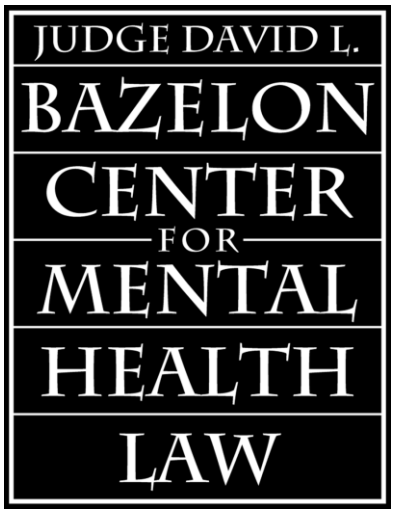

Steven H. Rosenbaum
Section Chief, Special Litigation Section
U.S. Department of Justice
Civil Rights Division
950 Pennsylvania Avenue, NW
Special Litigation Section
Washington, D.C. 20530

June 6, 2016

Dear Mr. Rosenbaum:

The undersigned organizations and individuals respectfully request that pursuant to the Civil Rights of Institutionalized Persons Act (CRIPA), 42 U.S.C. 1997 et seq., the Justice Department immediately begin an investigation into the circumstances and conditions at the Hampton Roads Regional Jail that led to the August 19, 2015 death of Jamycheal Mitchell, a 24-year old man

with a history of mental illness who was arrested for stealing $5 of junk food at a local convenience store.[i]

Mr. Mitchell died 109 days after his initial arrest and incarceration. In those 109 days he lost 40-50 pounds and he died "alone in a jail cell with feces on the wall and urine on the floor".[ii] A report from the state Medical Examiner's Office revealed that Mitchell died of probable cardiac arrhythmia and wasting syndrome. Wasting syndrome is defined as a profound loss of weight, greater than 10 percent of a person's original body weight.

Yet the Hampton Roads Regional Jail conducted an internal investigation and cleared itself of any wrongdoing. Therefore the ultimate question remains unknown: how did Mitchell starve to death before the jail staff's and medical staff's eyes?[iii]

The death of Mr. Mitchell reveals not only egregious problems at the local level, it also illustrates serious and widespread deficiencies in the lack of coordination across systems responsible for responding to individuals experiencing serious mental health crises. As we believe that preventing future tragedies of this magnitude requires a multi-systems response at both county and state levels, we request that your investigation include an assessment of the role that lack of coordination and accountability across systems may have played in contributing to Mr. Mitchell's deterioration and ultimate death.

Our request is based on the March 2016 investigation document from the Virginia Department of Behavioral Health and Developmental Disabilities (DBHDS) which revealed a number of mistakes that were made by government entities once Mr. Mitchell was jailed. For example, a court order that was faxed to Eastern State Hospital that would have put Mr. Mitchell in the care of a hospital was placed in a desk drawer by an "overwhelmed" employee[iv] and not discovered until after the young man had died. Additionally, the report revealed that the Portsmouth Department of Behavioral Healthcare Services (the city's local mental health agency responsible for conducting psychiatric assessments, including screening for hospitalization) had not completed an examination that could have led to Mr. Mitchell being quickly transferred to a psychiatric hospital.

The report further documented that:

- On April 22, 2015 Mr. Jamycheal Mitchell was arrested, charged with petit larceny and trespassing in Portsmouth, Virginia.
- Mr. Mitchell was incarcerated at the Hampton Roads Regional Jail in Portsmouth, Virginia.
- On May 21, 2015, a Competency Restoration Order (CRO) was issued in the Portsmouth General District Court.
- The CRO mandated that Mr. Mitchell be sent to Eastern State Hospital (ESH) to restore his competency to stand trial.
- Although the Portsmouth General District Court allegedly mailed the CRO to ESH on approximately May 27, 2015, representatives from ESH stated that they did not receive this order, and there was no record found that this CRO was mailed by the Portsmouth General District Court or received by ESH.

- On August 4, 2015, the Forensic Log at ESH showed there were 34 individuals on a wait list to be admitted to ESH.
- Mr. Mitchell's name was not on the August 4th, August 11th, or August 18, 2015 ESH Forensic Logs.
- Mr. Mitchell remained incarcerated at the Hampton Roads Regional Jail until his death on August 19, 2015.

