhibitors] will be added, probably Prozac for increased Serotonin."

Mr. Bessette was a person who needed and benefited from psychiatric interventions, including medications.

B. Suicide Watch Documents

Mr. Bessette was routinely on and off 15-minute checks, or suicide watch[10], while at CRCF. However, there are no *Authorization for Suicide Watch* or *Suicide Watch Observation Log* forms in his medical record[11]. (*See also footnote 1 and 4).* There is also no documentation at CRCF as to what type of cell Mr. Bessette was placed in while on these 15-minute checks[12]. And as noted earlier in this report, the type of watch Mr. Bessette was placed on was not documented in his record, i.e., **standard observation** versus **special observation**. Had the mental health contractors' documentation required a special observation status, the psychiatrist would have had a duty to evaluate the patient before he could be removed from this type of observation.[13]

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[10] Department of Corrections Protocol 361.01.13, Suicide Prevention, Definitions, *Suicide Watch: defines a level of increased supervision and observation of inmates believed to be at risk of suicide. Two levels of watch are possible: constant (continuous) and close. Watch may be authorized by mental health staff or supervisory correctional personnel.*

[11] Department of Corrections Protocol 361.01.13, Suicide Prevention, VI. Protocol, F. 4. *Copies of the Authorization for Suicide Watch and Suicide Watch Observation Sheet forms shall be filed in the inmate's medical chart.*

[12] Department of Corrections Protocol 361.01.13 Suicide Prevention, Definitions, *Safe Cells: designated cells located within each institution for placement of inmates on watch status. With few exceptions, these cells should be located in the infirmary or mental health unit or booking unit; such cells are never to be located in administrative segregation units. Safe cells must allow unobstructed visibility to all areas of the cell and contain no hooks or other places to hang oneself.* And VI. Protocol B. 1. …*An inmate suspected of being suicidal shall be housed in the facility crisis cell (safe cell) or other secure housing and placed on suicide watch until seen by clinical staff.*

[13] Department of Corrections Protocol 361.01.13, D. Monitoring – Levels of Supervision, 3. Special Observation, d. *This level of observation may only be discontinued by a psychologist or psychiatrist after a face-to-face assessment of the inmate.*

C. Transfer Between Facilities

Likewise, when Mr. Bessette first arrived at NSCF, a shift supervisor put him on 15-minute checks on May 11, 2003. There was no documentation in his medical record as referenced in the paragraph above regarding those checks other than on the INS. There is also no documentation to show what kind of cell Mr. Bessette was housed in while on 15-minute checks. Those checks were subsequently discontinued by the mental health contractor there.

The CRCF mental health contractor's May 9, 2003, recommendation that Mr. Bessette be evaluated for possible medications to treat his depression (by the psychiatrist) was not implemented when Mr. Bessette was transferred to NSCF in Newport. The Correctional Medical Services staff at CRCF played a tragic role in ensuring that Mr. Bessette was not scheduled with either a physician or a psychiatrist by incorrectly documenting his mental health history and needs on the transfer form, which is a violation of Department protocols[14]. Staff at CRCF also failed to have a mental health provider review and sign off on the transfer of Mr. Bessette to NSCF as indicated by the fact that the transfer form was blank under 'cleared by mental health'.[15]

D. Other DOC Procedural Failures

Several procedural steps were not adhered to upon Mr. Bessette's arrival and subsequent stay at NSCF. According to Department of Corrections' protocol[16], a mental health intake assessment is supposed to be completed within 7 days of an inmate's admission to a central facility. No *Mental Health Intake Assessment* form could be found in Mr. Bessette's medical record after his transfer to NSCF.

The *Problem List* in Mr. Bessette's medical record was left blank. According to Department of Corrections' protocol[17], there is specific information that must be recorded on the *Problem List* for each inmate. CRCF and NSCF both failed to document information on this form.

