

**REPORT OF**  
**AN INVESTIGATION INTO THE CIRCUMSTANCES**  
**SURROUNDING THE DEATH OF**  
**JAMES QUIGLEY**  
**AT THE NORTHWEST STATE CORRECTIONAL FACILITY**

*Tina Wood*  
Advocate/Paralegal

*A.J. Ruben*  
Supervising Attorney

*Ed Paquin*  
Executive Director

Vermont Protection & Advocacy, Inc.  
141 Main Street, Suite 7  
Montpelier, Vermont 05602  
(802) 229-1355

[www.vtpa.org](http://www.vtpa.org)

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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 surrounding the suicide death of James Quigley on October 7, 2003, at the Northwest State Correctional Facility in St. Albans, Vermont.

Mr. Quigley was a 52-year old white male serving a life sentence for a conviction of first-degree murder and attempted murder in Florida. In February 2001 he was transferred from Florida to Vermont and was housed at the Northern State Correctional Facility (NSCF) in Newport, Vermont. Vermont participates in the exchange of prisoners with other states under the Interstate Prisoner Compact. Mr. Quigley was described as a “jail house lawyer” who helped other inmates with legal issues. Mr. Quigley was also an outspoken critic of the Department of Correction’s (DOC) system and routinely filed grievances.

In July of 2002, Mr. Quigley was moved from NSCF to the Northwest State Correctional Facility (NWSCF) in St. Albans and placed in a segregation cell in the D-Unit. The move occurred, according to DOC officials, because he was deemed a security risk due to maps of Vermont that were found in his possession and informants who stated he was planning an escape.

Mr. Quigley’s caseworker at NWSCF wrote to the Director of Offender Classification suggesting that Mr. Quigley be sent back to Florida because he was a security risk. The case worker noted that “[T]his inmate like [sic] to write tons of greiviences [sic] over petty issues. Also a legal paper pusher.”

While Mr. Quigley at the time of his initial incarceration in Vermont was not considered an individual with a mental illness, his DOC medical and mental health records show that in the months preceding his death his mental status began to deteriorate, most likely due to continual segregation and emotional abuse by particular correctional officers at NWSCF.

Mr. Quigley hung himself in his segregation cell at NWSCF on October 7, 2003, sometime before 6:10am.

## II. Background

### A. James Quigley

Mr. Quigley was a 52-year old male who was convicted of murder and attempted murder in 1980 in Florida. He was transferred to NSCF in Newport in February 2001. Mr. Quigley was never a disciplinary problem, though often at odds with the administration in Newport. He strived to make the system better for all people incarcerated and to that end he acted as an advocate for other inmates who needed assistance. Mr. Quigley was routinely in contact with VP&A via letters with the intent of

bringing attention to a wide variety of issues within the DOC. He is survived by his sister and his mother.

**B. Northern State Correctional Facility**

The NSCF is a medium-security prison located in Newport, Vermont. This facility has no mental health unit. Contracted staff from Matrix Health Systems and Correctional Medical Services (CMS) provided mental health and medical care during the time relevant to this investigation.

**C. Northwest State Correctional Facility**

The NWSCF is a medium-security prison located in St. Albans, Vermont. This facility has a mental health unit. Contracted staff from Matrix Health Systems and Correctional Medical Services provided mental health and medical care during the times relevant to this investigation. The D-Unit where Mr. Quigley was housed is the facility's segregation unit.

**D. Vermont Protection & Advocacy, Inc.**

Vermont Protection & Advocacy, Inc. (VP&A) is a federally-funded, non-profit whose mission is to advance and protect the rights of individuals with disabilities. VP&A is mandated to investigate abuse, neglect and rights violations among this population wherever they may reside, e.g., in the community, private hospitals, residential care homes, or prisons and jails.

