OSIG NEWS

Office of the State Inspector General ● Post Office Box 1151 ● Richmond, VA 23218

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Contact: Julie C. Grimes, Communications Coordinator, (804) 625-3276

OSIG Releases Report to Governor McAuliffe

Investigation of Critical Incident at Hampton Roads Regional Jail Now Available

The Office of the State Inspector General (OSIG) today released its Investigation of Critical Incident at Hampton Roads Regional Jail report to Governor Terry McAuliffe. The report included recommendations based on five observations made during OSIG's review.

OSIG's report follows the March 21 release by the Department of Behavioral Health and Developmental Services' (DBHDS) Office of Internal Audit Investigation Report related to a death at the Hampton Roads Regional Jail on August 19, 2015. The DBHDS report was requested on September 1, 2015, by then-Commissioner Debra Ferguson.

Under Virginia law (§ 2.2-309.1) related to behavioral health, OSIG has the authority to "review, comment on, and make recommendations about, as appropriate, any reports prepared by the Department of Behavioral Health and Developmental Services." That legal authority gives OSIG responsibility for inspecting, monitoring, and reviewing the quality of behavioral health and developmental services provided in state facilities and by providers, and making policy and operational recommendations to prevent problems, abuses, and deficiencies of behavioral health treatment by state facilities and providers. In addition, OSIG has jurisdiction to review services of a private provider contracted with the jail.

"Conducting a thorough review has been a priority for OSIG," State Inspector General June W. Jennings said. "We took the time necessary to ensure that this report addressed the issues we have the authority to investigate. This required OSIG to examine and investigate events and processes across multiple agencies and facilities that occurred over a four month time span. It is our belief that the individual in question, and all those who suffer with mental illness and encounter the justice system, are deserving of the in-depth review conducted by our office."

OSIG's review of this event involved multiple agencies and facilities including the DBHDS, Eastern State Hospital, Hampton Roads Regional Jail, Portsmouth Department of Behavioral Healthcare Services, Portsmouth General District Court, NaphCare Inc., and Bon Secours Maryview Medical Center.

The OSIG report was prepared in compliance with the Association of Inspectors General (AIG) Principles and Standards for Offices of Inspectors General. Those standards provide the framework for inspections, evaluations, and reviews that meet quality standards including providing factual and analytical information, monitoring compliance, measuring performance, and assessing the efficiency and effectiveness of operations.

OSIG focused on evaluating existing operations and programs related to referrals and admissions of inmates, identifying high-risk points, determining where system processes should be strengthened,

and making recommendations for systemic improvements to prevent similar events from occurring in the future.

While some information related to the clinical care and treatment of the individual was reviewed by OSIG, the scope of OSIG's review was not to evaluate the medical care provided in Hampton Roads Regional Jail.

The OSIG report — as well as information on the agency — is available on the agency website (http://osig.virginia.gov/) by going to the Reports section and clicking on the Investigation of Critical Incident at Hampton Roads Regional Jail.

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