Final Report

December 27, 2022

Allegheny County Jail

TECHNICAL ASSISTANCE REPORT

This report details findings from a site visit conducted November 1, 2, and 3, 2022.

SOLUTIONS FROM THE MOST TRUSTED NAME IN

CORRECTIONAL HEALTH CARE

Allegheny County Jail
Technical Assistance Report

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DISCLAIMER

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Allegheny County Jail
Technical Assistance Report

INTRODUCTION

The Jail Oversight Board has raised concerns regarding recent deaths in the Allegheny County Jail. At the request of the County Manager's Office, NCCHC Resources, Inc., was asked to review the 27 inmate deaths from January 2017 to October 2022. A team of professionals experienced in correctional medicine, consisting of Randall Stoltz, MD, CCHP; Nikki Johnson, Psy.D., CAS, CCHP; Nancy Booth, RN, PHN, MSN, CCHP-RN; and Richard A. Forbus Jr., CCHP; were on site November 1 through 3, 2022.

Abbreviations Used in this Report	
ACJ	Allegheny County Jail
AED	automated external defibrillator
CIWA	Clinical Institute Withdrawal Assessment
COWS	Clinical Opioid Withdrawal Scale
EMS	emergency medical services
HTN	hypertension (high blood pressure)
JOB	Jail Oversight Board
MAT	medication-assisted treatment
NA	not applicable
QMHP	qualified mental health professional

Due to the complexity of the health conditions discussed herein, definitions have been provided.

Definitions

Atherosclerotic cardiovascular disease is a type of heart disease caused by consistent high levels of bad cholesterol that lead to the buildup of plaque on the walls of the arteries. When plaques in the arteries that supply the heart or brain limit blood flow, they can lead to a lack of oxygen for these organs. When the lack of oxygen is severe enough, a heart attack or stroke can occur.

Bacterial endocarditis occurs when bacteria or other pathogens enter the bloodstream and travel to the heart. The microbes then stick to damaged heart valves or damaged heart tissue. Endocarditis is a life-threatening inflammation of the inner lining of the heart's chambers and valves. Certain behaviors, such as intravenous drug use, increase the odds of developing bacterial endocarditis.

Bilateral aspiration pneumonia is an inflammation (swelling) and infection of both lungs. Aspiration pneumonia occurs when food or liquid is breathed into the airways or lungs. Risk factors for aspiration include being less alert due to medication, illness, or anesthesia; large amounts of alcohol consumption; and use of illicit drugs such as opioids.

Bipolar disorder causes a person to have cycles of extreme mood changes that go beyond normal ups and downs. In addition to depression symptoms, a person with this disorder will have periods of feeling joyful, energized, and excited (called mania). A common medication used in the management of bipolar disorder is lithium.

Cardiomegaly is an enlargement of the heart. An enlarged heart can be caused by untreated hypertension, viral infections (including HIV), alcohol or cocaine abuse, and diseased heart valves.

Central brain herniation is a serious medical condition that that happens when brain tissues move from one part of the brain to another, adjacent part of the brain. It is usually caused when another condition causes swelling or pressure inside the brain such as blunt head trauma. Blunt head trauma can result in brain bleeding and can lead to herniation. Cerebral herniations are severe and need immediate treatment.

The **Clinical Institute Withdrawal Assessment for Alcohol**, commonly abbreviated as CIWA or CIWA-Ar, is a 10-item scale used in the assessment and management of alcohol withdrawal. The CIWA-Ar scale is the most sensitive tool for assessment of the patient experiencing alcohol withdrawal. Nursing assessment during alcohol withdrawal is vitally important. Early intervention for a CIWA-Ar score of 8 or greater provides the best opportunity to prevent the progression of withdrawal.

The **Clinical Opioid Withdrawal Scale** quantifies the severity of opiate withdrawal and is used in the management of symptoms.

Congestive heart failure is a condition where the heart is less efficient than normal. This can cause the blood to back up, cause a fluid buildup in the lungs, and subsequently increase the pressure in the heart.

Fentanyl is a synthetic opioid 50 to 100 times stronger than morphine. Individuals addicted to opioids use Fentanyl to increase its potency.