**III. CIRCUMSTANCES SURROUNDING THE DEATH OF JAMES QUIGLEY**

**A. Sequence of Events at NSCF**

On May 20, 2003, Mr. Quigley attended a Recreation Committee meeting of which he had been a member since 2001. According to a letter from Mr. Quigley, at that May meeting the Superintendent of NSCF made a request to spend \$900 from the recreation fund to pay for flowers and seeds. Mr. Quigley and another inmate on the committee voiced their opposition to this request as they did not feel the expenditure met the criteria outlined for the fund.

On June 3, 2003, according to a letter from Mr. Quigley, he was informed by the local Recreation Services Coordinator that the superintendent no longer wanted out-of-state prisoners on the Recreation Committee. Mr. Quigley and the other inmate noted above were removed from the committee. Prior to Mr. Quigley's removal from the Recreation Committee he had also been arbitrarily removed from his job in the law library while he was in Newport, a job that provided him with literary enjoyment and allowed him to help other inmates. From what Mr. Quigley had reported to VP&A, it would appear the decision to remove him from the law library was a form of

administrative retaliation for Mr. Quigley filing grievances and assisting other inmates in filing grievances.

On June 11, 2003, Mr. Quigley, who had been residing without incident at NSCF since being transferred there in February 2001, was placed in segregation based on allegations that he was planning an escape.

In a computerized case note acquired from NSCF, Mr. Quigley's case manager wrote on June 11, 2003: *"Quigley had a hearing via phone today with the Florida Parole commission. The call took about 15 minutes where James discussed possible employment if paroled and circumstances around his crime. James was told by the commission that he would hear something definite [sic] after the board makes there [sic] discision [sic] looks like it may be possible Parole in 2013. James was upset with this discision [sic] and said it was not what he wanted to hear. I placed James on 15 minute check for behavior for his safety [sic]."*

A case note dated June 16, 2003 read: *"Mr. Quigley was placed in SMU [Special Management Unit] on Ad. [Administrative] Seg [Segregation] status on June 11, 2003. He is awaiting an AD seg hearing."*

On June 19, 2003, Mr. Quigley submitted a CMS Health Services Request Form stating: *"Since I was placed in SMU, I have been unable to get any quality sleep. It seems like every little sound, including my heart beat, awakens. I also have no appetite, and it appears as though I've lost a lot of weight."*

On June 21, 2003, Mr. Quigley was seen by a registered nurse who noted, *"[A]lteration in coping r/t SMU housing. Refer to MH [mental health]."* Mr. Quigley was put on sleep checks by the mental health contracted clinician on June 24, 2003.

A case note dated July 16, 2003 states: *"...Mr. Quigley is currently on Administrative Segregation status at the NSCF with a review date of July 17, 2003. Mr. Quigley has been placed on the Administrative status due to a potential risk of flight and possible retribution to what Mr. Quigley believes is a confidential informant in the facility. Discussion was had in regards to placement of Mr. Quigley should the Administrative Review allow him to return to general population and/or not. The plan from this group was for inquiry to movement to NWCF if the Due Process Hearing allows Mr. Quigley to return to general population status. If the decision is for continued Administrative status then he will be reviewed for continued placement in the SMU Unit."*

A case note dated July 17, 2003 states: *"James Quigley has been reviewed by the Administrative Due Process this morning and the determination has been to discontinue the Administrative Segregation. The Superintendent has concurred [sic] with this decision. The case plan has now been reviewed and Mr. Quigley has been overridden to close custody and is currently being moved to the NWCF for close custody housing. Further case planning will be developed through the NWCF and be determined*

by Mr. Quigley's behavior.”

**B. Sequence of Events at NWSCF**

On July 17, 2003, Mr. Quigley arrived at NWSCF. He was initially housed the first night in booking. On July 18, 2003, he was moved into the D-Unit. A *Mental Status Evaluation* was completed on July 18, at which time a note was made on the top of the form which read: “Admits to suicidal thinking at times, no risk at this time.”

