The Death of Timothy Perry

An Investigative Report

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INTRODUCTION

This report summarizes the results of an investigation into circumstances surrounding the death of Timothy Perry at the Hartford Correctional Center on April 12, 1999. The investigation was conducted by the Protection and Advocacy for Individuals with Mental Illness (PAIMI) program of the Office of Protection and Advocacy for Persons with Disabilities. When he died, Mr. Perry had just turned twenty-one. He had been incarcerated following arraignment on charges of third degree assault, second degree assault, threatening, and criminal mischief in the fourth degree. The charges stemmed from two incidents where staff at Cedarcrest Hospital, a State psychiatric facility where Mr. Perry was an inpatient, had been injured by him.

Separate investigations into Mr. Perry's death have been conducted by the Connecticut State Police and the Department of Corrections (DOC). Additionally, the Office of the Chief Medical Examiner conducted a post mortem examination, and the Department of Mental Health and Addiction Services initiated a review of practices for patient arrests. This investigation reviewed the findings of these other investigations and reviews, along with information from Mr. Perry's clinical records. It is intended to examine two sets of questions: 1) How and why was Tim Perry, a young man with a long established history of psychiatric disability, sent from a State psychiatric hospital to prison; and, 2) Did he receive negligent, improper or unsafe treatment while in prison, and if so, did that treatment cause or contribute to his death? The report concludes with recommendations for both DMHAS and DOC.

In issuing this report, the Office of Protection and Advocacy hopes that the lessons learned from Mr. Perry's tragic death will translate into change within both the mental health service system and correctional facilities where, unfortunately, an increasing number of individuals with significant mental illness are being incarcerated.

EXECUTIVE SUMMARY

Who was Tim Perry and how did he wind up in jail?

During his brief life, Timothy Perry had considerable contact with State service systems. As a child he had been placed into a variety of foster and residential programs, and, at the age of 18 began a series of stays in adult psychiatric hospitals and supervised residential programs. Reading his clinical records it is easy to get the impression that he was a troubled young man whose life was defined by intractable psychiatric and behavior problems. Indeed, it is clear that many of those who worked with him at Cedarcrest Hospital came to see him in precisely those terms, growing increasingly frustrated with his apparent inability to achieve treatment goals, and with what they interpreted as "self-sabotaging behavior". Yet, at various times in his life, Tim Perry had also experienced periods of relative success. He had secured a high school diploma, pursued his love of music and his religious commitment by singing in his church choir, had volunteered with children, enjoyed working out and playing sports, and had worked as a building maintainer. While he acknowledged that he had problems with relationships and controlling his temper, and at one point indicated that he preferred to stay in the hospital rather than leave, Mr. Perry's records indicate that he saw these problems as tied in with emotionally traumatic childhood experiences involving abuse and abandonment by family members.

For all but six months of the last three years of his life, Mr. Perry was an inpatient in psychiatric hospitals. For most of that time he was at Cedarcrest, a DMHAS facility in Newington, Connecticut. Hospital records indicate that, at times, he actively participated in group sessions and other structured programs aimed at assisting patients to assume more responsibility for their behavior. The records also note the introduction of various medications intended to reduce impulsive, explosive behavior, although none of these drugs seemed to have much long-term effect. His diagnoses were initially listed as schizoaffective disorder and borderline personality disorder, with specific problems identified as depression, suicidal feelings, impulsive behavior and mood swings. While the hospital records note Mr. Perry's frequent references to his unresolved family issues, and his attempts to reunite with his mother and confront his adoptive father had both precipitated hospital admissions, there seems to have been little done to help him gain insight or otherwise resolve the emotional wounds associated with the traumatic events he consistently reported. In fact, two notable themes emerge from these records: 1) the consistency with which Mr. Perry's identity and needs were interpreted not in terms of his self-reported issues, but rather in terms of the degree of difficulty he experienced conforming to more or less generic behavioral treatment goals; and, 2) the increasing frequency with which he was mechanically restrained following struggles with others whom he perceived as challenging him or denying him something he wanted.

While reviewing records, one cannot help but observe that as hospital staff became increasingly frustrated with Mr. Perry's lack of progress toward meeting their treatment goals, their perspective on who he was and what he needed as a human being grew narrower, to the point where the types of behavior that had occasioned his hospitalizations were eventually perceived as criminal in nature. The decision to prefer charges against him was made following discussions amongst members of his treatment team. In fact, at his March 31, 1999, arraignment, a representative from Cedarcrest

Hospital (a DMHAS Police Officer) represented to the Court that Mr. Perry was not mentally ill, but rather had a personality disorder and that Cedarcrest could not provide the services he needed. The Officer also told the Court that he understood that some kind of consultation had taken place between Cedarcrest and staff from the Whiting Forensic Institute (a high security DMHAS facility to which assaultive patients are sometimes transferred), but that he understood there was some problem with availability of beds at the later facility.

At that arraignment, the public defender assigned to represent Mr. Perry requested that the Court order a competency evaluation, as she questioned whether he could effectively understand the charges against him or assist in his defense. She also requested that he be remanded back to the custody of DMHAS while the evaluation was conducted, arguing that holding Mr. Perry in a correctional facility would be inappropriate. The Judge granted the petition for a competency evaluation, but, having heard the representations from DMHAS about Cedarcrest's unsuitability and Whiting's unavailability, he ordered Mr. Perry to be held by the Department of Corrections pending the evaluation.

And so, on March 31, 1999, two days prior to his twenty-first birthday, Timothy Perry was sent to the Hartford Correctional Center on Weston Street, where he was assigned a cell in the South Block mental health unit. Notes made by the unit nurse record receipt of a call "from the court" alerting the facility to expect Mr. Perry, and informing her that "[h]e had been hitting Cedarcrest staff on a regular basis and was being sent to us to teach him a lesson."

What happened to him in jail, and how did he die?

Despite some initial difficulty during his admission processing, it appears that Mr. Perry presented no major problems to HCC staff until April 12, 1999, the day he died. He had initially been placed on "KIC" (keep in cell) status, but had been taken off that status by April 9th, when a DOC Mental Health Treatment Plan was developed. The plan provided for one-to-one mental health counseling, taking medications (Mr. Perry was continued on the four medications he had been receiving at Cedarcrest), and follow-up with outpatient services (mental health services provided to inmates in the general population) when he was ultimately released from the unit. The unit nurse spoke with Mr. Perry on a number of occasions during his first week at HCC, and she apparently developed some rapport with him.

On the evening of April 12th, however, Mr. Perry was in the unit day room with several other inmates for a recreation period when he asked to speak to the nurse. The officer on duty (who was new to Mr. Perry), and the nurse both indicated that he could speak to her later, as she was busy at the time. Mr. Perry then started to pace and began yelling and banging on the windows. He refused orders to return to his cell. Backup officers were called in and Mr. Perry was again ordered to go to his cell. According to witness statements, Mr. Perry then suddenly assaulted the duty officer who, along with three other officers who had arrived in response to the call for help, subdued him, holding him face down on the floor while he continued to struggle. A "code orange" (call to assist an officer who is being assaulted) was initiated. Handcuffs were applied. Mr. Perry apparently continued to struggle for several minutes while being held, face down, on the floor. In response to what some witnesses described as "gurgling" or "spitting" noises, a towel was placed over his head and apparently held in place by one of the officers.

(Witness accounts vary as to how, or even whether the towel was held.) Other officers arrived, including a lieutenant/supervisor. Mr. Perry was then carried to his cell where he was placed, again face down, on his bed and leg irons were applied. .

Either just before or shortly after Mr. Perry had been carried to his cell and shackled, the unit head nurse paged the on-call psychiatrist and obtained an order for tranquilizing medication and "soft", four-point restraints. As his own cell was not equipped for the use of these restraints, Mr. Perry was carried to another cell. As he arrived at this second cell a handheld camcorder was employed, and a videotape of the incident was begun. (Taping such incidents is required by DOC policy; failure to videotape the initial sequence of events was first attributed to dead batteries in the camcorder, although DOC's internal investigation later found there was no facility protocol concerning who was responsible for operating the camcorder.) The tape shows Mr. Perry being held, face down on the cot in the second cell. The towel is still over his head, although neither the towel nor the officer holding it are clearly visible until later in the tape when the other officers begin to leave the cell. The cell is extremely small. The tape shows seven officers crowded around Mr. Perry, holding him at each ankle and wrist, one of whom is prepared to apply a pain/control hold to Mr. Perry's left wrist while another presses his knee down on the back of Mr. Perry's upper legs. At the time the taping began Mr. Perry was naked from the waist down. The nurse them enters along with a health aide, and quickly administers two injections. Mr. Perry was then rolled onto his back, his shirt cut off, was loosely covered with a paper gown, and the restraint cuffs applied to his wrists and ankles.

Throughout the entire tape, Mr. Perry is not seen to resist or even to move. Yet, at one point, the officer filming the event clearly remarks that, "Inmate Perry is still resisting." Indeed, the most notable aspect of the entire scene is the extent to which all involved seem so focused on maintaining control over particular limbs or on accomplishing particular tasks, including the administration of injections and application of restraints. They either do not realize he has ceased to struggle, or attribute no significance to that fact. No one speaks to, or pays attention to Mr. Perry himself. In the final scene of the tape, the nurse and correctional supervisor are heard discussing the need to re-enter the cell to make minor adjustments to the restraints so they will not impede circulation. This was apparently done, but, again without addressing Mr. Perry or noticing that he was utterly motionless.

Exactly when Tim Perry died is not clear. While in restraints he was monitored by the unit supervisor from the unit control station via closed circuit television, and was observed through the cell door window at fifteen minute intervals by a correctional officer cadet assigned to the unit. The unit head nurse stated she also observed him "at least ten times" through the cell window, although none of these observations were documented. Several hours after he had been placed into restraints, however, another nurse was assigned to cover the unit. She noticed that Mr. Perry's feet were cyanotic. She and the unit supervisor then entered the cell and found him cold and stiff. CPR was initiated, 911 called, and he was transported to Hartford Hospital where he was pronounced dead.

What was learned from autopsy and other investigations?