Ejection fraction is a measurement, expressed as a percentage, of how much blood the left ventricle pumps out with each contraction. An ejection fraction below 40% means the heart isn't pumping enough blood and may be failing. Normal ejection fractions range from 50% to 75%.

Heart failure occurs when the heart muscle doesn't pump blood as well as it should. Blood often backs up and causes fluid to build up in the lungs (congestion) and in the legs. This fluid buildup can cause shortness of breath and swelling of the legs and feet.

Hepatitis C is a viral infection that is spread by contact with contaminated blood such as that which occurs by accidental needle sticks, or sharing needles. The virus attacks the liver and leads to inflammation.

Medication-assisted treatment is the use of medications, in combination with counseling and behavioral therapies, to provide a whole-patient approach to the treatment of substance use disorders. Medication choices used to treat substance abuse disorders include methadone, Suboxone, and buprenorphine.

Opioid toxicity is life-threatening and requires immediate emergency attention. Symptoms of toxicity include, but are not limited to, inability to awaken, slowed or absent breathing, and decreased or absent heartbeat.

PowerDMS is a software application used by Allegheny County Jail to maintain current documents and archived documents. It is also used as an online learning system to provide training to jail personnel and to track their training records.

Pulmonary embolism occurs when a blood clot gets stuck in an artery in the lung, blocking blood flow to part of the lung. These blood clots most often start in the legs and travel up through the right side of the heart and into the lungs.

Ruptured spleen occurs because of a break in the spleen's surface. This could be caused by trauma such as a forceful blow to the abdomen during a sporting accident, a fistfight, or a car crash.

A **stroke** occurs when there is an interruption of blood flow to a portion of the brain. A stroke can be caused by a blocked vessel or a blood vessel that breaks.

SITE VISIT OVERVIEW

After an initial introduction meeting with interdisciplinary administrative leaders, the warden of the facility conducted our tour, including the receiving area, outpatient clinic, medication room, dental area, and housing modules (including medical, mental health, and administrative segregation) which provided us with an understanding of the operational processes of the jail.

Custody documents of the deaths, causation of death by the medical examiner, incident reports and logs were available for the team's review. Access to the electronic health record provided the team the ability to review all past health records as well as specialty consultations and hospitalizations of those individuals who died in custody. We gathered information and reviewed specific data points on each case for the purpose of identifying similarities and variances in processes.

Interviews conducted

Custody
Warden Harper
Chief Beasom
Various custody staff and supervisors in Units 4A, 5B, Intake, and Processing
MAJ Jason Batykeefer

Mental Health
Charlotte Porter, mental health specialist
Candice Schall, mental health RN

Nursing
Holly Martin, DON
Garett Wagner, ADON
Mike Elick, detoxification nurse
Robyn Smith, staffing educator

Administration
Ashley Brinkman, HSA
Nora Gillespie, QA and accreditation
Mary Jeanne Serafin, project manager

Documents reviewed

- Allegheny Health Network positions
- County positions
- Policies
- Suicide deaths and attempts
- Mental Health Medical Advisory Committee meeting minutes
- Intake screening form
- Staff model
- Mental health forms
- Training
- Death in custody review
- Jail organization chart
- Interdisciplinary meeting minutes
- Custody reporting packets for in-custody deaths and suicides
- Medical examiner findings for all deaths

FACILITY OVERVIEW

Allegheny County Jail is a pretrial and sentenced detention facility that houses both male and female adult inmates, as well as some youth offenders under 18 years of age who are being tried as adults. Its initial capacity when it opened in 1995 was approximately 1,800 inmates. The overall capacity of the jail is now approximately 2,000. The population has remained around 1,400 since the COVID outbreak, and on the dates of our site visit, the census was approximately 1,386. The scope of our report covers only the main facility described above.

The Allegheny County Jail is a central booking facility, meaning arrestees are processed from multiple agencies and are booked into the facility straight from the street after an arrest is made by a law enforcement agency. Some arrestees are transferred or remanded from other facilities to face local charges in Allegheny County.

As a central booking facility, many individuals arrive actively under the influence of illicit drugs, alcohol, or other substances. All arrestees are given a receiving screening to determine if they may be accepted for booking and to identify any potential medical conditions, mental health issues, or other areas of concern to allow for their proper care while in the facility.