On July 22, 2003, Mr. Quigley submitted a grievance #1 stating that since his arrival on July 17 he had no opportunity to exercise. The response to his grievance by a correctional officer on July 23, 2003, read: “Mr. Quigley arrived at NWCFS on 7/17/03. On 7/18/03 Mr. Quigley was moved to Delta Act #3 due to lack of bed space. On 7/20/03 Mr. Quigley was moved into D-46 and was allowed full privileges of Delta Unit...Recommendation: None needed. Mr. Quigley has from approx. 0800 hours until 1800 hours with the exception of meal times to be out of his cell for various reasons. Mr. Quigley has ample time to exercise.” Mr. Quigley submitted grievance #3 on July 25, 2003, stating that being allowed time out of his room does not equate to meaningful exercise. Mr. Quigley wrote: “The lack of exercise is injuring me mentally and physically. This situation must be promptly rectified. Enough of the lies, please.”

A case note dated July 28, 2003: “...Inmate Qiglet [sic] is a ISC inmate who was transferred from Newport for Close Custody --- overridden from medium—per Newport---Security issue---Maps in his possession and informants stated that he was going to Escape. I have written Ray Flum and made a case that this inmate should return back to Florida as he is a security risk—no word back yet. This inmate like [sic] to write tons of greivences [sic] over petty issues. Also a legal paperpusher.”

In July and August of 2003, VP&A submitted grievances on behalf of certain inmates to the DOC outlining complaints regarding abuse and neglect on the D-Unit.

In a letter to VP&A from Mr. Quigley dated August 11, 2003, he wrote: “...The chainings and the sprayings are almost daily occurrences on D-Wing, and it seems like prisoner's are constantly attempting suicide back here, and I can see why. There is an atmosphere of malevolence, and the conditions are punitive...there are two cells on my wing whose windows are welded closed and have no water (37 and 38) except for the toilets.”

In a letter to VP&A from Mr. Quigley dated August 15, 2003, he wrote: “...this place is absolute bedlam, and many of the guards are brutally callous, particular [sic] [officer], who is the regular 2<sup>nd</sup> shift shift supervisor...Perhaps the worst aspect, is he routinely fabricates misbehavior reports about the prisoner's in D-Wing, which result in their missed recreation and prolonged segregation. I strongly suspect he has been prolonging my tenure back here. Can you imagine, if these people can abuse someone as

*sophisticated as me, the way they are treating me, what can they get away with the mentally ill? The constant use of chemical sprays, and the routine chaining to bunks that I have observed is horrifying. The systematic denial of out-of-cell exercise is both a violation of DOC Policy 411 and the 8<sup>th</sup> Amendment, but it's been approved by... [the] Superintendent."*

In a letter to VP&A from Mr. Quigley dated August 17, 2003, he wrote: *"You know something, not once did a guard enter my wing after 7:30, even though DOC policy requires checks of each cell every 30 minutes, and this is an every night routine when [officer] on duty."*

On August 20, 2003, Mr. Quigley submitted a handwritten note to mental health which read: *"For some reason, I cannot seem to read effectively anymore. It's as though my mind is wanting to adsorb the information at a faster pace than is physically possible. This has been going on for about a week and it's terribly frustrating because there is nothing else to do in segregation, and I have a lot on my agenda, but it all involves reading. Is this a common problem and if it is, can it be [illegible]."*

On August 27, 2003<sup>1</sup>, Mr. Quigley was seen by a mental health clinician who noted on the bottom of Mr. Quigley's handwritten request above, *"Anxiety, exercise, increase psychosocial."* This clinician also noted in the Mental Health Progress Notes: *"Patient reported having problems with reading which is his main source of activity. Stated that during this process he will lose his place, experience a tightening in his chest, and not be able to think clearly. These conditions are typically temporary but disconcerting. Acknowledged increase in psychosocial stress, goal oriented. (A) No obvious major mental illness – r/o adjustment disorder. (P) Discussed about move out of D-Unit..."*