The post mortem examination revealed that the medication injected into his buttocks had not circulated throughout his body, indicating that Mr. Perry may have already been

dead or at least close to death at the time the injections were administered. Small hemorrhages were noted in his eyelids, tongue and facial muscles. According to the Deputy Chief Medical Examiner who conducted the autopsy, this finding is consistent with either asphyxial death, or death during a state of "excited delirium". Based on conflicting statements to police concerning the extent to which Mr. Perry was still struggling as he was carried between cells, the medical examiner could not determine with certainty when, or exactly how he had died. The adrenaline coursing through his body while he struggled so intensely (e.g. in a state of "excited delirium") in the day room area or in the first cell to which he had been brought may have produced a fatal cardiac arrythmia. Alternatively, compression applied to his chest area while he was being physically held in a face down position by a number of correctional officers may have prevented him from inhaling. The final cause of death was listed as "Sudden Death During Restraint", but the Medical Examiner could not determine the exact manner in which it occurred. (An independent pathologist commissioned by PAIMI to review the autopsy results determined that asphyxial death was the more likely scenario, but, could not rule out the other possibility.)

However, the post mortem also noted a number of other irregularities, including the presence of a third, non-prescribed psychotropic drug, (to which Mr. Perry was known to be allergic) at the injection site. A subsequent analysis of stomach contents also revealed high concentrations of oral medications in his stomach – concentrations that were inconsistent with the time that unit records indicated he had supposedly last received them. Neither the Medical Examiner's Office nor the independent pathologist employed by PAIMI believe that these irregularities caused Mr. Perry's death. But, they do raise questions regarding the accuracy of unit records, the veracity of statements by nursing staff, and the overall quality of health care in the unit. (Health care, including mental health care in DOC facilities is provided through a contract with UCONN Health Care Center. Doctors and nurses who treat inmates are employed by UCONN, not directly by DOC.)

Both the State Police and the Department of Corrections conducted comprehensive investigations into Mr. Perry's death. A number of HCC staff were disciplined for failures to adhere to DOC policies. The police investigation (which occurred first), determined that several of the corrections officers had initially made misleading statements concerning their actions during the incident. The nurse who had obtained the doctor's order for restraints and administered the injections, claimed to be unaware of any requirement to check vital signs prior to administering medication or applying restraints, She indicated that she thought she had felt a pulse when adjusting the restraint cuffs. (DOC referred the question of discipline for nursing staff to its health care subcontractor, UCONN Health Care Center. The nurse subsequently resigned.) The DOC policy requiring physical assessments while inmates are restrained was found to be missing from the unit policy manual, and there was no record that staff had received training in its requirements. In addition it was noted that supervisors had observed the unauthorized placement of the towel over Mr. Perry's head, but did nothing to cause its removal. Upon reviewing the medical examiner's report and the findings of the police investigation, the State's Attorney declined to pursue criminal charges against any of those who participated in the incident.

In the wake of Mr. Perry's death, DMHAS convened a committee to review its practices with respect to seeking arrest and prosecution of its clients. After determining that practices varied considerably between different elements of its system, the committee

developed a draft policy. At the time of the completion of this report, that policy is still in draft form.

What should be done to prevent similar tragedies from occurring in the future?

Based on its findings, OPA has offered recommendations to both DMHAS and DOC. In addition, the Office is requesting the Chief State's Attorney to review the investigations generated by Tim Perry's death to determine if stronger statutory language is necessary or desirable to provide criminal penalties for those who make misleading statements to police agencies investigating deaths or allegations of mistreatment of individuals in State custody.

Recommendations for DMHAS:

1. Develop a formal mechanism to initiate multi-disciplinary, external review and consultation regarding the treatment of individuals whose behaviors are proving to be especially challenging despite efforts of clinical staff of a particular facility. Particular attention should be paid to those individuals whose treatment goals are consistently not realized despite the use of various therapies and interventions, and whose behaviors are deteriorating and potentially dangerous, as evidenced by an increase in the use of physical interventions, seclusion, and the use of PRN medication.

2. Review current guidelines regarding the arrest of clients, to ensure that decisions to arrest clients are made only under very limited circumstances and only when the alleged criminal conduct is clearly not a manifestation of a client's mental illness.

Recommendations for DOC:

1. Review current policies and procedures regarding both custodial restraint practices and the use of physical and chemical restraints as psychiatric interventions, in order to ensure that both conform to accepted medical standards and do not place individuals at risk of injury or death. It should be clear that in both custodial and medically-ordered restraint situations that inmates are not to be held face down; that breathing may not be impaired by physical holds; that covering of a restrained inmate's head or face is not permitted; and that both the reasons for using the restraints, and conditions necessary for their discontinuation should be explained to the inmate. These policies should also make clear that, especially when dealing with inmates known to have psychiatric involvement, genuine attempts must be made to de-escalate the situation prior to employing physical force or restraints. Procedures for the use of emergency or involuntary administration of psychoactive medication should also be modified to require qualified personnel to assess the physical status of the inmate prior to administration of the drugs and at regular intervals thereafter.

2. Establish a protocol for assigning objective supervision to manage physical interventions for inmates with psychiatric disabilities, and the investigation of problematic events and practices. This protocol should include the designation of a staff person who has not been involved in the development of a particular intervention to act as an objective evaluator of the situation and provide guidance to staff, as needed, in order to ensure that appropriate and safe approaches are followed.

3. Establish a protocol to ensure that when unprofessional acts and omissions by health care professionals are suspected by DOC investigators, they are directly reported to appropriate licensing agencies for review.

4. Establish a protocol for ensuring that advocacy services are made available to inmates with mental illness.

INVESTIGATION BACKGROUND

The Office of Protection and Advocacy for Persons with Disabilities (OPA) operates in accordance with State and federal statutory mandates that have been established to protect and advance the civil rights of people with disabilities in Connecticut. In keeping with its federal mandate under the Protection and Advocacy for Individuals with Mental Illness (PAIMI) Act of 1986, as amended (Title 42 U.S. Code section 10801 et. seq.), OPA has the authority to investigate allegations of abuse and/or neglect of persons with psychiatric disabilities, including the death of such individuals, which occur in psychiatric facilities, or facilities such as prisons or jails.

This report chronicles the circumstances leading up to and surrounding the death of Mr. Timothy Perry, a young man with a psychiatric disability whose life ended prematurely during the application of a four-point restraint at the Hartford Correctional Center on April 12, 1999. It results from an extensive review of records and reports obtained by the Protection and Advocacy for Individuals with Mental Illness (PAIMI) unit at OPA following Mr. Perry's death, including expert opinions and collateral materials acquired by PAIMI as recently as May 2001.

The purpose of this report is to examine issues and concerns regarding Mr. Perry's treatment during the course of his psychiatric hospitalizations and subsequent incarceration and to offer recommendations related to specific aspects of his care and custody.

Materials reviewed for purposes of this report include:

- Inpatient records of Mr. Perry's most recent psychiatric hospitalizations at Cedarcrest Hospital (Dates of Admission and Discharge: 8/17/98 to10/6/98, 10/7/98 to 1/21/99 and 1/26/99 to 3/31/99)

- Medical records of Mr. Perry from Capitol Region Mental Health Center (Dates of Admission and Discharge: 1/21/99 to 1/26/99)

- Department of Mental Health and Addiction Services Guidelines on the Arrest of Clients (Effective: 3/1/00)

- Transcript of Mr. Perry's appearance before the Honorable William L. Wollenberg, Judge, New Britain Superior Court (3/31/00)

- Department of Correction Incident Report Package (Incident Date: 4/12/99)

- Connecticut State Police Investigation Report, including witness statements and reports of witness interviews (Report Date: 4/16/99)

- Report prepared by Ronald Cilyo, Captain/Investigator, Department of Correction (Report Date: 9/24/99)

- Report from the American Medical Response of CT Ambulance Company (Date of Transport: 4/12/99)

- Medical records of Mr. Perry from the Hartford Hospital emergency room (Date of Service: 4/12/99)

- Medical records of Mr. Perry from the Department of Correction (Dates of Admission and Discharge: 3/31/99 to 4/12/99)

- Videotapes (2) labeled "4 Point Restraint of I/M Perry" and "Code White Timothy Perry" (Dated: 4/12/99)

- Department of Correction Administrative Directive 6.5 on the Use of Force, including Authorized Use of Restraints and Video Recording (Effective: 8/3/98)

- Department of Corrections Administrative Directive 8.14 on Suicide Prevention (effective 8/26/99)

- Department of Corrections Administrative Directive 8.5 on Mental Health Services (effective 6/19/00)

- Department of Corrections Administrative Directive 8.8 on Psychoactive Medication (effective 8/16/99)

- Department of Correction Training Curriculum on Use of Restraints

- A copy of the Memorandum of Understanding between the Department of Correction and University of Connecticut Health Center (Dated: 8/11/97)

- Report of the postmortem examination and findings performed by Edward T. McDonough, M.D., Deputy Chief Medical Examiner of the State of Connecticut Office of the Chief Medical Examiner prepared from Mr. Perry's autopsy (Dated: 7/26/99)

- Report of postmortem toxicological studies and supplemental report prepared by Sherwood C. Lewis, Ph.D., Director of Toxicology of the State of Connecticut Office of the Chief Medical Examiner (Dated: 8/4/99 and 2/8/01, respectively)

- Report of Barbara C. Wolf, M.D., Forensic Pathologist (Dated: 10/23/00)

- Forensic Toxicology Report and Supplemental Report regarding the death of Mr. Perry prepared by Thomas G. Rosano, Ph.D., DABFT, DABCC (Dated: 11/30/00 and 3/17/01, respectively)

- "What Killed Timothy Perry?" by Jayne Keedle, Hartford Advocate (Dated: 11/16/00)

BACKGROUND INFORMATION

Timothy Perry was born on April 2, 1978 in Hartford, CT. By Mr. Perry's own account, and, as reported in his hospital records, he was the victim of neglect, and physical and emotional abuse since early childhood. Mr. Perry's records state that for the first three years of his life he was under the care of the Department of Children and Youth Services. He lived in various foster homes until the age of three, when he was placed in a home for adoption. According to his records, Mr. Perry had a history of aggression in school and, at the age of ten, was removed from school and placed on homebound instruction.

Although no court charges against his (adoptive) parents were ever filed, the Department of Children and Families removed Mr. Perry from their care at the age of eleven. For the next seven years, Mr. Perry moved in and out of a number of foster homes, institutions, and other residential programs and, according to hospital records, his behavioral and emotional problems continued. In 1996, at the age of eighteen, Mr. Perry entered into a series of frequent psychiatric hospitalizations. Between April 1996 and March 31, 1999, Mr. Perry spent approximately six months outside of inpatient mental health facilities.