Once accepted, arrestees are processed into the facility and subject to a body scan. Within 24 hours, they are moved to the processing area. While in the processing area, arrestees receive a more thorough health screening. Arrestees are seen by a judge via video while in this area and a decision is made as to the setting of bail, whether the arrestee can be released on their own recognizance, or if they are to remain in custody. Inmates who are released from custody at this point are picked up by the Allegheny County Sheriff. Arrestees remaining in custody are subject to another body scan before being moved into the secure facility.

Offenders may remain in custody for a range of time, from hours to years, pending the outcome of their case(s). ACJ is responsible for the custody and care of all offenders once they are booked into the facility. Due to the ongoing effects of the COVID-19 pandemic a 10-day quarantine process is in effect for new arrestees, with those coming into the facility who are arraigned and directed to stay in custody are moved upstairs into an intake unit. Those with additional needs, such as suicide watches, are housed in a health care housing unit.

The pretrial offenders held by the facility are facing charges ranging from traffic offenses to homicide. The intake unit is separated by gender but houses all classifications and statuses of newly arrested offenders together, including some on withdrawal protocols.

Offenders are classified while in the intake unit and if still in custody once they pass the 10-day quarantine requirement, they will be housed in a unit appropriate to their classification level and/or status. Offenders will remain in custody until they are either released by a judge; bail is posted; they are sentenced to serve their sentence locally in the Allegheny County Jail; or they are sentenced to prison and moved to the state prison system. Sentenced inmates who serve their sentence in the ACJ may work within the facility until they complete their sentence.

CLINICAL MEDICAL AND MENTAL HEALTH FINDINGS

Summary of Deaths and Comorbidities					
Gender	**Booking Date**	**Date of Death**	**Cause of Death**	**Manner of Death**	**Comorbidities**
Female	1/21/2017	4/18/2017	Asphyxia	Suicide	
Male	5/24/2017	6/3/2017	Asphyxia	Suicide	
Male	9/16/2017	9/22/2017	Asphyxia	Suicide	
Female	4/14/2018	4/27/2018	Asphyxia	Suicide	
Male	7/12/2017	9/8/2018	Asphyxia	Suicide	
Female	11/3/2018	11/6/2018	OD - fentanyl, bupropion, promethazine, diazepam	Accident	
Male	9/3/2018	12/15/2018	Heart failure	Natural	
Male	6/30/2018	1/28/2019	Pulmonary embolism	Natural	
Male	12/12/2018	4/11/2019	Asphyxia	Suicide	
Male	12/13/2019	12/30/2019	Coronary artery disease	Natural	
Male	2/26/2020	4/11/2020	Atherosclerotic cardiovascular disease	Natural	
Male	4/11/2020	5/25/2020	Asphyxia	Suicide	
Male	9/20/2020	10/1/2020	Mycotic aneurysm	Not found in information reviewed	
Male	11/7/2020	11/26/2020	Atherosclerotic cardiovascular disease	Natural	
Male	11/20/2020	11/30/2020	Opioid toxicity	Accident	

Male	6/23/2021	7/3/2021	Asphyxia-food obstruction	Un-determined	
Male	11/7/2020	9/12/2021	Pneumonia secondary to COVID-19	Natural	
Male	9/17/2021	9/20/2021	Hemorrhagic shock - ruptured spleen	Accident	
Male	9/16/2021	9/23/2021	Aspiration pneumonia, opioid withdrawal	Accident	
Male	9/11/2021	10/9/2021	Bronchial asthma	Natural	
Male	10/21/2021	12/22/2021	Atherosclerotic cardiovascular disease	Natural	
Male	1/4/2022	1/30/2022	Blunt force trauma to the head	Accident	
Male	3/21/2021	3/6/2022	Bilateral pulmonary embolism	Natural	
Male	3/1/2022	4/28/2022	Cardiomegaly	Natural	
Male	7/12/2022	7/13/2022	Multidrug toxicity (fentanyl and meth-amphetamine)	Accident	
Male	7/18/2022	8/14/2022	Ventricular fibrillation	Natural	
Male	9/10/2022	9/22/2022	Pending	Pending	

Below are the details of the in-custody deaths we reviewed, in chronological order.