Our request is also based on the investigation report conducted by the State Office of Inspector General (OSIG), released on April 5, 2016- nearly 8 months after Mitchell's death. The report outlines a number of systemic failures that led to the death of Jamycheal Mitchell and says that these systemic weaknesses were known to lawmakers and government agencies long before Mitchell died and had been recommended to be addressed- some urgently- but that various policy, procedural, and legislative changes had nonetheless not been enacted. Notably, the OSIG report also says that the root causes of the incident remain at risk for recurrence without enacting changes. This is an ominous warning and warrants thorough investigation and urgent remedial action.

We are extremely concerned about the likelihood of future deaths if the problems are not remedied. According to the 2015 Virginia Criminal Compensation Board *Mental Illness in Jails Report* (most recent report for which data is available)[v]:

- In June 2015 there were 7,054 individuals identified as having mental illness in Virginia's jails
- 16.81% of total jail population was reported as suffering from some form of mental illness
- 7.87% reported as suffering from "serious mental illness"
- Female inmates were disproportionately more likely to be identified as mentally ill compared to male inmates

We believe that the problems illustrated in this case, including neglect and possible abuse within the jail as well as lack of systemic coordination among responsible systems, are not isolated to this particular example.

In past cases, the Department of Justice's intervention has served as a catalyst for significant improvements in mental health treatment capacity in local jails, including Los Angeles, Miami, and Chicago. The Department's intervention has also stimulated systemic improvements in states, including Georgia, New Hampshire, and Massachusetts. In light of the magnitude and scope of the problems documented in this tragic case, the Department's expertise and experience, formal findings, and if necessary litigation will play an important, constructive role in working to achieve desperately needed reforms. Federal action is imperative to prevent further tragedies and to facilitate sustained improvements in coordinated responses to justice involved persons with mental illness in Virginia.

Thank you for your consideration.

Sincerely,

Mira Signer
Executive Director
NAMI Virginia

Claire Guthrie Gastañaga
Executive Director
ACLU of Virginia

Evelyn Steward
President
NAMI Hampton-Newport News

Bruce Cruser
Executive Director
Mental Health America of Virginia

James P. Boyd
President
Portsmouth Branch of the NAACP

Mary Giliberti, J.D.
Chief Executive Office
NAMI

Ira Burnim, Esq.
Legal Director
Judge David L. Bazelon Center for Mental Health Law

[i] "Help was ordered, but time ran out for Jamycheal Mitchell, found dead in jail cell," By Gary A. Harki, The Virginian-Pilot, November 1, 2015, Retrieved from http://pilotonline.com/news/local/crime/help-was-ordered-but-time-ran-out-for-jamycheal-mitchell/article_2b2e7630-0d99-50cd-89e3-6720fe707605.html

[ii] Inmate was beaten, starved, treated "like a circus animal" before left to die, family's lawsuit claims, By Gary A. Harki, The Virginian Pilot, May 10, 2016, Retrieved from http://pilotonline.com/news/government/virginia/inmate-was-beaten-starved-treated-like-a-circus-animal-before/article_056f5e36-4001-51f7-9225-f506a76fe8e2.html

[iii] Help was ordered, but time ran out for Jamycheal Mitchell, found dead in jail cell, By Gary A. Harki, The Virginian-Pilot, November 1, 2015, Retrieved from http://pilotonline.com/news/local/crime/help-was-ordered-but-time-ran-out-for-jamycheal-mitchell/article_2b2e7630-0d99-50cd-89e3-6720fe707605.html

[iv] State agency releases full report on Jamycheal Mitchell, series of system failures, By Gary A. Harki, The Virginian-Pilot, March 30, 2016, Retrieved from http://pilotonline.com/news/government/virginia/state-agency-releases-full-report-on-jamycheal-mitchell-series-of/article_c071c420-59fa-50b8-9434-ba2bfaa253a2.html

[v] 2015 Mental Illness in Jails Compensation Board Report Retrieved from http://www.scb.virginia.gov/docs/2015mentalhealthreport.pdf