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Carmage Walls Commentary Prize

2017 Entry Form

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What is the subject/title of the entry? The Jailhouse Death of Jamycheal Mitchell

Date(s) of publication? May 13, July 21, July 31, Sept. 2 and Nov. 3, 2016

Is your newspaper under 50,000 circulation or above 50,000 circulation? More than 50,000 circulation

Please give a brief explanation of issues discussed and the results achieved. (This space will expand as you type in your comments.)

Throughout 2016, The Virginian-Pilot's opinion page published a series of editorials about Jamycheal Mitchell, a 24-year-old resident of Portsmouth, Va.

Mitchell was arrested in April 2015 for stealing $5 in snacks from a convenience store and ordered by a District Court judge to undergo a psychological evaluation at a nearby hospital. He was sent to the regional jail for holding until his transfer.

He was held for 101 days. A series of bureaucratic blunders meant Mitchell wallowed in the jail without the care needed to adequately treat his mental illness.

In August 2015, he was found unresponsive in a cell, which was covered in human waste, and was pronounced dead. Soon after, questions about Mitchell's death mounted.

Our investigation, which has stretched for more than a year, resembled the peeling of a rotten onion, with each removed layer revealing something more putrid within.

The editorials included in the entry were published shortly after the first report into the case was issued by the Virginia Department of Behavioral Health and Developmental Services. It was incorrectly redacted, and we were able to secure a full copy of that report after challenging for it under the Virginia Freedom of Information Act.

We first confirmed in our editorials the existence of video footage taken outside of Mitchell's cell, following up on a FOIA request made by another newspaper that was initially declined by jail officials. The jail's poor handling of the questions in this case, along with the concealment of the videotape, led to the superintendent's abrupt resignation in October.

Our editorials successfully encouraged renewed scrutiny given the case by the Virginia State Police. We pressed for a formal, independent inquiry with an eye toward possible criminal charges, and our continued advocacy and refusal to let the case be pushed aside resulted in an investigation that is still ongoing.

We called into question the work of the Office of the State Inspector General, whose report into the case was the subject of a whistleblower complaint alleging officials conducted a cursory review and failed to account for conflicts of interest in the office's handling of its investigation.

In February, Del. Rob Bell used the Nov. 3 editorial as justification for rejecting the recommendation by Gov. Terry McAuliffe that the inspector general continue for another term. His colleagues agreed, the Senate consented and the inspector general was removed from office as a result.

After a second inmate death at the jail, we reiterated our demand for a federal investigation into possible civil rights violations. The attorney general submitted his request for Justice Department intervention the day that editorial was published, a call that was supported by the governor as well. That investigation is also ongoing.

Finally, our editorials have helped guide and support the heavy lifting being done in Richmond by lawmakers looking to reform the mental health system. The Mitchell case itself is tragic, but speaks to a larger failing in the commonwealth. We advocated for change and the requisite funding needed to make it effective, and the General Assembly approved legislation earlier this year with the potential to dramatically improve mental health services in Virginia.

The fight goes on. There are more questions to be answered, investigations to complete and the legislature must fully fund mental health services for them to be effective. Our work on these topics continues.

However, the editorials included in this entry rooted out answers and made a compelling argument for reform. We believe it worthy of this honor.

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MITCHELL CASE NEEDS STATE INQUIRY

THE ISSUE No clarity yet in Portsmouth jail death

WHERE WE STAND Allegations of torture buoy prosecutor's request for the Virginia State Police to investigate.

START WITH the straightforward premise that 24-year-old Jamycheal Mitchell shouldn't have died in a cell at the Hampton Roads Regional Jail.

After Mitchell was arrested on April 22, 2015, and charged with stealing $5 in snacks from a Portsmouth convenience store, a judge ordered that he be evaluated at Eastern State Hospital. That decision landed the young man in a jail cell, where he stayed for 101 days before his death in August.

The Virginia court system, its corrections system and its mental health system should be capable of handling a case such as Mitchell's. That they failed — and did so in spectacular, ham-handed and tragic fashion — should compel an urgent and thorough self-assessment and reforms aimed at preventing future loss of life.

So it is infuriating to see so much reluctance, so much nonchalance, so much obfuscation and foot dragging when it comes to this vital undertaking. The process that follows a case like this should provide clarity, but each investigation into Mitchell's death has been wanting.