In a letter to VP&A from Mr. Quigley dated September 10, 2003, he wrote: *"Today is my 92<sup>nd</sup> day in segregation for no legitimate reason, and with no end in sight...A month ago or so I began to notice my ability to read was becoming impaired by what appears to be a psychological impediment that I suspect is directly related to a lack of exercise, a transition that would likely be more pronounced in my case because I have been almost hyperactive most of my life...about a month ago I sent a request to mental health for an assessment, and a man came to interview me on August 27, but I don't know his name...In any event, this mystery mental health worker left me with the impression that he was going to: (1) discuss the situation with [clinician] and (2) the D-Wing case worker... It's now been two weeks with no response...Suppose the condition was driving me nuts? Perhaps it is!"*

In a letter to VP&A from Mr. Quigley dated September 25, 2003, he wrote: *"I am in receipt of your letter, dated Sept. 23, 2003 along with an authorization*

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<sup>1</sup> Department of Corrections Protocol 361.01.03 Mental Health Intake Assessment. There is a 3 working day response requirement once an inmates submits a slip requesting medical or mental health treatment. This rule was not adhered to as Mr. Quigley submitted his request on August 20<sup>th</sup>, and was not seen until August 27<sup>th</sup>, 2003.

*and consent for release form...I must caution that I do not agree with your premise that the named individuals 'are not fully aware of how inmates are being treated' in D-Wing. Plus I would remind you that the reason I have been in segregation since June 11 is because I have spoken out against prison conditions in Vermont, and help other prisoners to do the same...Certainly the only reason I am still confined to D-Wing is because I filed 10 grievances related to D-Wing conditions or my confinement thereto. This was made unequivocally clear to me by the Delta Unit case worker... at my one and only status review on July 28...Indeed, it's all about repression, which is why I close by cautioning you that I have no doubt that I will be tortured further, if you show my letters to any prison official...I enjoy helping people in need, and I would very much like to help improve the system, but look where it's gotten me."*

In the week before Mr. Quigley's death, Ed Paquin, Executive Director of VP&A, discussed with Janice Ryan, Deputy Commissioner – DOC, the various complaints that VP&A was receiving about the D-Unit conditions.

In a letter to VP&A from Mr. Quigley dated October 1, 2003, he wrote: *"...I suspect they intend to send me to Springfield next week to inaugurate their new 48-bed 'close custody' unit. This means I'll be locked in a cell for 23 hours a day for who knows how long. This is more punitive treatment than prisoner's receive for actually breaking the rules, and they get 'due process hearings'. I've done nothing wrong and they think they're going to torture me until their sadistic, malevolent souls have had their fill. No way...There is no question I have been singled out for abuse, and it's got me livid...This is a corrupt system, and it's getting worse. I'm looked at as a whistleblower, and the only thing I've changed is my circumstances – for the worse."*

In a letter to VP&A from Mr. Quigley dated October 4, 2003, he wrote: *"Who says Vermont does not have a death penalty. Simple commitment to the Vermont DOC care an implicit death penalty element, I suppose. At least the dead no longer have to endure the torture."* VP&A did not receive this letter until after Mr. Quigley's death.

On October 7, 2003, at approximately 4:30 am, three other inmates housed in the D-Unit near Mr. Quigley's cell reported hearing what sounded like a gagging/choking noise coming from Mr. Quigley's cell.

On October 7, 2003, 6:10 am, Mr. Quigley was found hanging in his segregation cell. He was transported via Amcare Ambulance to Northwestern Medical Center in St. Albans where he was pronounced dead at 7:16 am.