During those six months, he received day treatment services and lived in a supervised apartment in Middletown, CT. According to his records, Mr. Perry did fairly well in the community when provided with a lot of supervision and supportive services. Mr. Perry claimed that due to his long history of institutionalization and abuse, he had "lots of difficulties relating to and understanding people."

According to his records, Mr. Perry completed high school, did maintenance work, and volunteered with children. He also sang in the church choir and attended services on a regular basis. He enjoyed listening to music, playing sports, and exercising.

At the age of eighteen or nineteen, Mr. Perry attempted to reunite with his biological mother, who also has a history of mental illness. According to inpatient progress notes, his unresolved relationship with her was the source of much distress and grief. Mr. Perry expressed a deep resentment towards his (adoptive) father, due to his self-reported history of abuse. There is no evidence of contact with other family members in Mr. Perry's records, with the exception of an aunt whom he regularly visited in Hartford.

PSYCHIATRIC HOSPITALIZATIONS AND ARREST

Third Admission to Cedarcrest

Prior to his incarceration at the Hartford Correctional Center on March 31, 1999, Mr. Perry had five admissions to psychiatric facilities, four of which were to Cedarcrest Hospital. This report begins with his third admission to Cedarcrest Hospital, which occurred on August 17, 1998. At that time, Mr. Perry was admitted on a fifteen-day emergency certificate from the Institute of Living, where he had been an inpatient for one week. Mr. Perry had been accused of fondling a woman he believed to be his girlfriend. The police had been notified and the case was being investigated, along with three complaints of a similar nature. Mr. Perry expressed a fear that he might, "end up in jail – I was depressed and having suicidal thoughts – I requested hospitalization."

At the time of this admission to Cedarcrest Hospital, Mr. Perry had diagnoses of schizoaffective disorder, borderline personality disorder, and asthma. Problems related to his interaction with the legal system were also noted. His admission notes indicate an allergy to Thorazine in the form of a skin rash or hives and below average/borderline intelligence. According to Mr. Perry's self-assessment, "I'm not suicidal, I'm only very anxious because this girl is accusing me of touching her…I don't know why she's doing this, as to me, she was consenting…I don't know how to cope with this problem."
Mr. Perry's problems, as identified in his individualized treatment plan, were depression, suicidal feelings, impulsive behavior, and mood swings. Long-range

treatment goals were that he would no longer feel suicidal and would have control of his impulses. Specific treatment approaches identified to meet these goals were that Mr. Perry's psychiatrist regularly assess his level of dangerousness to himself or others, that his medication be assessed and adjusted as needed, that he be assessed for medication understanding and compliance, and that he be referred to a dialectical behavior therapy (DBT) program, related skills groups, and weekly sessions with a DBT therapist. Established discharge criteria for community placement were that Mr. Perry be stable in mood with adequate control of his suicidal thoughts and impulsive behavior. In addition, that he maintain DBT, a day program, and anger management support services.
During this hospitalization, Mr. Perry regularly attended group activities and was an active participant in them. Progress notes indicate that he seemed committed to the DBT program, worked hard on his skills and interpersonal effectiveness, maintained a diary, and was compliant with his medications. At the same time, he also experienced frequent setbacks and episodes of unpredictable behavior. During this hospitalization, Mr. Perry was physically restrained and/or placed into seclusion a total of seven times. Precipitating factors included discussion of his discharge, being accused of looking at a female patient while she was taking a bath, fighting with other patients, and becoming angry when his requests for PRN (as needed) medication were not satisfied. In addition, on October 2, 1998, three days before his discharge, Mr. Perry requested to be placed in physical restraints because he felt like hurting someone "and I will."

There is evidence in the progress notes that Mr. Perry was trying to gain insight into his emotional and psychological problems and that he had, in general, a positive attitude towards his treatment. Of note, however, was Mr. Perry's anxiety about his discharge plans. On September 9, 1998 he told his psychiatrist that he didn't want to live alone in his own apartment. On September 10, 1998 he told his treatment team that he was afraid of being back in his apartment and needed a roommate. On October 2, 1998 he told his treatment team that he didn't want to return to Middletown and expressed an interest in living in Hartford.

On October 6, 1998 Mr. Perry was discharged back to his supervised apartment in Middletown to receive outpatient follow-up at River Valley Services. According to his psychiatric discharge summary, his prognosis was "guarded, in view of the chronicity of his illness and marginal response to medications."

Fourth Admission to Cedarcrest

On October 7, 1998 Mr. Perry was re-admitted to Cedarcrest Hospital one day after his discharge. According to hospital notes, Mr. Perry became "enraged" after seeing his (adoptive) father allegedly "look at him, laugh, and walk away" on the streets of Middletown. Mr. Perry "lost control, threatened to kill his (adoptive) father, and caused damage to a parked State vehicle." A medical note on October 8, 1998 reports the following:

> Patient was discharged from CRH on 10/5/98; he had no desire to leave the facility, was telling other patients that he likes it here and wants to stay. During interview patient was told that he did not have to threaten other people, destroy property in order to come back to the hospital.

When asked to identify the problems and goals he needed to address while hospitalized, Mr. Perry reported his problems to be “anger, patience, depression, frustration, and confusion with how to deal with stress.” His goals were “to move to Hartford and to work on anger.”

At the time of his fourth admission, Mr. Perry had diagnoses of schizoaffective disorder, borderline personality disorder, and asthma. Problems related to conflicts with service providers and his (adoptive) father were also noted. Mr. Perry’s problem, as identified in his individualized treatment plan, was poor anger management. His long-range treatment goal was to maintain control of angry feelings through means other than acting out. Specific treatment approaches identified to address this goal were that Mr. Perry’s psychiatrist meet with him regularly to assess risk factors, that his medication be monitored and adjusted as needed, that he be offered medication as needed for increased agitation, that mental health staff members interact with him individually and in group settings to build therapeutic relationships, that the use of DBT skills be encouraged and reinforced, and that alternative living arrangements in other towns be explored.

In addition, Mr. Perry’s treatment plan addressed his tendency to touch and hug people inappropriately by having mental health staff remind him of its inappropriateness upon occurrence, stress the importance of boundaries, and emphasize the risk of his behavior interfering with another patient’s progress and his own treatment. Established criteria for discharge were that Mr. Perry be free of aggressiveness and self-harmful behavior. In addition, that he agree to and obtain a placement that meets his needs.

While initially quite stressful, the first month of Mr. Perry’s treatment team reviews report a positive response to treatment. On October 20, 1998 Mr. Perry reported that he needed to be away from his (adoptive) father in Middletown. He stated, “I’ll get more support from my Mom’s family in Hartford…I want to be part of a family.” Records from this time period report that Mr. Perry was working daily to control and manage his frustration without the need for “time out” or physical restraint, and was meeting with staff members to discuss “anger management, more patience, and minding my business.” There was one incident of sexually inappropriate behavior reported during this time period.

By the second month of treatment, Mr. Perry’s treatment team reviews and progress notes reflect a shift in his behavior. Mr. Perry reports that he doesn’t know what works to manage his anger. He states that while he believes the behavioral interventions he has been taught will be useful and helpful to him, he

continues to have difficulty remembering the interventions when his anger escalates. Staff also report that he conveys a sense of being overwhelmed and needing help in managing his feelings of abandonment and rejection. Mr. Perry acknowledges that he struggles daily with issues of anger and rejection. On December 14, 1998 the treatment team review contains the following note:

> Tim presents increased violence when he is unable to have a desire met or when told he has to wait and he disagrees that he should. He admits that his patience is limited. Timothy has identified that when he gets angry he is unable to consider the consequences for his anger. He reports difficulty recalling past conversations, questions, or issues previously addressed. He can only think about his current desire or issue at that time.

During this hospitalization, Mr. Perry was physically restrained and/or placed into seclusion a total of fifteen times. Examples of precipitating factors include his wanting to smoke, wanting courtyard privileges, a telephone call to his mother, altercations with other patients, and the imposition of unit restrictions.
On December 20, 1998 Mr. Perry was seen by staff from the Capital Region Mental Health Center (CRMHC) and accepted for outpatient services there. As in the case of his previous hospitalization, Mr. Perry expressed ambivalence about his pending discharge. On December 14, 1998 Mr. Perry reports looking forward to his discharge and placement into a supervised apartment. On January 13, 1999 he tells his social worker that he feels he is ready to go to the respite program at CRMHC. On January 20, 1999 he reports periods of some anxiety. While he likes the idea of leaving the hospital, he indicates that he has an attachment there. Nursing notes written on January 21, 1999, the day of Mr. Perry's discharge, report that he continues to have increased anxiety over his pending discharge, having difficulty with his anger management.

Also noted during this hospitalization are frequent references to Mr. Perry's unresolved relationship with his biological mother. Progress notes report periods of tearfulness, depression, suicidal feelings, and anger due to her refusal to talk with him and eventually changing her phone number.

On January 21, 1999 Mr. Perry was discharged to CRMHC to receive respite and intensive outpatient services while awaiting acceptance into the Center for Human Development (CHD) Connecticut Outreach program. According to Mr. Perry's psychiatric discharge summary, his prognosis was "guarded, in view of the chronicity of his illness and poor impulse control."

A comprehensive assessment was completed by CRMHC on December 17, 1998. At that time, Mr. Perry's diagnoses are major depression, recurrent, borderline personality disorder, and history of asthma. A mental status examination reports that Mr. Perry's "thinking is concrete to bizarre, with inappropriate/nervous laughter when he didn't understand the

abstractions…Client states that he hears voices in his head; when he does, it is always his father's voice making degrading statements." In addition, Mr. Perry reported that he experienced flashbacks and nightmares due to his history of victimization.

Fifth Admission to Cedarcrest

On January 26, 1999, just four days after being discharged, Mr. Perry was re-admitted to Cedarcrest Hospital on an emergency certificate from CRMHC for assaulting another resident and reportedly pushing a female staff member.

At the time of this admission to Cedarcrest Hospital, Mr. Perry's diagnoses were impulse control disorder, borderline personality disorder with antisocial traits, and asthma. Problems concerning his conflicts in the respite program were also noted. Mr. Perry's problems, as identified in his individualized treatment plan, were poor impulse control and an inability to control anger. Long-range treatment goals were that he would maintain control of his anger through the use of learned skills when faced with stressful situations. Specific treatment approaches identified to meet this goal were that Mr. Perry's psychiatrist would regularly meet with him to assess his risk to others and level of impulsivity, that his medication be assessed and adjusted as needed, that he be offered medication as needed when showing signs of "bravado, paranoia, and aggression," and that mental health workers and medical staff interact with him individually and in group settings to review DBT skills, assist him to identify triggers to his losing control, and with the development of interpersonal skills.