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[14] Department of Corrections Protocol 361.01.07, V., A., 2., b, (1): *When an inmate is transferred to another DOC facility, the top portion of the Intrasystem Transfer Summary form will be completed by the sending facility identifying current problems, medications and outstanding appointments/consultations.*

[15] Department of Corrections Protocol 361.01.07, V. A., 2.a.(1): *All inmates who are transferring to another facility within VDOC will have their mental health records reviewed by the designated mental health staff prior to transfer.*

[16] Department of Corrections Protocol 361.01.03 Mental Health Intake Assessment, V. Procedure, A. *A Mental Health Intake Assessment will be administered to all inmates by medical staff within 14 days of admission or earlier upon referral. At central facilities, this assessment must be administered within 7 days.*

[17] Department of Corrections Protocol 361.01.06 Individualized Treatment Planning, V. Protocol, B. Treatment Planning, 3. *In addition to completing the mental health treatment plan, each problem identified must be documented on the Problem List located at the front of the medical chart. In this way, only the number of the problem need be referenced on the treatment plan form.*

One of the CMS employees at CRCF failed to document on Mr. Bessette's transfer form on May 11, 2003 that his last mental health evaluation was completed May 1, 2003 and was present in his medical record that was being sent to NSCF. Subsequently, the mental health contractor at NSCF failed to document in Mr. Bessette's medical record that he reviewed Mr. Bessette's prior mental health evaluation and related documentation[18].

And even though Mr. Bessette was being seen routinely by mental health contractors at CRCF for severe symptoms of depression including suicidal ideation, there is no documentation in his medical record why he was never included on the *Mental Health Roster.*[19] While a mental health contractor did attempt to discuss Mr. Bessette's case at the treatment team meetings, and had made more than three contacts with him for mental health purposes, there is no documentation that the treatment team considered inclusion of Mr. Bessette onto the roster.

Another failure on the part of CMS staff at CRCF and NSCF included failing to satisfy their duty to manage the symptoms that Mr. Bessette's record noted he was suffering in regard to an alleged cocaine addiction. While medical staff had a duty to manage these symptoms as stated in the Department's own protocols, they failed to do so as evidenced by complete lack of records noting any such treatment.[20] A physician never saw Mr. Bessette from April 30, 2003 until his death on May 22, 2003.

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[18] Department of Corrections Protocol 361.01.04 Mental Health Evaluation, V. 2. a. *due to the fact that a majority of inmates admitted to central facilities are sent from regional facilities where the mental health evaluation may already have taken place, it need not be repeated if it has been done within the preceding three months.* b. *in such cases, the sending facility must document on the transfer form that the mental health evaluation is present in the inmate's medical chart and mental health staff at the receiving facility must document that they have reviewed the evaluation and related documentation.*

[19] Department of Corrections Protocol 361.01.12 Mental Health Roster: Admission/Discharge Criteria, V. Protocol, 3. *The inmate's case will be discussed at the weekly mental health team meeting and inclusion on the mental health roster will be determined by the team. This discussion and decision and decision process shall be completed following no more than three contacts with the inmate.* 4. *An inmate may be included on the mental health roster if it appears that active mental health treatment is needed on an ongoing basis. This would include individuals with acute or chronic mental illness, those undergoing continued psychopharmacotherapy, and those with significant psychiatric symptoms related to their incarceration.* 8. *If an inmate is not included on the mental health roster, a note must be placed in the inmate's chart documenting the reasons for this decision. Alternative options for treatment may be discussed with the inmate.*

[20] Department of Corrections Protocol 361.01.08, Management of Chemical Dependency and Withdrawal, V. Protocol, B. Management of Inmates Experiencing Acute Withdrawal, 2. *Treatment and observation of inmates manifesting mild or moderate symptoms of withdrawal from alcohol or other drugs (b) detoxification of these individuals remains a medical issue and should be managed by the medical staff. Mental health staff shall be consulted for the following: (1) when an inmate has special emotional needs at the time of detoxification such as suicidality; and (2) questions related to any potential relationships between substance abuse and mental illness.*

E. Failure of Supervision at NSCF

Aside from the lack of adequate mental health treatment that may have contributed to the death of Mr. Bessette, there is also some discrepancy regarding what time the correctional officer on duty the day of Mr. Bessette's death in the Delta Bravo Unit actually found Mr. Bessette hanging in his cell. The correctional officer documented on the NSCF Unit Travel Log on May 22, 2003, that he conducted a 'unit tour' at 3:05p.m. The correctional officer stated in his interview with the Vermont State Police that the last time he had checked on Mr. Bessette was around 3:07p.m. and he was in his cell, locked in. This correctional officer also noted on the Unit Travel Log that he conducted a unit tour at 3:35p.m., and following that at 3:35pm he noted the "10-33 DB medical." The correctional officer stated that Mr. Bessette's roommate came back from recreation time somewhere around 3:30pm and motioned to the correctional officer that Mr. Bessette was hanging.