#### **IV. INVESTIGATIONS INTO THE DEATH OF JAMES QUIGLEY**

##### **A. Vermont Department of Corrections**

The Vermont Department of Corrections conducted their own internal investigation into the death of James Quigley. Their report does not offer any conclusion and lacks objectivity. It ignores factual information available to the Department such as a



memo from John Murphy, Hearings/Deputy Compact Administrator to Lawrence McLiverty, Director/Security & Supervision, dated September 11, 2003, which read, "*The purpose of this memo is to apprise you of the possibility that Mr. Quigley is being retaliated against for his grievance activity.*" The memo went on to read, "*[I] believe that a determination needs to be made about possible employee misconduct before I can craft a response to his most serious issues regarding retaliation. Please advise.*" Despite this and copies of other documents provided in the Department's own report, the impression the report leaves the reader with is that Mr. Quigley exhibited behavior over the course of the past few years that warranted being housed in segregation for almost four months.

Mr. Quigley's allegation of possible retaliation is further supported by review of the Hearing Officer's Report dated June 11, 2003, completed at NSCF. The officer's findings were: "*After reviewing the information presented at the hearing, I find there to be insufficient documentation to place James Quigley on Administrative Segregation status. There doesn't seem to be adequate documentation for me to believe that James Quigley had any intention to escape from this institution.*"

The Department's report ended with a 'case analysis' section that outlined the following recommendations, none of which addressed the issues of psychological abuse by correctional staff, lack of mental health follow up by the contracted providers, retaliation, or the effectiveness of the hearing process, all issues relevant to Mr. Quigley's untimely death.

1. The Department review its criteria for Interstate compact selection. Vermont sends its long term offender out of state because its facilities are not well suited for them but takes similar cases in return.
2. A training should be conducted for the casework and security staff at facilities that would receive Interstate Compact offenders to ensure that they are clear on the criteria and governing directives on how these cases should be handled.
3. A separate directive should be drafted that details the Interstate Compact case planning process. This directive should detail lines of authority and time frames for the case planning process, to include return of the inmate to the sending state.
4. Training and a description of the governing parole statutes be provided to casework staff to ensure they understand what individual Interstate Compact inmates are facing in their respective states.
5. The Department continue its training for all hearing officers and investigators on the process for managing confidential information and informants.
6. The Department needs to continue to develop various types of housing for those requiring restrictive housing. The opening of Springfield should provide that opportunity. D unit in St. Albans should not contain both segregation and Level 1 offenders. Level 1 or close custody should be housed in a separate unit.

7. The Department continue to work with the Department of Buildings and General Services to ensure that all such cells are free of possible means of self-harm.

**B. Vermont State Police**

The Vermont State Police conducted an investigation into the death of Mr. Quigley. Upon review of the scene of the death, interviews with witnesses and DOC staff and the assistant medical examiner, the Vermont State Police concluded that he had committed suicide by hanging. The police report did not address to what extent the DOC and its contractors complied with policies relevant to Mr. Quigley's care and treatment prior to his death. Nor did it discuss the verbal harassment by DOC staff reported by Mr. Quigley.

**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. Quigley. It was concluded to be a suicide by hanging.

**D. Report Completed by Michael Marks and Philip McLaughlin**

On March 13, 2004, Michael Marks and Philip McLaughlin, special investigators contracted by the Governor's Office to investigate issues in DOC, released their findings. Their report documents that not only were correctional officers involved in the abuse of Mr. Quigley, but higher level DOC officials were also involved, and condoned the continued retaliation and mistreatment that subsequently contributed to Mr. Quigley's untimely death. Their report shows that on October 6, 2003, the decision was finally made to remove Mr. Quigley from D-Unit as soon as possible. That decision was never shared with Mr. Quigley, and he subsequently hung himself in the early morning hours on October 7, 2003. Had that information been shared with him, it potentially could have saved his life. The following are just a few excerpts from this report.