Mr. Perry's treatment team reviews and progress notes during the first month of hospitalization indicate that he was demonstrating improvement in controlling his behavior. By February 24, 1999 Mr. Perry had moved from the most to least restrictive level on his unit. A transition plan was developed for Mr. Perry involving Cedarcrest Hospital and the CHD Connecticut Outreach program and a discharge date of March 5, 1999 was set. The transition plan included a behavioral contract that Mr. Perry agreed to follow in order to be accepted for services in the community. The contract stipulated that Mr. Perry take his prescribed medications, continue his participation in DBT classes, not physically injure himself or others, and maintain a structured day by attending Life Skills programming at CRMHC with a gradual transition to the Chrysalis program. In addition, the contract included the provision that support staff would be instructed to notify the police and press legal charges should Mr. Perry injure someone.

On March 3, 1999 Mr. Perry became combative during a discharge group. According to hospital records, Mr. Perry threatened a staff member, and when two other staff members attempted to intervene, he threw one of them to the floor.

Following this episode, Mr. Perry's discharge date was postponed and he experienced almost another full month of "incident free" behavior. A new discharge date of March 30, 1999 was established. On March 27, 1999 Mr. Perry complained of foot pain. He was examined by a physician on-call, who recommended cold compresses and Motrin for treatment. Mr. Perry requested to be taken to the emergency room, but was advised to wait and try what the doctor had recommended. Initially, Mr. Perry agreed to this plan, but after exiting the treatment room, he approached the on-call physician and threatened to kill him. Two staff members sustained injuries in an effort to intervene. A psychiatric emergency was called and Mr. Perry was placed in physical restraints with a net.

On March 28, 1999 Mr. Perry met with a staff psychiatrist for an evaluation of his condition. Mr. Perry was informed that, due to his behavior on March 27th, he had been placed on continuous observation and needed to remain in his room. He was also informed that he would be transferred to Whiting Forensic Institute perhaps as soon as the following Monday. Records indicate that as soon as the staff psychiatrist left his room, Mr. Perry walked out and yelled, "I have nothing to lose if I'm going to Whiting." As a result, Mr. Perry was again placed into physical restraints with the use of a net. Later that same day, Mr. Perry was placed in locked ambulatory restraints on a 1:1 status.

On March 29, 1999 Mr. Perry's DBT therapist noted the following:

> Patient continues to give only lip service to DBT – At the beginning of the month, patient did one set of behavioral alternatives over an incident in a discharge group – after that, however, patient has failed to submit even one diary card and has resisted initiating and completing one – in recent attempts to do a behavioral alternative, patient was very resistant. Patient has made some efforts when happier and more "stable" to do skills, but there has been little observable change when any more emotional stage exists. There is serious question whether DBT treatment should continue – patient will be approached to ascertain commitment for the remainder of his time at Cedarcrest.

Hospital staff injured in the March 3, 1999 and March 27, 1999 incidents filed complaints against Mr. Perry with the agency police officer and an application for an arrest warrant was filed on March 29, 1999. Mr. Perry was charged with third-degree assault, second-degree assault, threatening, and criminal mischief in the fourth degree. A consultation was requested by Cedarcrest Hospital of the Whiting Forensic Institute Team regarding the possible transfer of Mr. Perry to Whiting Forensic Institute or to the criminal justice system.

On March 30, 1999 the assistant director and staff from Whiting Forensic Institute met with Mr. Perry's treatment team, Cedarcrest administrative staff, Mr. Perry's CRMHC case manager, and their hospital liaison. According to written progress notes, the Whiting Forensic Institute team "agreed that Mr. Perry should face

legal charges and recommended that, if full consultation was desired, the director of Whiting Forensic Institute should be contacted." There is no written evaluation report on file.

On March 30, 1999 a telephone consultation was completed between medical staff at Cedarcrest Hospital and Whiting Forensic Institute. According to medical notes, Mr. Perry's psychiatric history, medication regimen, treatment approaches, and most recent behavior were discussed. The response reported from medical staff of Whiting Forensic Institute was that, "I cannot think of what else to do, it looks like everything is tried, unfortunately I do not have any wisdom."

On March 30, 1999 Mr. Perry's medical records contain the following notation made by his psychiatrist:

> Patient was made aware that he sabotages his discharge plans. He knew that he was going to be accepted by CHD (Center for Human Development) and would start looking for an apartment as of today. Patient has been ready for discharge for several weeks; placement has been very difficult because he acts out a few days before his discharge.

During this hospitalization, Mr. Perry was physically restrained and/or placed into seclusion a total of four times prior to the March 27, 1999 incident, which resulted in his being physically restrained twice with a net and then being placed into locked ambulatory restraints for the remainder of his stay at Cedarcrest Hospital. Examples of precipitating factors include his wanting another cigarette, altercation with patients, general agitation, and becoming angry when his request for outside medical attention was not satisfied.

According to Mr. Perry's psychiatric discharge summary, his final diagnoses were impulse control disorder, personality disorder, with antisocial, narcissistic, and borderline features, borderline intellectual functioning, and bronchial asthma. His prognosis was "guarded, in view of poor response to medications and poor impulse control."
On March 31,1999 Mr. Perry was escorted to New Britain Superior Court by the agency police officer and a caseworker to face charges.

According to a transcript of the court proceeding, the judge was informed by the agency police officer that Cedarcrest Hospital's position with regard to Mr. Perry was that "he was not mentally ill but suffering more of a personality disorder." In addition, the agency police officer reported that the hospital believed that "they cannot provide the services he needs at that particular setting." Mr. Perry's public defender petitioned the court for an evaluation for Mr. Perry as she questioned whether he could effectively understand the charges against him or assist with his defense. She reported that her interest was in securing further treatment for Mr. Perry. She stated, "I do believe that he (Mr. Perry) has a number of problems and that's one of the reasons, the main reason that he was

hospitalized…I would certainly argue that Corrections is not the place for him but a treatment facility…and, unfortunately, there is no phone that we can pick up and just have something available today." According to the transcript, the agency police officer was unsure as to what the Whiting Forensic Institute treatment team recommended in Mr. Perry's case, "but there was something about availability of beds, his space, at that facility."

In closing, the presiding judge granted the defense attorney's request for Mr. Perry to undergo an evaluation. A future hearing date was arranged and Mr. Perry was remanded to the Hartford Correctional Center.

ISSUES AND CONCERNS

1. Mr. Perry's records reveal that while a patient at Cedarcrest Hospital, he experienced intermittent periods of progress toward recovery. Although it is not clear which of the different combinations of medications, behavioral therapy, physical interventions or "time out," strategies was most helpful in this regard, it is clear that he was, at times, able to assume responsibility for his behavior and improve his relationships with others. However, it also seems apparent that he was unable to sustain the kind of continuous growth and stability necessary to succeed in a typical community based program. As his hospitalization(s) progressed, there is significant evidence of an increase in both the number and intensity of aggressive episodes requiring physical intervention, seclusion, and the use of PRN medication. His records also reflect a concurrent rise in the frustration level of his treaters. Yet, there does not appear to have been a mechanism in place for Mr. Perry's treatment team to step back and ponder what was not working; to seek an external consultation from a source that was both sufficiently expert in behavioral analysis, and sufficiently independent, to look objectively at what was really going on. While Cedarcrest staff did seek the opinion of Whiting Forensic Institute, the consultation was informal, and occurred only after an incident where Mr. Perry had threatened a physician and injured two staff members who were trying to restrain him. When Whiting staff indicated they were unable to offer treatment alternatives, the decision was made to seek Mr. Perry's arrest and ultimately his transfer to the Department of Corrections.
2. There does not appear to have been a programmatic response to Mr. Perry's recurring ambivalence and anxiety just prior to and immediately following discharge. While mention is made in Mr. Perry's medical records that he "undermined" his discharge plans, his treatment team reviews do not reflect discussions of alternative interventions. Mr. Perry's statements about his issues and concerns were apparently not given much credibility, especially during his later admissions. Hospital staff had a treatment plan in mind and insisted that Mr. Perry conform to it even when it was clear that, at that time in his life, he couldn't. Mr. Perry may have been told that he didn't have to

threaten other people or destroy property in order to stay in the hospital, but that wasn't really true. In the face of other alternatives, it appears as if Mr. Perry's experience taught him how to work a system that was leading him in a direction about which he was reporting, and demonstrating, he felt ambivalent.

3. One of the themes that emerges from reviewing Mr. Perry's records is that, despite their efforts to help him succeed, his treaters seemed to lose sight of what it was like to be him. The whole treatment plan was built around his achieving self-control, and when he did not do so, it is apparent that the interpretation of who he was and what he needed began to change. Nowhere in the hospital records is there a sense that the system might be failing Mr. Perry. Instead, the reports are more about how he failed to meet the standards of the system. In this context, Mr. Perry's arrest seems to reflect a hopelessness on the part of staff – partly a "we give up," statement of frustration, partly a punishment imposed for violently rejecting the help they had offered.

4. There is evidence in Mr. Perry's records that he was eligible to participate in the Department of Mental Health and Addiction Services (DMHAS) Specialized Services for Transitioning Youth, also known as the Special Populations Project. The project's purpose is to assist young people like Mr. Perry to make a successful transition to adulthood. Services available through participation in this project include housing, vocational support, treatment, and supervision. There is no indication in Mr. Perry's records that these services were ever made available to him.

5. According to PAIMI records, Mr. Perry received advocacy services from the Connecticut Legal Rights Project (CLRP). There is, however, no record of Mr. Perry having any contact with a CLRP advocate during his hospitalization(s) or arrest.

6. At the time of Mr. Perry's arrest, DMHAS had no policies or procedures in place to ensure that decisions to pursue arrest of clients were made in a consistent manner, according to objective criteria.

INCARCERATION AND DEATH

On March 31, 2001 Mr. Perry was transferred to the South Block Unit at the Hartford Correctional Center (HCC). South Block Unit is a mental health unit that is staffed by both custody and medical/mental health staff and managed by the University of Connecticut Health Center (UCHC) in partnership with the Department of Correction (DOC). In a Memorandum of Understanding signed and dated August 11, 1997, UCHC agreed to manage a comprehensive health care delivery system that includes the provision of medical, mental health, dental,

and ancillary services to inmates in DOC correctional facilities. While delivery of health care and clinical services to inmates is managed by UCHC, the DOC retains the authority for the care and custody of inmates and has responsibility for the supervision and direction of all DOC facilities. UCHC, however, assumes full responsibility for correctional health care personnel under this agreement.