This correctional officer's accounting of the time does not coincide with the times given by other personnel involved in responding to this incident. All other personnel interviewed by police who responded to the call for help identified 3:57p.m. as the approximate time of the call. Mr. Bessette's roommate stated to the Vermont State Police that he came back from the recreation yard around 3:30pm and "…noticed there was a sign up on the door saying he's going to the bathroom, so I stayed downstairs until the officer called head count at 4:00, around 4:00." This contradicts the correctional officer's assertion that the roommate found Mr. Bessette around 3:35pm upon arriving back from the recreation yard. No action on the part of the Department to acknowledge this contradiction or discipline the officer if there was a violation of rules has been made known to VP&A.

Another disturbing fact regarding Mr. Bessette's death is that Cardiopulmonary Resuscitation (CPR) was not immediately started by the correctional officer upon his taking down Mr. Bessette's body. The correctional officer indicated in his statement to the Vermont State Police, when asked if he performed CPR on Mr. Bessette, "No, sir, the medical staff and, were right at the door. I allowed them in because I was unit officer, I had to take care of the unit." The Vermont State Police detective then asked the correctional officer within how many minutes or seconds of the discovery would that have been? The correctional officer answered, "With, inside, way inside of five minutes." This failure to immediately start CPR is a violation of the Department's protocol.[21] Again, no action on the part of the Department to acknowledge this failure or discipline the officer if there was a violation of rules has been made known to VP&A.

[21] Department of Corrections Protocol 361.01.13 Suicide Prevention, E. Intervention, 2. Intervention for suicide attempts (a) *When an inmate is discovered hanging, having made a potentially lethal cut, is unconscious or seriously disoriented, staff will immediately initiate appropriate first aid measures including, but not limited to, cutting the apparatus that is choking the inmate, calling for assistance and initiating CPR.* (b)(2) *Staff shall never wait for medical personnel to arrive before initiating life-saving measures.*

F. Other Findings

VP&A is also concerned that the Department's own internal investigation procedure is flawed. Besides not noting the discrepancies identified above, the scope of the investigation is too narrow to be an accurate accounting of the entire event.

Aside from Department protocols already noted as having been violated in this case, VP&A also finds the following were violated as well:

■ DOC Directive 361.01 Mental Health Directive II. Purpose, *The mission of the Vermont Department of Corrections' (VDOC) mental health services is three-fold: (1) to provide comprehensive clinical services to alleviate symptoms and reduce suffering; (2) to enhance the safety of the correctional facility environment for inmates, staff and visitors; and (3) To ready inmates with mental illness for participation in risk reducing programs through direct services, case coordination, and research evaluations."*

This directive was violated as evidenced by the fact that Mr. Bessette did not receive adequate mental health treatment as he was not evaluated by a psychiatrist even though several attempts were made at CRCF to have him evaluated, and he was not receiving medication to treat his depressive symptoms, which may have contributed to his untimely death.

■ DOC Protocol 361.01.14 Psychotropic Medications, V. …*Medications will be prescribed based on clinical presentation, mental health diagnosis and in accordance with the prevailing standard of care in the psychiatric community.* D. 7. *Medication management of inmates with substance abuse problems; C. When a question of major mental illness exists, or when an inmate is intransigent about reformulating his or her problems and persists in seeking medication, the psychiatrist should consult with the primary mental health provider in the development of psychiatric intervention. E. 1. Psychiatrist documentation (a) initial psychiatric evaluation shall be recorded as indicated in the Mental Health Evaluation policy and made a permanent part of the inmate's mental health record, and shall include the clinical rationale for any medication prescribed.*

This protocol was violated as evidenced by the fact that Mr. Bessette had a substance abuse problem and was also seeking medication. Per the mental health contractor at CRCF, and documentation in Mr. Bessette's medical record, the psychiatrists contracted to provide care for Vermont's inmates were notified of Mr. Bessette's condition, yet did not evaluate him as per this protocol.

VI. EXPERT OPINION

An independent psychiatrist had an opportunity to review this investigation report and contributed the following opinion:

"Many of the procedures that were not followed represent accepted standards of care in all treatment settings…It is clear to this writer that there were multiple areas where the standard of care was not rendered and these breeches in standard of care contributed to the unfortunate outcome for Mr. Bessette."