*"There is no evidence of any behavior by Mr. Quigley in St. Albans that would have justified the conclusion that Mr. Quigley was an escape risk. Nor is there any evidence of any behavior that would have justified keeping Mr. Quigley in D-Wing beyond his initial thirty days there. The record establishes that the staff in St. Albans was determined to keep Mr. Quigley in D-wing until Vermont would transfer him back to Florida.*

*Mr. Quigley's correspondence in the last days prior to his death documents profound dissatisfaction with his circumstances. His condition deteriorated markedly during the 118 consecutive days he spent in segregated or close custody status.*

*We have concluded that Mr. Quigley's continued placement on D-Wing was not justified. If the system had worked correctly, it should have moved Mr. Quigley from D-Wing long before his death.*

*Vermont's correctional system treated Mr. Quigley differently because he had filed grievances and objected to institutional practices...Retaliation for the filing of grievances is a significant mistake.*

*It is also significant that on the night of his death there was a violation of the regulations requiring the guard to check inmate cells every thirty minutes and see the inmate's skin. The guard should have conducted further investigation once he could not see Mr. Quigley's skin. It is impossible to say whether adherence to this policy would have prevented Mr. Quigley's death. There is no way of knowing whether Mr. Quigley took his life just after a thirty minute check and would have been dead by the next check even if the guard had made the check and observed his skin. We do know that this failure lost a potential opportunity for preventing his death."*

E. **Vermont Protection & Advocacy, Inc.**

VP&A first learned of Mr. Quigley's death as a result of a phone conversation with another inmate at NWSCF on October 7, 2003. VP&A opened its own investigation, which included the following:

- ➔ Review of Mr. Quigley's medical and mental health record.
- ➔ Review of Vermont Department of Correction's Protocols regarding medical and mental health treatment and NWSCF D-Unit policies.
- ➔ Review of the Vermont State Police investigation report and supporting documents.
- ➔ Review of the Chief Medical Examiner's autopsy report.
- ➔ Review of records from the Northwestern Medical Center.
- ➔ Interview with several of the inmates on D-Unit at the time of Mr. Quigley's death.
- ➔ Review of letters written by Mr. Quigley.
- ➔ Review of Vermont Department of Correction's incident report forms.
- ➔ Review of records from Amcare Ambulance Service.
- ➔ Review of the Investigative Report into the Deaths of Seven Vermont Inmates and Related Issues by Michael Marks and Philip McLaughlin, March 13, 2004

- ➔ Review of the Department of Correction's Internal Investigation into Mr. Quigley's Death Completed February 13, 2004

## V. **FINDINGS AND CONCLUSIONS**

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

VP&A's investigation did find evidence that DOC and its contracted agent, Matrix Health Systems, knowingly contributed to the untimely death of Mr. Quigley. The DOC allowed continued psychological abuse and punitive segregation by administration and correctional officers. DOC and Matrix did not follow up on mental health services for Mr. Quigley after he reported having difficulties on August 20, 2003, directly attributed to being housed in the D-Unit in St. Albans. DOC failed to immediately make changes in the facility after a report submitted by Jeffrey Metzner, M.D., P.C., to Thomas Powell, Ph.D., Director of Clinical Programs for the DOC that detailed problems in the D-Unit. DOC failed to heed warnings given by VP&A and Mr. Quigley.

### A. **Segregation**

Mr. Quigley was not a disciplinary problem as evidenced by the lack of any disciplinary reports while he was housed in the D-Unit in St. Albans. It is unconscionable that Mr. Quigley was held in segregation for approximately 118 days, a status typically reserved for inmates who exhibit severe disciplinary problems or are high security risks. This is especially so in light of the note in a grievance response to Mr. Quigley that he was only in that unit due to lack of bed space elsewhere in the facility. A correctional officer who routinely worked in the D-Unit stated in his sworn statement to the Vermont State Police, referring to Mr. Quigley, "...[H]e's always quiet and got a long with everybody."