	DOC#
Age:	33
Gender:	Female
Incident Type:	Suicide - hanging
Booking Date:	1/21/2017
Date of Death:	4/18/2017
Time of Death:	0227
Date of Incident:	4/18/2017

Time of Incident:	0212
Housing Unit:	4E, cell M-8
Medical Transport:	No
911 (EMS) Request:	Unknown
CPR:	Yes
AED:	Unknown
Staff Use of Force:	No
Cause of Death:	Asphyxiation by hanging
Manner of Death:	Suicide

Incident details

[redacted] She was returned to ACJ and housed in [redacted] At approximately 0210 hours, the female officer working the unit asked for the new relief officer who had just arrived to do a guard tour for her on the female side of the housing unit. The male officer reached [redacted]' cell and found her hanging from the [redacted] in the room. He immediately broadcast a medical emergency, cut her down, and initiated CPR. Medical staff responded and CPR was continued. It was not clear from the documentation if EMS was requested. [redacted] was pronounced dead at 0227 hours. It is not clear if EMS or ACJ staff pronounced her deceased.

[redacted] was placed in a [redacted] in January 2017, but walked away from the program in February 2017. A warrant of arrest for escape was issued. She was arrested on 4/9/2017 and [redacted] returned to ACJ on 4/13/2017. Health records were included in the critical incident packet, and it was not clear regarding her status at the time of her death, but it appeared she was on a [redacted] upon return to the facility on 4/13/2017. [redacted] also had [redacted], which was referred to as an [redacted] in custody reports.

It appeared there were significant issues with the guard tours for this incident. When [redacted] was cut down she had discoloration from ligature marks on her neck and appeared to have been hanging for some time, but the logbooks showed checks had been conducted. According to Allegheny County officials, disciplinary action was taken in this case based on policy violations.

[redacted]	**DOC#** [redacted]
AGE:	39
GENDER:	Male
Incident Type:	Suicide - hanging
Booking Date:	5/24/2017
Date of Death:	6/3/2017
Time of Death:	2004
Date of Incident:	6/3/2017
Time of Incident:	1945
Housing Unit:	[redacted]
Medical Transport:	No
911 (EMS) Request:	No
CPR:	Yes
AED:	Unknown
Staff Use of Force:	No
Cause of Death:	Asphyxiation by hanging
Manner of Death:	Suicide

Incident details

[REDACTED] was housed in [REDACTED] was conducted, and he did not come to [REDACTED]. The housing unit officer asked his roommate where he was and the roommate stated he had not seen him. The officer went to his room with the nurse and found him hanging from the [REDACTED], using a [REDACTED]

He was cut down and the nurse performed CPR. The officer called a medical emergency. Medical responded and [REDACTED] was pronounced dead at the facility at 2004 hours. It was not clear from the documentation provided if EMS was ever requested or responded to the facility. In the documentation, the officer stated guard tours were missed due to [REDACTED]. According to Allegheny County officials, disciplinary action was taken in this case based on policy violations by involved staff.

[REDACTED]	**DOC#[REDACTED]**
Age:	62
Gender:	Male
Incident Type:	Suicide - hanging
Booking Date:	9/16/2017
Date of Death:	9/22/2017
Time of Death:	2004
Date of Incident:	9/17/2017
Time of Incident:	0955
Housing Unit:	4A, cell 211
Medical Transport:	Yes
911 (EMS) Request:	Yes
CPR:	Yes
AED:	Unknown
Staff Use of Force:	No
Cause of Death:	Asphyxiation by hanging
Manner of Death:	Suicide

Incident details

[REDACTED] was housed in unit 4A. Officers conducting a guard tour found him hanging from the [REDACTED] and called a medical emergency. Officers cut him down from the [REDACTED], but according to documentation they waited for health staff to arrive to do CPR. EMS responded to the facility and transported [REDACTED] to the hospital at an unknown time. He did have a pulse when he was transported. [REDACTED] remained at the hospital until his death on 9/22/2017. He had been released from custody at some point prior to his death.