VII. RECOMMENDATIONS

Based on its findings and conclusions, VP&A recommends that the following actions be undertaken by staff and all contracted employees at the Chittenden Regional Correctional Facility, the Northern State Correctional Facility, and the Department as a whole:

1. **Verifiable and ongoing staff training in recognizing and reporting behaviors that are potentially life threatening for the individual experiencing them.**

2. **Requiring psychiatrists to spend enough time in facilities to adequately assess the mental health needs of inmates.** Psychiatrists have the ultimate duty to provide mental health treatment to inmates when those inmates are referred to them. The psychiatrist must ensure that when an inmate has been referred for psychiatric evaluation and that inmate is transferred before the psychiatrist has had a chance to evaluate that inmate, that the receiving facility be aware of the need for an immediate psychiatric evaluation. A system to verify the actual amount of time psychiatrists spend with individual inmate/patients is strongly recommended.

3. **Assure that outside records are obtained when an inmate is lodged who has a history of mental illness or is experiencing symptoms of a mental illness.** In Mr. Bessette's case, CRCF did not request records, and the clinician at NSCF made the arbitrary decision to not request Mr. Bessette's outside records because Mr. Bessette seemed to be getting better. Had anyone taken the time to access his outside records, they would have found valuable information relating to Mr. Bessette's past mental health history. This process is currently required by Department of Correction's policy, but does not appear to be carried out consistently. VP&A strongly suggests the implementation of a program to both adequately train staff in the importance of obtaining these outside records and to assess adherence to this requirement.

4. **Continuity of Care.** Medications that were being taken on the outside before incarceration must be consistently verified and continued upon an individual's incarceration. The Department of Corrections' practice of 'base-lining' inmates for 14 days, or longer in some instances, when they have a substance abuse history creates an unnecessarily long length of time before an incarcerated individual is able to receive medications they were previously prescribed. This practice is not specifically allowed by the Department's rules, and particularly in the absence of any medical or therapeutic intervention regarding the effects of withdrawal, is unacceptable and must be addressed.

5. **Assure through repeated testing that policies, directives, and procedures are taught to all staff and contracted employees, including the psychiatrists, and that these rules are followed consistently**.

6. **The Department of Corrections should change its internal investigation procedures.** As demonstrated by Mr. Bessette's death, the Department must broaden the lens of its internal investigations to take into account all aspects of an inmate's incarceration when investigating a death and should review the medical and mental health records. When factors such as described in this report are relevant to a suicide, yet are not included in the Department's investigation, the conclusions of any such report are not comprehensive or conclusive. In addition, when a valid investigation is completed and errors or violations are uncovered, the Department should acknowledge them and demonstrate to the parties affected, and the public, what actions the Department has taken to impose discipline or remedy the situation.

7. **Appoint an independent review panel to provide oversight of mental health and medical treatment services provided to Vermont's inmate population.** VP&A strongly suggests that appointing an independent review panel, made of former inmates, advocacy groups, and attorneys familiar with the Department of Corrections, to oversee quality assurance programs and report to the Commissioner is an appropriate step to take to regain public confidence in a system which has recently experienced several untimely deaths and allegations of substandard care. Such an independent review panel will ensure that there is transparency and accountability within the Department. In addition, utilizing outside resources for the panel will provide different perspectives and problem solving skills to the difficult task of providing adequate services to Vermont's inmate population.

VIII. CONCLUSION

Mr. Bessette committed suicide at the NSCF after having voiced suicidal feelings several times while incarcerated at CRCF and NSCF between April 30, 2003 and May 22, 2003. The Department of Corrections and its contractors did not follow numerous rules, policies and protocols during this time period. Together these failures created circumstances in which Mr. Bessette did not obtain mental health treatment appropriate to his condition and as required by accepted standards of care and the Department rules. Mr. Bessette's death may have been avoided had all rules, policies, protocols and applicable treatment standards been satisfied. The Department's own investigation of Mr. Bessette's death did not review all the relevant circumstances, did not acknowledge all failures, and did not demonstrate with transparency what remedial actions would be taken as a result of Mr. Bessette's death. In order to prevent future suicides and other self-harming behavior by Vermont's disabled inmate population, verifiable training of all staff regarding relevant issues and rules, quality assurance programs to track adherence to the rules, and outside oversight of services should be instituted immediately.