The Department of Behavioral Health and Developmental Services' effort yielded a heavily redacted report, though the agency acceded quickly to a request by The Pilot for an unaltered copy. It cites minor bureaucratic blunders that contributed to Mitchell's death — for instance, a clerk who left a court order for Mitchell's evaluation in a desk drawer — and makes correspondingly tepid suggestions for reform.

A report by the state Inspector General takes a broader view of what happened, identifying specific reforms that were never implemented which may have allowed a more deft and attentive handling of Mitchell's situation. Curiously, the IG report never mentions Mitchell by name and omits any firm conclusion of how he died, which seems central to any investigation of this case.

The state Medical Examiner's Office concluded in November that Mitchell died of heart problems and weight loss, a condition known as "wasting syndrome." To illustrate the severity of his condition, Mitchell weighed 190 pounds on May 11 and 144 on Aug. 19, per the autopsy.

So was Mitchell not eating his food? That's the logical conclusion, but jail officials say they had no indication that was the case. He should have been checked by guards every 30 minutes and received a medical evaluation daily. Did none of these indicate a problem?

Those are questions that should be answered by an investigation conducted by the Hampton Roads jail. However, officials there have thus far refused requests to release their report, though they insist it shows no wrongdoing by officers.

Their stone-walling on a matter of such importance is unacceptable. Virginia open government law does not mandate this report be kept from public view. Rather, citizen interest and the cause of public safety demand it be made available.

The jail's position is less defensible given the Richmond Times-Dispatch's report last week that the security footage from outside Mitchell's cell was not preserved. That is critical evidence, gone forever.

Surely that, if nothing else, calls into question how forthcoming officials are being in this case. It cries out for accountability.

The wheels of justice, already disposed to turn slowly, seem to creak and groan against every effort to determine what happened to this young man while in the care of the state.

A lawsuit filed this week by Mitchell's family paints a more harrowing and brutal picture of conditions in the jail. It alleges the young man was beaten and abused while in custody. A former Virginia inspector general equated the descriptions set forth in the suit to torture.

Those accusations are for a court to weigh. But such serious charges leveled against public institutions are right to give the public pause, particularly given a demonstrated inability to get to the bottom of what happened.

Portsmouth Commonwealth's Attorney Stephanie Morales this week requested that Virginia State Police launch a criminal investigation of this matter. That now seems warranted and should receive the public's endorsement.

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DOUBTS SURROUNDING DEATH ARE JAIL'S FAULT

THE ISSUE In the wake of Jamycheal Mitchell's death, Hampton Roads Regional Jail officials are hiding behind a FOIA exemption.

WHERE WE STAND Stonewalling and secrecy are no way to run a public institution.

JAMYCHEAL MITCHELL died alone at the Hampton Roads Regional Jail nearly one year ago.

In the time since, the public has learned something about the circumstances that landed him in that cell, the mistakes that allowed him to languish there and the medical cause for the 24-year-old's death.

The account has been neither a complete nor satisfying record of events. That is largely due to the jail's refusal to disclose what it knows about Mitchell's time there.

Jail officials conducted an investigation but have rejected calls to release their report. It is a choice afforded them through an exemption in Virginia's Freedom of Information Act — one made out of convenience rather than necessity.

They have also spurned FOIA requests made for video taken by security cameras located outside Mitchell's cell.

"There is no security footage taken outside of Mr. Mitchell's cell during his incarceration at Hampton Roads Regional Jail," Superintendent David L. Simons told the Richmond Times-Dispatch in April.

The jail maintained its wall of silence despite the serious allegations leveled against it in a lawsuit filed by Mitchell's family. It argues that the young man was the victim of abuse, that he was denied proper care and that, in essence, responsibility for his death can be laid at the feet of officials at that facility.

Last month, jail officials finally responded to these accusations, issuing a disingenuous press release accompanying a legal rebuttal of the lawsuit's claims.

Officials contend that many of the details that have circulated in the media are incorrect, notably that Mitchell lost only one pound while in their care. The release says he refused only three meals while incarcerated.

That revelation seems entirely incongruent with other available information.