There was minimal documentation for this incident. Disciplinary action was taken in this case based on policy violations by involved staff.

[redacted], ALLISON DOC#[redacted]

Age:	57
Gender:	Female
Incident Type:	Suicide - hanging
Booking Date:	4/14/2018
Date of Death:	4/27/2018
Time of Death:	2216
Date of Incident:	4/27/2018
Time of Incident:	2135
Housing Unit:	4E, cell 119
Medical Transport:	No
911 (EMS) Request:	Yes
CPR:	Yes
AED:	Unknown
Staff Use of Force:	No
Cause of Death:	Asphyxiation by hanging
Manner of Death:	Suicide

Incident details

[redacted] was housed in unit 4E. Officers conducting a guard tour found she had hung herself from the [redacted] using a [redacted]. A medical emergency was broadcast, and officers started CPR. Medical staff arrived and took over lifesaving measures. EMS arrived and continued efforts unsuccessfully. [redacted] was pronounced dead on scene at 2216 hours.

[redacted] had known [redacted]. Her ex-husband had written to the jail via their public contact email and requested a psychological evaluation the day before the suicide. Medical staff responded to him, and she was on [redacted] earlier in the day per internal emails. However, nothing within the critical incident packet indicated what had been done on the day of the suicide. [redacted] left a suicide note blaming the judge and her family for her suicide.

Her criminal charges stemmed from stolen property from family members. She had been transferred to ACJ from Butler County Jail and had a [redacted] on January 19, 2018, but it is not clear if that [redacted] occurred in the community or in a correctional facility.

[redacted] DOC#[redacted]

Age:	68
Gender:	Male
Incident Type:	Suicide
Booking Date:	7/25/2017
Date of Death:	9/8/2018
Time of Death:	1630 hours
Date of Incident:	9/8/2018
Time of Incident:	1630
Housing Unit:	8D
Medical Transport:	No
911 (EMS) Request:	Yes, arrived at 1653
CPR:	Yes
AED:	Yes

Staff Use of Force:	No
Cause of Death:	Asphyxiation by hanging
Manner of Death:	Suicide

Incident details

Inmate [REDACTED] was housed in unit 8D. Officers completed their guard tour and upon arrival at [REDACTED] cell, 212, noted the window was covered. Officers received no response and opened the food pass-through port on the door. [REDACTED] was in a seated position and appeared to be hanging. Unit officers broadcast a medical emergency, made entry into the cell, and cut him down. Reports noted [REDACTED] fell to the ground. Officers initiated CPR until ACJ medical personnel arrived and took over lifesaving measures. The AED was used and advised that compressions should be continued.

EMS arrived at 1653 hours and pronounced [REDACTED] dead on scene at 1654 hours. A suicide note was found in the cell but we were unable to read it due to the quality of the copy of the note enclosed in the file we reviewed. No medical information was contained in the incident file. [REDACTED] had a minor disciplinary report from 8/4/2017 for contraband and damage to linen.

[REDACTED] **DOC#[REDACTED]**

Age:	39
Gender:	Female
Incident Type:	Unresponsive inmate in cell
Booking Date:	11/3/2018
Date of Death:	11/6/2018
Time of Death:	0915
Date of Incident:	11/6/2018
Time of Incident:	0855
Housing Unit:	4F, cell 108
Medical Transport:	No
911 (EMS) Request:	Yes
CPR:	Yes
AED:	Yes
Staff Use of Force:	No
Cause of Death:	Overdose – fentanyl, bupropion, promethazine, diazepam
Manner of Death:	Accident

Incident details

[REDACTED] was found unresponsive in her cell by officers in housing unit 4F at approximately 0855 hours. Officers had gone to her cell because a nurse was in the unit to see her for [REDACTED] follow-up. A medical emergency was broadcast, staff started CPR, and EMS was requested. The medical emergency team arrived at 0859 and took over lifesaving efforts. [REDACTED] was administered by medical personnel as well with negative results. EMS arrived at the facility at 0908 hours. [REDACTED] was pronounced deceased at 0915 hours and was not transported to the hospital.