### B. **Suicide Prevention**

Dr. Metzner completed a psychiatric consultation "...concerning issues relevant to the mental health system in the Vermont Department of Corrections." On August 13, 2003, Dr. Metzner met with key employees of the Department of Corrections, Matrix Health Systems, and Correctional Medical Services regarding this consultation. His report, dated August 16, 2003, was then sent to Dr. Thomas Powell. The report noted that "*Suicide prevention issues are difficult to assess due to the lack of adequate written QI review as required by the August 20, 1997 suicide prevention directive (361.01.13)...The 1997 suicide prevention protocol is not being followed relevant to the required QI written report. It is my recommendation that such a report continue to be required and actually performed...An adequate review process is necessary in order to*

*identify potential system problems and make appropriate corrections. Based on lack of implementation of the quality improvement report requirement, I have concerns whether other aspects of the suicide prevention directive are being followed. This question should be reviewed and corrective action steps implemented as appropriate.”* Furthermore, despite Dr. Metzner’s warning, there is no evidence that the Department of Corrections did anything to correct the problems identified in St. Albans prior to Mr. Quigley’s death.

Mr. Quigley was not placed on suicide watch<sup>2</sup> after the *Mental Status Evaluation* which noted he had suicidal thinking at times. Neither *Authorization for Suicide Watch* nor *Suicide Watch Observation Log* forms could be found in his medical record<sup>3</sup>.

### **C. Transfer Between Facilities**

Staff at NSCF failed to have a mental health provider review and sign off on the transfer of Mr. Quigley to NWSCF as indicated by the fact that the transfer form was blank under ‘cleared by mental health’.<sup>4</sup>

### **D. Other DOC Procedural Failures**

Several procedural steps were not adhered to upon Mr. Quigley’s arrival and subsequent stay at NWSCF. According to DOC protocol<sup>5</sup>, 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. Quigley’s medical record after his transfer to NWSCF.

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<sup>2</sup> 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.*

<sup>3</sup> 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.*

<sup>4</sup> 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.*

<sup>5</sup> 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.*

The mental health clinician at NWSCF failed to document in Mr. Quigley's medical record that he reviewed his prior mental health evaluation and related documentation<sup>6</sup>.

### **E. Failure of Supervision at NWSCF**

Aside from the lack of adequate mental health follow up that may have contributed to the death of Mr. Quigley, there is disturbing evidence that the correctional officer on third-shift duty at the time of Mr. Quigley's death did not follow the Northwest State Correctional Facility procedure that requires "seeing skin"<sup>7</sup> when doing the unit tour checks every 30 minutes. According to the State Police interview with the correctional officer, he reported that he did not remember at what point he stopped seeing skin while doing the 30-minute checks. This same correctional officer also noted in his incident report, *"I try to alternate my checks so that the inmates do not get a pattern of what I am doing at night. I did see I/M Quigley at the beginning of the shift and a few times after that. I do not remember when I did not see skin. It gets cold down there at night so a few of the inmates bundle right up under their covers to stay warm...Everytime a checked I/M Quigley, it appeared to be a body laying down on the bunk. I did my last check at approx. 0520hrs before the first shift officers took over the unit."* After Mr. Quigley was found hanging, it was discovered that his bed was full of books that were positioned to resemble a body lying under the covers. It is also noteworthy that this correctional officer reported in his statement to the State Police that he had a television playing in his work area. That noise could have muffled out the sounds that were very clearly heard by at least two other inmates in the unit at the potential time that Mr. Quigley hung himself.

In a letter dated September 25, 2003, Mr. Quigley wrote: *"By the way, after 5 p.m., the Delta Unit 'activity rooms' become a guards' lounge. Whether it's Monday Night Football, WWF Smackdown, or a movie, that's where the guards will be. Someone could be dying on one of the wings and they wouldn't find out until rigor mortis set in."*

Several inmates who were interviewed for this report stated that the correctional officers did not perform the mandated 30-minute checks, even though the Unit Log indicates the checks were completed. One inmate stated he felt Mr. Quigley's death could have been prevented, or the attempted interrupted, if the officer on duty actually performed the checks.

The Marks/McLaughlin report shows that the Superintendent at NWSCF was well aware of and condoned Mr. Quigley's continued segregation in the D-Unit.