The South Block Unit at HCC consists of two tiers which house "exclusively mental health inmates." Each tier contains twelve single cells for a total of twenty-four inmates.

Mr. Perry was admitted to the South Block Unit on a Psychiatric Watch (PW) and Keep In Cell (KIC) status. According to the Mental Health Initial Assessment completed by the Correctional Head Nurse on March 31, 1999:

> This 20-year-old black male is transferred to jail from Cedarcrest Hospital after assaulting a staff member. He is on Clozaril, Depakote, Prozac, Klonopin. He is angry with an angry, irritable affect. Got into a situation with an officer while awaiting his intake and was escorted back to the unit without his intake. He is explosive with no impulse control. Denies voices. Admits to being adopted and beaten by father two times a day until placed by the state.

In a statement to DOC investigators on September 7, 1999, the same correctional head nurse made the following statement:

> The day of Timothy Perry's admission, I received a telephone call from the court, apprising me of his admission status. I was informed that Perry was assaultive and was a patient at Cedarcrest. He had been hitting Cedarcrest staff on a regular basis and was being sent to us to teach him a lesson.

On April 5, 1999 the following note was made by the South Block Unit psychiatric social worker:

> Inmate has been well behaved in his cell on PW and KIC status. I let him out of his cell this evening to speak to me. He expressed remorse regarding the assault (alleged) on staff at Cedarcrest Regional Hospital. Stated he has a temper problem. Stated he hopes he will be allowed out of his cell soon. States he intends to be well behaved because jail is a terrible place.

According to a DOC Mental Health Treatment Plan developed on April 9, 1999, Mr. Perry's problem was identified as "inmate has been aggressive with his behavior towards others." The treatment goal established was to "decrease and cease aggressive, assaultive behavior." Interventions included 1:1 mental health

counseling, taking medications as prescribed, and follow-up outpatient services when discontinued from the court.

By April 9, 1999 Mr. Perry had been removed from KIC and PW status and on April 12, 1999 he was cleared for Unit C-2 status. Unit C-2 houses inmates with mental health needs, but their problems are less acute. Mr. Perry's clinical records report that a social worker from the public defender's office was due to visit him on April 13, 1999.

On April 12, 1999, approximately two hours after being placed into 4-point restraints, DOC and UCHC staff discovered Mr. Perry to be unresponsive. Resuscitative efforts were initiated and Mr. Perry was transported to Hartford Hospital by ambulance. Within minutes after arriving at the hospital, Mr. Perry was pronounced dead. The following chronology of events and witness statements are taken from comprehensive State Police and DOC investigative reports, which were conducted in response to the untimely and suspicious death of Mr. Perry.

SUMMARY OF EVENTS

On April 12, 1999, prior to 7:45 PM, Mr. Perry was in the South Block west dayroom for evening recreation. Prior to this date, the unit rover (correctional officer on duty) had never worked with or seen Mr. Perry. According to statements provided to DOC investigators, the unit rover's first interaction with Mr. Perry was when Mr. Perry let him know that he wanted to see the nurse. The unit rover told Mr. Perry that he would see her when she came around. In a statement provided by the nurse, she indicated that she had the opportunity to speak with Mr. Perry on a number of previous occasions and had developed a rapport with him. She reported that on the evening of the incident, she was very busy in her outpatient area with new admissions. At one point, she walked past the dayroom and Mr. Perry asked to talk with her. She told him that she would speak with him later, but she never had the opportunity.

<u>7:45 PM</u>

According to all witnesses present, at approximately 7:45 PM, on that same evening, Mr. Perry began pacing around the dayroom, yelling and banging on the windows, and standing on the table and chairs. Both the correctional head nurse assigned to the South Block Unit and the unit rover spoke to Mr. Perry, urging him to calm down. Mr. Perry remained anxious and uncooperative and subsequently refused several orders to return to his cell or "lock up." There were two inmates in the dayroom at this point and they returned to their respective cells without incident.

The unit officer contacted the control center officer, who dispatched three correctional officers to assist the unit rover. All three officers and the unit rover entered the dayroom and attempted to convince Mr. Perry to return to his cell. After a short time, Mr. Perry looked as if he had calmed down and appeared as if he was going to return to his cell without further incident.

According to witness reports, Mr. Perry began walking towards the dayroom door when suddenly, apparently without warning or provocation, he charged the unit rover. The unit rover then pushed Mr. Perry backwards and he and the other correctional officers began struggling to restrain Mr. Perry. The unit officer then called a code orange, alerting facility personnel that an officer was being assaulted and needed additional back up.

A fourth officer arrived on the scene and witnessed Mr. Perry thrashing around on the floor. This officer assisted in turning Mr. Perry on to his stomach. According to witnesses present, with a struggle and the help of other officers, this officer then handcuffed Mr. Perry behind his back. According to most of the facility personnel present, Mr. Perry stopped speaking once the use of force began.

8:00 PM

By this time, other facility staff had arrived, including another correctional officer and the scene supervisor, who was a lieutenant, both of whom directly assisted. By this time, Mr. Perry was face down on the dayroom floor, handcuffed behind his back. Several minutes had elapsed and Mr. Perry was still described as "actively resisting." Four correctional officers and the unit rover then carried Mr. Perry face down to his cell, which was Cell #10, and placed him face down on to his bunk. The lieutenant/scene supervisor supervised the staff throughout this portion of the incident, and, while in Cell #10, also applied leg irons to Mr. Perry.

One of the correctional officers was maintaining control of Mr. Perry's head. He, along with several other facility staff, stated that Mr. Perry was either spitting or making "gurgling noises" as if he was about to spit. While in Cell #10, the officer maintaining control of Mr. Perry's head called out for a towel. A towel was passed to him and the officer either placed the towel over Mr. Perry's mouth or his entire face, as witness accounts differ concerning the exact placement of the towel.

The correctional head nurse, in her statement to DOC investigators, reported that from the time the unit rover and Mr. Perry struggled in the dayroom to the time Mr. Perry was in Cell #10 appeared to have been approximately ten minutes. According to her statements, the correctional head nurse, who was in charge of the medical and mental health areas for the 4:00 PM to midnight shift, informed the lieutenant/scene supervisor, who identified himself as the officer in charge, that she was going to contact the staff psychiatrist.

The correctional head nurse contacted the staff psychiatrist via pager. According to her statements, the staff psychiatrist called back quickly. The correctional head nurse gave the staff psychiatrist a brief history and summarized Mr. Perry's actions. According to her statements, the staff psychiatrist ordered Mr. Perry to be medicated with 2 milligrams of Ativan and 10 milligrams of Haldol and that he be placed into 4-point restraints. The correctional head nurse then relayed this information to the lieutenant/scene supervisor. It should be noted that the lieutenant/scene supervisor indicated in statements to DOC investigators that it was hard for him to believe that they were placing Mr. Perry in 4-point restraints. He felt that Mr. Perry's behavior didn't warrant 4-point placement, only cell restraint. In a statement to DOC investigators the lieutenant/scene supervisor reported the following:

> The correctional head nurse was making the calls and other staff in the immediate area was confirming this is how it is done here. I was not used to medical staff calling shots in incidents such as this and this to me was a custody issue.

It should be noted that the 2nd shift commander reported to DOC investigators that he also didn't feel comfortable with "this 4-point restraint and I questioned who made the decision…the lieutenant/scene supervisor informed me that the nurse stated that a doctor ordered the 4-point restraint and that was the policy for this facility."

In the South Block Unit, Cell #13 and Cell #24 are designated for 4-point restraints. Each cell has a surveillance camera that is monitored at the unit officer's station. The cameras do not have recording capability, nor are they monitored from any other location in the facility. Both Cell #13 and Cell #24 were occupied at this time, but neither inmate was in restraints.

According to statements provided to DOC investigators, the correctional head nurse and a second lieutenant on the scene assisted in preparing Cell #24 for Mr. Perry's transfer. After the inmate in Cell #24 was moved, Mr. Perry was carried face down from Cell #10 to Cell #24. At this point, witness accounts still place the towel over Mr. Perry's head/face. It should be noted that, according to witness accounts, Mr. Perry's level of resistance decreased to "minimal" as the incident progressed.

<u>8:20 PM</u>

Immediately after being placed face down on the bunk in Cell #24, the unit officer began filming the incident. When the filming begins, Mr. Perry is on his stomach and correctional officers are removing his leg irons, pants, and underwear. Both lieutenants are actively supervising the officers. Mr. Perry is quiet and does not appear to be resisting in any way. Medical staff informs the lieutenants that Mr.

Perry must be placed on his back, but will first be given medication by injection. The correctional head nurse and a correctional medical attendant enter Cell #24 and Mr. Perry is given two injections in his right buttocks. Mr. Perry is silent and doesn't appear to react at all when the injections are administered. In her statements to DOC investigators, the correctional head nurse reported that "Mr. Perry did not move or flinch when I injected him like most patients do."

Next, Mr. Perry is turned over onto his back, leg and wrist restraints applied and his shirt and t-shirt are cut/torn off. The scissors don't cut very well and correctional officers manipulate Mr. Perry's body to remove his shirt and t-shirt. Finally, they actually end up tearing the shirts off of him. Throughout this time, correctional staff maintains controlling techniques, ready to apply pain compliance if necessary. One correctional officer can be seen on the videotape applying a bent wrist technique to Mr. Perry at 8:24:54 PM, and looking for some type of response. Throughout this time period, Mr. Perry does not appear to resist in any way. Mr. Perry does not utter a sound and no one present, neither the correctional officers nor the lieutenants, give instructions to Mr. Perry or advise him to stop resisting.

Of note is that the unit officer filming the incident can be heard commenting on the videotape that Mr. Perry is still resisting when, in fact, no resistance can be seen. After reviewing the tape, the unit officer acknowledged that Mr. Perry was not resisting and offered that he thought he had seen movement out of the corner of his eye as he looked between the viewfinder and the top of the camera.

Although the videotape doesn't show Mr. Perry's face, at various points during the film a correctional officer is observed continuing to hold a towel over Mr. Perry's mouth/face. At 8:29 PM, this same correctional officer is clearly seen holding a towel over Mr. Perry's face. Immediately before exiting the cell, this same correctional officer can be seen removing the towel from Mr. Perry's head. The videotape never shows Mr. Perry's face or eyes.