The Mitchell family's lawsuit says the young man lost 40 pounds while in custody. And the state Medical Examiner's Office concluded that Mitchell died of "probable cardiac arrhythmia accompanying wasting syndrome of unknown etiology." In layman's terms, that's heart failure as a result of rapid weight loss.

Deep within the jail's filing is another curious detail: Footage from outside the cell actually exists.

In a letter to the Richmond Times-Dispatch, dated May 9, Superintendent Simons revised his response to the newspaper's records request, admitting that video outside of Mitchell's cell has been located and preserved, but that it was being held from release due to the "custodian's discretion" under FOIA.

As with the report, jail officials are deliberately choosing secrecy over transparency when it comes to disclosure of information about this case.

Jail officials say in their press release that they "do not intend to try this case in the press," but they could have erased most speculation and rumor by simply being more forthcoming about the details surrounding Mitchell's death. As it is, their stonewalling created the atmosphere of doubt surrounding this public facility. Citizens cannot be assured that the circumstances of Mitchell's death will not be repeated if they cannot be sure precisely what happened.

Many of those kept in the custody of the Hampton Roads Regional Jail have run afoul of the law. Others, such as Mitchell, may have ended up there thanks to Virginia's woeful inability to properly handle people with mental illness.

But all deserve to be treated with dignity and to be afforded proper care. Mistakes, when they occur, should be accounted for so that future missteps can be prevented.

Jamycheal Mitchell died alone in his cell nearly a year ago, and it's outrageous that we still do not know why.

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DID WATCHDOG FAIL IN MITCHELL CASE?

THE ISSUE The state inspector general is the subject of a whistleblower complaint.

WHERE WE STAND Can anyone be trusted to find out why Jamycheal Mitchell starved to death in jail?

THERE SEEMS TO BE some consensus that the death of Jamycheal Mitchell, the 24-year-old found dead in his cell at the Hampton Roads Regional Jail in August, resulted from a catastrophic bureaucratic failure, a series of mistakes made by a number of actors operating on behalf of several agencies.

That conclusion may not be wrong. Honestly, no one really knows. (Or if they do, they're not letting the public in on it.)

However, that explanation lends itself to the relatively comforting idea that Mitchell's death was an aberration, an all-but-impossible calamity that befell one young man and could only be replicated under the most unlikely of scenarios.

In fact, there is precious little evidence to support such a conclusion. That's because every investigation has been incomplete, dogged by unanswered questions or kept from public view.

Now there are allegations that the agency built to ensure thorough oversight may itself have failed in the Mitchell case.

This month, the report on the Mitchell case by the Office of the State Inspector General came under renewed scrutiny, the subject of a whistleblower complaint filed with the Virginia Attorney General's Office. The allegations, yet to be proven or substantiated, paint a troubling picture of the OSIG's efforts.

The complaint was filed by Cathy Hill from the inspector general's office and two consultants, William Thomas and Ann White. They have submitted their request for whistleblower protections to the office of Attorney General Mark Herring. That request is now in the trust of the governor's office, which oversees the inspector general.

Hill and the others call into question the methods the inspector general used while conducting the Mitchell investigation. They claim that the vast majority of the investigation was done from behind a desk rather than at the jail in Portsmouth. They claim public documents were deliberately withheld and that Inspector General June Jennings misled state officials when testifying before a joint legislative subcommittee in April.

That hearing of the Joint Subcommittee to Study Mental Health Services in the Commonwealth in the 21st Century, the group chaired by state Sen. Creigh Deeds, saw lawmakers assail Jennings and Priscilla Smith, the OSIG's director of behavioral health and developmental services, with questions about the inspector general's report into the Mitchell case.

They questioned the agency's methods, such as why investigators did not ask for a copy of the report compiled by the Hampton Roads Regional Jail, a document officials there refuse to make public. Lawmakers also challenged whether the OSIG was operating to the full extent of its authority.

The accusations contained in the whistleblower complaint, like those raised in the April hearing, are serious. They deserve an exhaustive and transparent investigation, be it through the Attorney General's Office, at the governor's direction or through any state agency that can provide a suitable level of accountability.
Not that they are likely to receive one.

There seems to be little appetite in the commonwealth to determine how a young man apparently starved to death in a regional jail and even less curiosity among the watchdog agencies tasked with figuring it out.