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<sup>6</sup> 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.*

<sup>7</sup> Northwest State Correctional Facility, Procedure 300.80, Delta C/O I Post Orders, General Orders #1.

*Superintendent...wrote that Mr. Quigley could earn his way out of D-Wing and into the general population by ‘appropriate behavior’ and ‘cooperation’.*” Given the evidence discussed previously, this statement can only be considered an intentional falsehood.

#### **F. VP&A’s Concerns About D-Unit**

In addition to Mr. Quigley’s own correspondence that went to many different individuals and agencies, including DOC, expressing his concerns about the treatment inmates were receiving in both D-Unit One and D-Unit Two, Vermont Protection & Advocacy, prior to and around the time of Mr. Quigley’s death, had brought it’s concerns to the attention of DOC officials to no avail. VP&A had been receiving numerous complaints from different inmates in the D-Units regarding abuse, both physical and emotional, being inflicted upon them by certain correctional officers who worked there. It is disconcerting that the Department ignored these serious warning signs and failed to investigate and correct problems that existed. If they had, there may have been a very different outcome for Mr. Quigley.

#### **G. Welfare of Inmates Affected by Mr. Quigley’s Death**

According to DOC protocol<sup>8</sup>, whenever there is a death of an inmate in a facility, both staff and inmates are to be given the opportunity for a debriefing session to address their emotional needs, as many inmates develop close bonds and friendships while incarcerated and can suffer emotional distress when a suicide occurs. VP&A staff conducted interviews with inmates who lived in the same unit as Mr. Quigley, and these inmates were specifically asked if the Department provided any kind of counseling or debriefing for them. The unanimous answer was no. This is very disturbing as many of the inmates interviewed were visibly upset over Mr. Quigley’s death.

#### **H. Other Findings**

In addition to the DOC 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. Quigley did not receive adequate mental health follow up after he was initially evaluated by a clinician

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<sup>8</sup> Department of Corrections Protocol 361.01.13, Suicide Prevention, VI. Protocol, H. 6. *All staff and inmates affected by serious or completed suicide attempts shall be provided with crisis intervention services. In addition, all affected parties shall be subject to the requirements of the Critical Incident Debriefing directive.*

after reporting symptoms of possible adjustment disorder and anxiety, which may have contributed to his untimely death.

- 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.*

This protocol was violated when medical staff at NWSCF failed to complete the appropriate mental health referral form even though it was documented that Mr. Quigley had reported suicidal thoughts.

## VI. **RECOMMENDATIONS**

Based on its findings and conclusions, VP&A recommends the following actions that should be taken by the Department of Corrections:

1. Any and all correctional employees involved at any level in the retaliation and mistreatment of Mr. Quigley should be immediately dismissed from employment. The Department needs to establish a no tolerance policy with regard to employee misconduct.
2. Review of quality of follow up services being provided by the contracted mental health providers.
3. Improvement and renovation of the physical plant and living conditions in D-Unit.
4. Staff training in recognizing and reporting behaviors that are potentially life threatening for the individual experiencing them.
5. Mandatory training on policies, directives, and procedures for all staff and contracted employees, including the psychiatrist, with an oversight mechanism that assures that these rules are followed consistently.
6. Review and revision of the current hearing process, including procedures to be followed when a hearing officer's recommendations are overridden by the Superintendent.
7. Review and revision of the current grievance process to assure timely and unbiased investigation into inmate complaints.
8. Develop a protocol to provide in depth, unbiased investigations into deaths that occur within Corrections. Quantifiable recommendations need to be provided, as well as corrective actions, including employee sanctions.



9. Develop a procedure whereby misconduct of administrative staff, i.e., assistant superintendents and superintendents, is reviewed and addressed when allegations of retaliatory acts are made.

Cc: Claire Quigley  
Honorable Governor James Douglas  
Steve Gold, Commissioner  
Janice Ryan, Deputy Commissioner  
Charles Smith, Agency of Human Services  
David Sleight, Attorney for Mr. Quigley's Estate