Just before the correctional officers exit the cell, a paper gown is loosely placed over Mr. Perry's body, obscuring any view of his face. According to the DOC investigation report:

> Significant is that during the entire videotape, Mr. Perry is silent, appears motionless, and totally unresponsive. No one is talking to Mr. Perry or giving him instructions. The involved staff consistently state that Mr. Perry ceased resisting but none of them found his behavior peculiar.

<u>8:30 PM</u>

After the correctional officers exit the cell, the lieutenant/scene supervisor briefly summarizes the incident and signs off the videotape. As the videotape ends, the correctional head nurse is seen informing the lieutenant that she must check the

4-point restraints. The videotape did not remain on for the restraint check, but according to statements provided to DOC investigators, both lieutenants entered the cell with the correctional head nurse. She determined that one or both of the wrist restraints required adjustment, which was accomplished by the lieutenants. During her final restraint check, the correctional head nurse "believed" she detected a pulse at each restraint location. She also could not recall any problems with Mr. Perry's respirations. She did not remember Mr. Perry speaking or looking at her. The lieutenant/scene supervisor, in a statement provided to DOC investigators, reported the following:

> I checked his left restraints. While checking his wrist restraint I do recall Mr. Perry's eyes were open. I just glanced at him and it appeared as if he looked at me. Throughout the incident it was hard for me to believe that we were placing him in 4-point restraints.

After Mr. Perry's cell was secured, everyone left the unit, except for the unit officer and a correction officer cadet. Cadets are assigned to the units for training and are instructed to observe, not become directly involved in incidents. The unit rover, in direct contradiction to a recent notice requiring the unit rover to remain in the unit at all times, left the South Block Unit to report to the medical unit to be examined.

After the unit rover left the unit, the unit officer monitored Mr. Perry from the officer's control station camera. According to statements provided to DOC investigators, the unit officer never saw any indication of trouble over the monitor. He reported that "Mr. Perry had been sedated and appeared to be sleeping." The correction officer cadet conducted the 15-minute checks of Mr. Perry and documented them on a Close Observation Checklist. In statements provided to DOC investigators, the correction officer cadet reported the following:

> I knew to look for living, breathing flesh. I thought I saw living, breathing flesh. He (Mr. Perry) had a paper gown thrown over him and I thought I saw the paper gown moving. I did not expect to see much movement from Mr. Perry due to the fact that he was sedated. He remained in the position he was in, on his back and I think his face was turned to the right. The inmate's face was partially covered by the paper gown that was laid on top of him.

The correctional head nurse reported to DOC investigators that she did "check in on Mr. Perry periodically and he appeared to be okay." She also reported that the last time she "peeked into his cell was about 9:15 PM." The unit officer and the correction officer cadet both stated that they never observed the correctional head nurse conduct these checks, nor was there documentation of them.

At approximately 10:05 PM, the correctional head nurse left the South Block Unit in order to tour Unit C-2. When she left, she informed the correctional head

nurse assigned to the outpatient area that she was leaving. At this point, the correctional head nurse assigned to the outpatient area was responsible for the South Block Unit.

Earlier in the evening the correctional head nurse assigned to the outpatient area told DOC investigators that at around 8:30 or 8:40 PM, when she found out that Mr. Perry had been "4-pointed and medicated," she went to Cell #24 "and peeked in and saw ankles and feet with a puffed up gown blocking my view of his face…I didn't look long enough to see the rise and fall of his chest…I was afraid he would see me and I would have to spend time with him, which I couldn't because of other duties."

10:30 PM

At approximately 10:30 PM the unit officer returned to the South Block Unit. He had been gone approximately two hours. As he entered the unit, he spoke with the correctional head nurse about how strong Mr. Perry was earlier. After speaking briefly, they went to check on him. When the correctional head nurse looked through the cell door window, she observed Mr. Perry's feet to be discolored. In a statement to DOC investigators, she reported the following:

> I saw Mr. Perry's feet discolored – they were blotchy and mottled. Mr. Perry was in the same position that I had seen him in earlier. I had the unit officer open the door. I went inside and tried to take his pulse. Mr. Perry was cold and stiff – he had been dead for some time.

A code white was then called, CPR was initiated, and an ambulance was summoned. According to the American Medical Response of CT ambulance report, rigor was noted in Mr. Perry's jaw and arms. Mr. Perry was transported to Hartford Hospital where he was pronounced dead at 11:10 PM.

FINDINGS

Office of the Chief Medical Examiner Postmortem Report

The report of the postmortem examination performed by Edward T. McDonough, M.D., Deputy Chief Medical Examiner, revealed the following evidence of injury:

> The presence of a thin superficial abrasion on the right side of Mr. Perry's neck, a compression band around the left wrist and a 3/8" abrasion over the right ulnar process. Internal examination revealed no hemorrhage in the soft tissues of the neck or injury to the laryngeal structures other than a 0.8 cm hemorrhage in the right piriform sinus. There were hemorrhages in the anterolateral aspects of the tongue bilaterally. Hemorrhages were also present in the temporalis muscle. Three pinpoint petechial hemorrhages were also present on the lower lid of the left eye. No other

injuries were noted, and there was no evidence of pre-existing natural disease which would have contributed to Mr. Perry's death.

Dr. McDonough concluded the following:

> There are two main possibilities for this gentleman's death. One would be an "excited delirium" type of death where during a struggle a hyperadrenergic (adrenaline) response would cause an abnormal heart rhythm even to a grossly or microscopically unremarkable cardiac tissue. This would cause a cardiac arrest. Secondly, in any situation involving multiple person restraint, the possibility of an asphyxial death is raised. This could occur by compression of an individual's chest, causing an inability to inhale air. Also, a form of neck or airway blockage could be accomplished. The autopsy examination did show three tiny petechial hemorrhages in the eyes. While these are seen in asphyxial deaths, these are nonspecific findings and can also be found in sudden cardiac deaths. A careful internal examination of the neck structures revealed no evidence of hemorrhage that would be consistent with a strangulation and no injury to the mouth suggestive of an oral airway blockage was identified. None of the investigative information allows for an accurate reconstruction in a second by second, moment to moment fashion that is required in order to make a diagnosis of a traumatic, or other type of asphyxial, death. Therefore, no specific diagnosis is able to be made at this time.
>
> Of note, a corrections nurse gave the deceased an injection in the right buttock reported to be lorazepam (Ativan 2 mg) and haloperidol (Haldol 10 mg). The toxicologic results revealed the presence of the lorazepam and also the haloperidol in the area of the injection site. Of note, the presence of chlorpromazine (Thorazine) was also detected in the area of the injection, which is not supported by the medical records.
>
> Final Cause of Death: Sudden Death During Restraint
> Final Manner of Death: Undetermined

Department of Corrections Investigation Findings

DOC investigators, in the summary section of their investigation report, made the following statements:

> From the time inmate Perry assaulted the unit rover until the 4-point placement was completed, approximately 20 minutes elapsed. Throughout this period, staff had their "hands on" Perry. Initially, Perry actively resisted. His level of resistance diminished as the incident progressed. When the filming began (approximately 10 minutes into the incident), Perry appears to be **totally unresponsive**. There is

> consistency in their statements that Perry was mute during the entire incident and no one is talking to him, for any reason. Disturbing is that not until the videotape was reviewed by some of the involved staff that they realized Perry was unresponsive, including the unit officer who states on the tape that Perry is still resisting. When the unit officer reviewed the tape, he realized Perry wasn't resisting at all and offered that he thought he saw resistance through his peripheral vision as he picked his head up from the camera viewfinder. No one, either custody or medical staff, thought Perry's actions were unusual.
>
> After being placed into restraints, Timothy Perry was monitored via camera by the unit officer at the unit officer's station. The correction officer cadet checked him every 15 minutes from the cell door observation window. In addition, the correctional head nurse claims she observed Perry from the cell door observation window at least 10 times between 8:30 PM and 10:10 PM. At approximately 10:30 PM, when the correctional head nurse originally assigned to the outpatient area discovered Perry unresponsive, she noted his feet were discolored and that he was cold and stiff. The correctional medical attendant (medic), who administered CPR, also described him the same way. The medical examiner's report did not establish the time of death. However, there is indication that he was deceased for some time.

In addition to the investigative summary, DOC investigators issued a number of findings, which resulted in disciplinary action being taken against DOC facility employees involved in the incident. DOC investigators also issued findings concerning the actions of the correctional head nurse and correctional medical attendant. However, as UCHC employees, UCHC assumed responsibility for determining whether any disciplinary action should be taken against them as a result of their involvement in the incident.

DOC findings included the following:

1. Although the incident lasted approximately 20 minutes, only the latter half is documented on videotape. During the course of the investigation it was learned that the HCC did not have a procedure designating staff responsible for videotaping incidents. A policy/procedure was not developed until after inmate Perry's death.

2. That initially, Perry resisted with great force. After about 10 minutes, when the videotape begins, Perry appears to be totally unresponsive. Careful review of the videotape fails to produce a single voluntary movement by inmate Perry. Staff observed this behavior yet none thought it to be unusual.

3. That Perry was mute from the point where he attacked the unit rover. No one is heard talking to the inmate or giving him any instructions, especially when

they turned him over or he was given the injections. No one ever tells Perry to stop resisting.

4. Throughout the videotape, the lieutenants actively supervised the officers. The lieutenants never give any instructions to Perry, only staff.

5. One correctional officer used a towel as a spit shield, which was observed by both lieutenants and allowed, although not authorized.

6. The incident videotape was not handled as evidence and the facility captain should not have allowed correctional officers to review the tape following the incident without a supervisor present.

7. That although the HCC Post Order 8.7, regarding the use of 4-point restraints for psychiatric intervention was in effect since 1994, the required checks of the pulse, respiration, circulation, blood pressure, and temperature were not conducted, and were not a matter of protocol. The medical staff claim they were never issued the post orders. Some acknowledged they were aware the post orders were located at the nurse's station. Review of their files failed to produce any documentation that the post orders were issued. (Note: On April 13, 1999, the day following this incident, it was discovered that a copy of Post Order 8.7 was missing from the policy manual at the South Block Unit nurse's station).

8. That the correctional head nurse failed to provide proper medical care for inmate Perry. She failed to conduct physical assessments (described in Post Order 8.7) and document them in the progress notes section of the inmate's medical chart. Furthermore, between 8:30 PM and 10:00 PM, the correctional head nurse claims she conducted visual checks of inmate Perry from the cell door window, but she did not document these checks in the medical chart, nor did she observe anything unusual. Furthermore, as the correctional head nurse monitoring inmate Perry, she was responsible to determine when inmate Perry's behavior warranted the removal of the 4-point restraints. According to everyone who observed him, Perry was calm since he was placed in Cell #24, thereby raising the question as to whether the 4-point restraints were necessary for as long as they were used.