This lends itself to the inescapable conclusion that lawmakers not only need to overhaul the state's mental health apparatus, they also need to revisit the 2012 law that redesigned the OSIG. That legislation, it appears, may not be working as intended and therefore isn't providing the level of oversight clearly needed in state government.

If those given the responsibility for investigating cases like Mitchell's — honest to goodness life-and-death matters — cannot capably do so, then perhaps Virginia needs to find someone who can.

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FINDING THE PATH FORWARD ON MENTAL HEALTH

THE ISSUE A General Assembly committee works to untangle Virginia's inhumane system.

WHERE WE STAND It's critical that the commonwealth — finally — gets this right.

FROM THE OUTSET, the legislative committee charged with conducting a three-year study of Virginia's chaotic system of mental health services faced a daunting task.

To even call the array of programs and agencies tasked with the care and treatment of mental illness a "system" is a misnomer. In fact, the commonwealth lacks a coherent, overarching approach to addressing this population of citizens and their challenges with the kind of humanity and compassion they deserve.

Virginia offers some traditional services, including the treatment provided at in-patient facilities and through community-based programs. The general assessment is that these are underfunded and poorly orchestrated.

Those struggling with mental illness more often intersect with state and local agencies in other ways, including in public schools and universities, and most critically via law enforcement, corrections facilities and the courts – all unprepared to help them.

Take measure of that landscape stretched out before the committee, and it's easy to understand why, with 16 months remaining before the study is expected to be completed, there is cause for concern. Even getting a handle on so large and complex an issue would be an accomplishment; proposing substantive reforms capable of "fixing" the problems might qualify as a miracle.

Still, what needs to emerge from this effort is an ambitious plan for how Virginia should proceed. While the work of the joint committee has revealed some steps that should be self-evident and easily taken – better collection and analysis of data, for instance – others will require heavy lifting by lawmakers and citizens and hundreds of millions of dollars.

The conclusion of the study will confront Virginia with a serious choice. Will we finally provide adequate, integrated care and treatment for our neighbors with mental illness? Or will we continue our ineffective and inhumane neglect?

The decision will speak volumes about the character of this commonwealth and the people who call it home.

The state has long known about the shortcomings of its mental health system.

It was clear before the 2015 death of Jamycheal Mitchell, the 24-year-old man with bipolar disorder and schizophrenia who died alone in his cell at the Hampton Roads Regional Jail instead of receiving treatment at a competent facility.

It was clear before the 2013 death of Gus Deeds, the 24-year-old son of state Sen. Creigh Deeds. Gus, who struggled with bipolar disorder, attacked his father before killing himself after mental health officials did not find an available psychiatric bed for him.

It was clear before poor communication, errant treatment and bungled coordination failed to stop Seung Hui-Cho, a deeply disturbed student at Virginia Tech, from a shooting rampage that claimed the lives of 32 students and faculty.

Though the state's history of providing mental health services stretches to 1773, when Virginia founded the first publicly funded facility, its modern offerings have been judged haphazard and inadequate. In the 1990s, it ran afoul of federal civil rights law, leading to a series of agreements between the commonwealth and the U.S. Justice Department defining the state's legal obligations.

While this should have led to more and better options for residents who require treatment, it led instead to larger populations of mentally ill inmates in Virginia jails and prisons, facilities ill-prepared and -equipped to handle the challenges these individuals pose and all but ensuring poor outcomes for all involved.

In the wake of the Deeds case, the General Assembly emerged from its 2014 session having taken two steps forward on mental health care reform.

The first was aimed at short-term changes. Legislation established a database of available psychiatric beds across the commonwealth and lengthened the time a patient could be subject to an emergency detention order.

The second step was focused on the horizon. Lawmakers passed a joint resolution ordering a three-year study of mental health services, including all aspects of care, treatment, detention and crisis intervention. It was to look at systematic problems and funding shortfalls, technical improvements and innovations. It was to report back in time for the 2018 session.

Casting so wide a net for the Joint Subcommittee to Study Mental Health Services in the Twenty-First Century serves an important purpose. It allows members to examine every area touched by mental illness across the commonwealth.

It also means that members have any number of rabbit holes into which they can plummet if they are not careful. It can be difficult to define the parameters of their work and remain focused, when the issue itself is so complex and pervasive, and the authority so broad.