9. The videotape depicts significant deficiencies in the overall condition of Cell #24. The cell is filthy with layers of paint peeling from the walls. This condition is unacceptable and far below DOC standards.

10. The stationary unit surveillance cameras do not have recording capability nor can they be monitored from the control center.

<u>Independent Toxicology Findings</u>

The results of post-mortem forensic toxicology reports prepared by Thomas G. Rosano, Ph.D., DABFT, DABCC, Forensic Toxicologist, dated as recently as March 17, 2001, revealed the following findings:

> The result of postmortem toxicologic studies reveals the presence of fluoxetine (Prozac) and clozapine (Clozaril) in Mr. Perry's blood. The postmortem level of fluoxetine (Prozac) in gastric content indicates recent oral ingestion of the drug that has not had sufficient time to distribute throughout the body. (Note: DOC medical records show that Mr. Perry was dispensed a 40 mg dose of Prozac at 12 PM on 4/12/99) The postmortem level of clozapine (Clozaril) is consistent with oral therapeutic use of Clozaril and is also consistent with the medication plan. (Note: DOC medical records show that Mr. Perry was dispensed a 300 mg dose of Clozaril at 10 PM on 4/12/99) The postmortem level of valproic acid (Depakene) is consistent with the oral use of Depakene and with the medication plan. (Note: DOC medical records show that Mr. Perry was dispensed a 1000 mg dose of Depakene at 10 PM on 4/12/99) The postmortem level of lorazepam (Ativan) is consistent with a perimortem intramuscular injection of Ativan. The undetectable level in iliac blood indicates insufficient time or insufficient circulation for systemic distribution of the drug. The postmortem level of haloperidol (Haldol) in iliac blood and tissue from the injection site are consistent with a local injection of the drug near or after the time of death. The elevated level of haloperidol (Haldol) in iliac blood indicates insufficient time or insufficient circulation for systemic distribution of the drug to body tissue. The postmortem blood and tissue studies of chlorpromazine (Thorazine) in this case are consistent with a perimortem intramuscular injection of chlorpromazine (Thorazine). The trace level of chlorpromazine (Thorazine) in iliac blood with high concentration at the injection site indicates insufficient time or insufficient circulation for systemic distribution of the drug.
>
> Based on the drug treatment information and toxicology studies reviewed in this case, the findings are consistent with oral therapeutic use of clozapine (Clozaril) and valproic (Depakene) as prescribed. The tissue and blood determinations of lorazepam (Ativan), chlorpromazine (Thorazine), and haloperidol (Haldol) indicate administration of these drugs at or around the time of death. The toxicology findings do not indicate a fatal drug overdose.

Independent Forensic Findings

The results of an independent forensic report prepared at the request of PAIMI by Barbara C. Wolf, M.D., Forensic Pathologist, dated October 23, 2000, reveal the following findings:

It is my opinion, to a reasonable degree of medical certainty, that the placement of Mr. Perry face down in a prone position with his hands restrained behind his back and his legs restrained, and with a towel held over his mouth, placed the inmate at a significant risk of death. It is my further opinion that these actions were more likely than not indeed the cause of his death. Such a position inhibits chest wall motion and compromises breathing. When restraint is required, an individual should not be left in a prone position once subdued. In this case the videotape of Mr. Perry's restraint shows him making no motion, suggesting he succumbed prior to his being placed in the supine position. Furthermore, the rigor mortis noted by ambulance personnel indicates that he had been dead for longer than indicated by the correctional head nurse, since rigor mortis usually requires at least a period of up to two hours before it becomes first detectable, indicating that Mr. Perry was not adequately monitored while under the observation of the correctional head nurse.

The term "restraint asphyxia" refers to deaths occurring under these circumstances, when an individual is restrained, usually in the prone position following a state of physical and emotional exertion. Extreme emotion and physical exertion increases the individual's requirement for oxygen. Clearly a multitude of factors can contribute to the sudden death of an individual during restraint, including physical compromise of breathing and hormonal responses of the body. Correction officers and other law enforcement officials should be trained in the proper methods of restraint, transport and monitoring of individuals when such restraint is necessary. An individual under restraint should not be left in the prone position but should be seated or placed on his side or back as soon as possible. The individual should be monitored for adequacy of air exchange and level of consciousness.

The detection of Thorazine in Mr. Perry's system at the time of his death is also a source of concern. His medical records indicate that he was allergic to Thorazine. Although the postmortem findings do not suggest an allergic or anaphylactic reaction as being a contributory factor in his death, his prescribed medications and the medications allegedly given during the inmate's restraint do not account for the presence of Thorazine.

PAIMI FINDINGS

In addition to the findings reached by the Office of the Chief Medical Examiner, DOC investigators, independent toxicology, and forensic reports, and based upon a review of all the available medical and investigative materials, PAIMI also concludes the following:

1. That Mr. Perry's medical records reveal that the correctional head nurse who was responsible for monitoring Mr. Perry the evening of his death initialed on his medication sheets that she dispensed prescribed doses of Depakene, Clozaril and Ativan to him orally at 10:00 PM on April 12, 1999. However, it is clear that documentation is in error, as at that time Mr. Perry was in cell # 24, in four-point restraint, and very likely had already expired.

2. That while the independent toxicology report concludes that Mr. Perry's postmortem level of Prozac in gastric content indicated recent oral ingestion of the drug (i.e. not very long before the occurrence of death), Mr. Perry's medical records indicate that his last dose of Prozac (40 mg) was dispensed at 12:00 PM on 4/12/99. There is no documentation in Mr. Perry's medical records to suggest that Prozac was dispensed orally at any later point in time.

3. That while the independent toxicology report reveals that Mr. Perry's postmortem blood and tissue levels of Thorazine are consistent with a perimortem intra-muscular injection of Thorazine, there is no documentation in Mr. Perry's medical records to suggest that Mr. Perry received an intra-muscular injection of Thorazine at any time. In fact, Mr. Perry's medical records clearly document an allergy to Thorazine.

4. That while independent toxicology studies and forensic reports determined that intra-muscular injections of Ativan and Haldol were administered to Mr. Perry just prior to, or even possibly after his death, and that by that time he appeared to be totally passive (indeed unresponsive), neither nursing nor custody staff considered whether the conditions which had precipitated the staff psychiatrist's initial order for the use of medication were still warranted, and whether, as Mr. Perry was no longer struggling, a change in the order should be sought.

5. That according to HCC Post Order 8.7, Restraints as a Psychiatric Intervention, dated May 1994, restraints are to be used only in situations in which a patient's behavior presents an imminent danger to himself or others and LESS (emphasis in the original) restrictive methods have either been unsuccessfully tried or cannot be safely implemented. Neither custody nor medical staff attempted to implement less restrictive measures with Mr. Perry once handcuffs and leg irons had been applied in Cell #10 and he had been effectively immobilized.

6. That according to HCC Post Order 8.7, Restraints as a Psychiatric Intervention, dated May 1994; the correctional head nurse is required to explain the restraint procedure and reasons for the restraint to the patient. There is no evidence to indicate that any of the custody or medical staff present attempted to communicate with Mr. Perry over the course of the entire incident.

7. That while the DOC investigation report states that the correction officer cadet conducted 15-minute checks of Mr. Perry between 8:45 PM and 10:15 PM, and documented such checks on the Close Observation Checklist, an examination of the checklist reveals that the 15-minute checks are not initialed.

8. That based upon the position of the paper gown used to cover Mr. Perry following the removal of his clothing and the application of 4-point restraint, the only part of his body that is likely to have been visible to custody or medical staff checking on his condition through the cell door window were his ankles and feet.

9. That while, as the postmortem report indicates, it is impossible to establish the exact time and nature of Mr. Perry's death, independent toxicology studies and forensic reports have determined that intra-muscular injections were administered to Mr. Perry just prior to or possibly even after his death. As many as ten custody and medical staff either had their hands directly on Mr. Perry or were present in Cell #24 just prior to, during, and immediately following his death, yet they neglected to, in any way, attend to his most basic physical and/or medical needs. In addition to significantly compromising his life during the application of restraint, they took no action to ensure that his life, once fatally threatened, had a chance of being saved.

RECOMMENDATIONS

The following recommendations are organized into two sections: one specific to the Department of Mental Health and Addiction Services (DMHAS), the other specific to the Department of Corrections (DOC). They are intended to stimulate discussion, and urge clarification of policies and procedures related to issues identified in the report.

Recommendations for DMHAS

1. **Develop a formal mechanism to initiate multi-disciplinary, external review and consultation regarding the treatment of individuals whose behaviors are proving to be especially challenging despite efforts of clinical staff of a particular facility. Particular attention should be paid to those individuals whose treatment goals are consistently not realized despite the use of various therapies and interventions, and whose behaviors are deteriorating and potentially dangerous, as evidenced by an increase in the use of physical interventions, seclusion, and the use of PRN medication.**

It is clear in Mr. Perry's case, as noted in his records, that as his hospitalizations progressed, there was a significant increase in both the number and intensity of

behavioral episodes. These were met with more restrictive levels of physical restriction and various pharmaceutical interventions, neither of which seemed to diminish the impulsive behavior. While Mr. Perry's case notes describe his behavior as unstable and lacking self-control, his treatment team reviews do not reflect any discussions of alternative courses of treatment or modifications to plans to discharge him to a community program. Nor do they explore how his cognitive limitations (noted in his final discharge summary) may have influenced his ability to fully participate in, and derive benefit from, the type of behavioral programming and other therapeutic interventions being provided. (For instance, dialectical behavior therapy requires that individuals keep extensive diaries, yet writing fluently may be difficult for someone with cognitive impairments.) As Mr. Perry's needs became more critical and his failure to meet the objectives established in his treatment plan became more pronounced, his treatment goals and discharge plans remained essentially unchanged.

When it became clear that Mr. Perry could not conform to the treatment plan hospital staff had in mind, bringing a discussion of his treatment history to objective, outside evaluators for consultation and review, could have created the opportunity for a greater understanding of his needs and an examination of other treatment approaches. Having an objective, outside evaluation could also have ensured that all of the services available to Mr. Perry were being offered. For instance, he might have benefited from a program established to assist youth with mental health needs transition to adulthood (Specialized Services for Transitioning Youth)

While Cedarcrest Hospital did informally seek the opinion of a psychiatrist at Whiting Forensic Institute, that discussion occurred following the incident which precipitated Mr. Perry's arrest. When that discussion failed to produce additional insight or treatment alternatives, no further outside opinions were sought.

2. **Review current guidelines regarding the arrest of clients, to ensure that decisions to arrest clients are made only under very limited circumstances and only when the alleged criminal conduct is clearly not a manifestation of a client's mental illness.**

In order to ensure that consistent standards are being applied, it is vital that there be a mutually agreed upon set of underlying principles to guide the response of mental health professionals across individual facilities whenever a client arrest is being considered. Although DMHAS has developed draft guidelines since Mr. Perry's death, the following issues need to be emphasized:

- While the current draft DMHAS guidelines state that "arrest is to be considered only when (a full array of clinical) interventions are either inadequate or inappropriate," <u>it is critical that DMHAS ensure that clients are not arrested for exhibiting behaviors for which they are specifically being provided treatment</u>. While it is true that Mr. Perry's aggressive

behavior presented particular challenges, and that staff members sustained physical injuries in their attempts to manage his behavior, his impulsivity and inability to utilize the behavioral alternatives that had been presented to him, as well as his lack of patience and admitted inability to cope with his anxiety, make it unlikely that at this point in his life he was capable of controlling his impulsive responses or assuming full responsibility for his behavior. There is no evidence that Mr. Perry's aggressive episodes were premeditated. Rather, the pattern of Mr. Perry's assaultive behavior indicates an almost reflexive response to certain stressors, and are characterized by an inability to form appropriate judgments when confronted by those stressors. (This is further evidenced by his inability to assess the danger he was placing himself in by antagonizing officers at the Hartford Correctional Center.)

- Before a client is arrested, or if an application for an arrest warrant is being sought, DMHAS should ensure that an external advocacy source, such as OPA or the Connecticut Legal Rights Project (CLRP) is notified. In Mr. Perry's case, although his records indicate that he received advocacy services from the CLRP, there is no evidence that he was provided with an opportunity to meet with his advocate regarding his impending arrest and appearance in court.

- If a client is transferred from a DMHAS facility to a correctional facility, as in the case of Mr. Perry, DMHAS should ensure that the treatment team responsible for providing mental health services in the correctional facility is accurately apprised of the client's treatment history and needs, and that contact by DMHAS staff is maintained with the client to ensure an appropriate level of care and support is being provided.

<u>Recommendations for DOC</u>

1. **Review current policies and procedures regarding both custodial restraint practices and the use of physical and chemical restraints as psychiatric interventions, in order to ensure that both conform to accepted medical standards and do not place individuals at risk of injury or death. It should be clear that in both custodial and medically-ordered restraint situations, inmates are not to be held face down; that breathing may not be impeded; that covering of a restrained inmate's head or face is not permitted; and that both the reasons for using the restraints, and conditions necessary for their discontinuation should be explained to the inmate. These policies should also make clear that, especially when dealing with inmates known to have psychiatric involvement, genuine attempts must be made to de-escalate the situation prior to employing physical force or restraints. Procedures for the use of emergency or involuntary administration of psychoactive medication should also be modified**

to require qualified personnel to assess the physical status of the inmate prior to administration and at regular intervals thereafter.

Subsequent to Tim Perry's death, DOC issued new or revised policies on mental health services for inmates (Administrative Directive 8.5, dated 6/19/00), Suicide Prevention (Administrative Directive 8.14, dated 8/26/99), and Psychoactive Medication (Administrative Directive 8.8, dated 7/23/99). The policy on suicide prevention also contains a section addressing the use of "Emergency Mental Health Intervention", including use of restraints. That section sets fairly comprehensive requirements for medical orders, documentation, and a schedule of checks for vital signs at regular intervals. It also prescribes the use of "soft" restraints in a face-up position only. However, these requirements apply only when on-site Health Services staff is on site. In situations where Health Services personnel are not present, correctional staff is to be initially guided by DOC's policy on Use of Force (Administrative Directive 6.5).

The Use of Force policy (Administrative Directive 6.5) covers a range of interventions up to and including the justifiable use of deadly force to protect life and prevent escape. While the policy requires supervisory authorization for the use of in-cell or full stationary restraints, and requires medical observation of restrained inmates every two hours, it does not provide specific directions regarding positioning nor detail regarding the specific requirements for medical monitoring. Especially with respect to inmates with mental health needs, this bifurcation of rules invites problems and confusion. It must be remembered that the initial response to Tim Perry's non-compliant behavior on the evening of April 12, 1999, was from custodial staff, apparently using customary custodial restraint techniques. These techniques included multiple staff members holding Mr. Perry, face down, for an extended period – possibly resulting in severe respiratory compromise and "restraint asphyxia". DOC should review the interplay between these two distinct restraint policies to ensure that, to the maximum extent possible, both are subject to the same limitations and requirements, stated in the same terms. For instance, it should be explicitly stated in both that face-down holds are prohibited, that physical holds may not impede breathing, and that inmates' faces and heads may not be covered during any restraint. Both custody and medical staff should be trained in methods of restraint that call for individuals to be seated or placed on their sides or backs as soon as possible after control is achieved. Staff should also be trained to specifically monitor adequacy of air exchange and level of consciousness. Most importantly, however, staff that work in mental health units should be trained in techniques for de-escalating and redirecting inmates who are becoming agitated.

It would also be useful for policy to direct that the circumstances under which inmates with mental health treatment plans might be subject to restraint be discussed with the inmate as part of the development of the plan. In that way, specific de-escalation strategies could also be identified, and pre-existing

medical conditions which might compromise an inmate's health and safety during restraint (e.g. asthma), could also be clearly identified.

DOC's policy on Psychoactive Medication (Administrative Directive 8.8) establishes procedures for obtaining inmate consent for the use of psychoactive medications, and for use of such drugs without consent in response to emergencies. (The policy also provides procedures for documenting medical justification for, and obtaining official review of, decisions to involuntarily administer drugs in non-emergency circumstances. Inmates who wish to contest decisions to involuntarily medicate them are to be provided notice and an opportunity for a hearing.) However, the policy does not require medical staff to check vital signs prior to administering medication on an emergency basis. Nor does it require subsequent assessments of the inmate's physical condition at regular intervals. These requirements should be added to the directive.

2. **Establish a protocol for assigning objective supervision to manage physical interventions for inmates with psychiatric disabilities, and the investigation of problematic events and practices. This protocol should include the designation of a staff person who has not been involved in the development of a particular intervention to act as an objective evaluator of the situation and provide guidance to staff, as needed, in order to ensure that appropriate and safe approaches are followed.**

It is clear that something is profoundly wrong when one views the videotape of Mr. Perry's restraint and sees the discrepancy between what was actually going on and what was reported by staff in witness statements. The correctional officers restraining Mr. Perry in Cell #24 were so completely focused on particular tasks that they paid no attention to the fact that Mr. Perry had ceased struggling, and perhaps had even ceased breathing. As indicated in the DOC investigation report, custody staff displays signs of physical exertion on the videotape, coinciding with their statements as to the level of intense resistance initially offered by Mr. Perry. However, by the time he was moved to Cell #24, Mr. Perry appeared totally *unresponsive* (emphasis in original report).

Although custody and medical staff bring different perspectives to interventions in mental health units, when both become involved in the evolution of an emergency situation, and each has responsibilities for carrying out specific tasks, it is possible for both to lose perspective on "big picture" issues. (Like whether an inmate who struggled with great strength and intensity has quieted down, and if so, whether restraints and/or medication are still warranted.) In such circumstances it would be useful for a supervisor who is not involved in the initial eruption to assume overall direction of the intervention. This individual would also be well positioned to ensure that required reporting, debriefing and evidence preservation occur following the incident.

3. **Establish a protocol to ensure that when unprofessional acts and omissions by health care professionals are suspected by DOC investigators, they are reported to appropriate licensing agencies for review.**

To its credit, DOC investigators conducted a commendably thorough investigation into the circumstances surrounding Tim Perry's death. DOC then took a variety of disciplinary measures with respect to HCC staff. However, because Health Services staff was employed by DOC's subcontractor, UCONN Health Center, and not by DOC itself, disciplinary action with respect to nursing staff was deferred to UCONN. While such deferral may make sense with respect to employer/employee disciplinary matters, it should not bar DOC from directly reporting questionable conduct by health care professionals to appropriate licensing review bodies. In Mr. Perry's case, reviews of autopsy results, unit logs and individual medical records revealed apparent errors in medication administration and documentation, failure to conduct even a rudimentary physical assessment prior to injecting major tranquilizers, the unexplained presence of Thorazine at the injection site (a drug that was not ordered by the on-call physician, and to which Mr. Perry was known to be allergic), and other apparent irregularities (e.g. claimed follow-up assessments were neither observed by other staff nor documented in medical records or logs). Acts and omissions such as these by a licensed health professional may justify disciplinary actions not only by employers, but by responsible licensing agencies mandated to protect the public from practitioners who do not meet professional standards. These reviews only occur, however, if suspected deviations from professional standards are reported.

4. **Establish a protocol for ensuring that advocacy services are made available to inmates with mental illness.**

According to the recent Report of the Governor's Blue Ribbon Commission on Mental Health, rates of "serious mental disorder" among the United States jail and prison population are considerably higher than in the general population. The report cites various studies conducted over the past decade which indicate that approximately one-tenth of all inmates in U.S. jail and prison have serious psychiatric disabilities. The correctional system was not designed to provide mental health services and treatment to individuals with significant mental illness. As a result, inmates with serious psychiatric disabilities are often at greater risk of experiencing abuse, neglect and other forms of harm within correctional facilities. They also tend to have higher rates of recidivism, perhaps due to difficulties securing post-release supports. These facts all argue for increased availability of advocates for inmates with psychiatric disabilities.

OPA has received an increasing number of telephone calls from inmates with mental illness, as well as mental health providers, regarding care and treatment within various correctional facilities. In addition, DOC's new policy on

Psychoactive Medication provides a mechanism for inmates to contest decisions to administer non-emergency medication. That mechanism allows inmates to be represented at hearings by patient advocates. The provision of advocacy services to inmates with psychiatric disabilities (whether or not they are being considered for involuntary administration of psychoactive drugs) could help protect them from abuse and neglect, safeguard their rights, and facilitate appropriate treatment and coordination of services and support upon their release from incarceration.