At their most recent gathering, members heard an update about systematic changes being implemented by the Department of Behavioral Health and Developmental Services, heard proposals for changing data collection, considered where to vest authority for investigating jail deaths like Jamycheal Mitchell's, and were briefed about the possible benefits of telepsychiatry.

The members of this committee, led by Deeds, are an engaged bunch. Their interest and inquisitiveness inspires confidence, and they seem determined to affect change on an intractable problem. For this, they deserve the commonwealth's appreciation.

What is also clear already is that no three-year study can propose all the changes needed to reverse decades of neglect. Providing the type of competent, efficient and compassionate care Virginians deserve will take extraordinary work, unwavering commitment and substantial resources.

These are the very things Virginia often seems incapable of mustering. This time, here and now, we must.

The commonwealth has for far too long ignored the plight of the mentally ill, or done the legal minimum to satisfy Washington or stay off the front pages. Virginia must do more, must be more effective and humane. It's this subcommittee's job to show all Virginians the way forward.

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WIDENING COVER-UP IN MITCHELL'S DEATH

THE PREVENTABLE DEATH of Jamycheal Mitchell at the Hampton Roads Regional Jail last year continues to illuminate flaws in the system of oversight meant to ensure accountability and improve the function of state government.

At a recent meeting of the joint subcommittee studying Virginia's mental health system, three people who worked with the Office of the State Inspector General outlined possible conflicts regarding investigations by the OSIG's office.

In particular, they claimed reports had been altered to make it appear that conditions at Eastern State Hospital were better than they are. They alleged that admissions staff was dangerously overworked, and that officials at the OSIG's office removed those concerns from a report about the hospital.

These are serious charges, and provide more context than was included in the whistleblower complaint filed by the three with Attorney General Mark Herring in July.

That petition argued that the OSIG did not conduct its investigation into Mitchell's death with the diligence the matter deserved, and that State Inspector General June Jennings violated provisions of the Virginia Freedom of Information Act by failing to properly respond to requests for documents that should be available to the public.

Herring forwarded the whistleblower complaint to the governor's office, which administers the OSIG. Gov. Terry McAuliffe's Chief of Staff Paul Reagan and administration attorney Carlos Hopkins dismissed the allegations — without interviewing the former OSIG employee and two contractors who filed the complaint — and the governor expressed "full confidence" in Jennings.

Left unmentioned at the time was that Jennings' husband, William D. Jennings, works at Eastern State as the director of quality management, and that Priscilla Smith held that position prior to William Jennings' appointment.

Smith now serves as the head of the OSIG division that reviews Eastern State and the rest of Virginia's Department of Behavioral Health and Developmental Services. And it was Smith who these whistleblowers allege removed sections critical of Eastern State from reports rather than recusing herself from investigations pertaining to the hospital.

Recall that Mitchell was incarcerated at the regional jail for about 100 days owing to the fact that paperwork to transfer him to Eastern State was, at first, not sent properly and, later, received by the hospital but stashed in a desk drawer to be forgotten.

According to a lawsuit filed by Mitchell's family, the 24-year-old with a history of mental illness lost more than 40 pounds during his time at the regional jail. The state medical examiner ruled his death was the result of "probable cardiac arrhythmia accompanying wasting syndrome of unknown etiology."

Mitchell never should have been in the jail. Yes, he was charged with theft and trespass for taking $5 worth of snacks from a convenience store. But his history of mental illness should have landed him in a place equipped to care for him and ensure he received proper treatment.

The OSIG, beginning in January 2015, investigated complaints about overworked admissions staff at Eastern State and excessive overtime. Any report that emerged, even one that detailed those problems, would have come too late for Mitchell, who was arrested in April 2015 and died four months later. But that does not excuse the lack of transparency about this case or the conflicts alleged by the whistleblowers.

It is unlikely that the joint Subcommittee to Study Mental Health Services will get to the bottom of this issue. In fact, it's difficult to know what should come next beyond a detailed and thorough investigation of what happened here and an explanation from the OSIG as to why the potential conflicts were omitted from these reports.

But it is clear that the apparatus meant to investigate issues such as this is broken, and it will fall to lawmakers, beginning in January when the legislature convenes, to fix it.