Inmate [REDACTED] was on a [REDACTED] at the time of her death. She was noted as being blue in appearance and unresponsive to any lifesaving efforts. No discrepancies were noted in logbooks or video reviews with respect to walkthroughs. [REDACTED]

. She had been in the facility for approximately 1 week at the time of her death.

	DOC#
Age:	59
Gender:	Male
Incident Type:	Medical emergency
Booking Date:	9/3/2018
Date of Death:	12/15/2018
Time of Death:	Unknown
Date of Incident:	12/15/2018
Time of Incident:	1050
Housing Unit:	2D cell 112
Medical Transport:	Yes, 1117 hours
911 (EMS) Request:	Yes, unknown arrival time
CPR:	Unknown
AED:	Unknown
Staff Use of Force:	No
Cause of Death:	Heart failure
Manner of Death:	Natural causes

Incident details

On 12/15/2018 at 1050 hours, the housing unit officer in 2D found Inmate on his bunk. was having trouble and had what was described as a appearance. A medical emergency was broadcast, and EMS was requested to respond to the facility. was transported to the hospital by EMS at approximately 1117 hours. He died at an unknown time later that day at the hospital. Minimal information was available in reports or in public media sources.

	DOC#
Age:	55
Gender:	Male
Incident Type:	Medical emergency
Booking Date:	6/30/2018
Date of Death:	1/28/2019
Time of Death:	1344
Date of Incident:	1/28/2019
Time of Incident:	1230
Housing Unit:	2F
Medical Transport:	Yes
911 (EMS) Request:	Yes, arrived 1302
CPR:	Yes
AED:	Unknown
Staff Use of Force:	No
Cause of Death:	Bilateral pulmonary embolism
Manner of Death:	Natural causes

Incident details

[REDACTED] was in the dayroom near the shower area in 2F. He was encountered by the housing unit officer lying on the ground rolling around in pain and in visible distress. He was noted as having difficulty breathing. A medical emergency was broadcast. The unit officer sent an inmate to [REDACTED] room to retrieve his [REDACTED], but the [REDACTED] was ineffective. Medical personnel arrived and attempted to speak to [REDACTED], but he continued to roll around and was not answering questions. EMS was requested at 1237 hours.

At 1244 hours, [REDACTED] became unresponsive, and CPR was started by medical staff. EMS arrived at approximately 1302 hours. At 1323 hours, he was transported to the hospital. He was pronounced dead at the hospital at 1344 hours.

The documentation indicated a delay in the arrival of EMS, with the request time showing 1237 and arrival time being 1302. It is unknown at this time if the request time was accurately recorded. This response time is significantly slower than any other event the team reviewed.

[REDACTED]	**DOC#** [REDACTED]
AGE:	34
GENDER:	Male
Incident Type:	Suicide attempt - hanging
Booking Date:	12/12/2018
Date of Death:	4/11/2019
Time of Death:	Unknown
Date of Incident:	4/7/2019
Time of Incident:	1730
Housing Unit:	8D, cell 213
Medical Transport:	Yes
911 (EMS) Request:	Yes
CPR:	Yes
AED:	Unknown
Staff Use of Force:	No
Cause of Death:	Asphyxiation by hanging
Manner of Death:	Suicide

Incident details

[REDACTED] was in custody for murder and was housed in a high security unit in 8D. On 4/7/2019, at approximately 1657 hours, officers conducted a guard tour and visual check of his room. Within a short time after that tour, [REDACTED] covered the window to his room. When officers conducted their next tour, at approximately 1730 hours, the window was noted as being blocked. An officer attempted to contact [REDACTED] by intercom but received no answer. Two officers and a supervisor are required to enter rooms in this housing unit.

Officers could see the inmate was hanging (apparently through the food port) and requested permission to enter the cell. A medical emergency was broadcast for the housing unit. The officers made entry, cut down [REDACTED], and began CPR. No detail is available regarding when EMS arrived and transported him, but [REDACTED] was taken to the hospital. He died at an unknown time on 4/11/2019.

Documentation in the file indicated ███ had not had any sort of follow-up with ███ ███ He left an extensive suicide letter to a family member that discussed his murder case details and his reasons for killing himself. The primary reason was a lack of support from friends and family while he was held pending his criminal trial.

███	**DOC#███**
Age:	68
Gender:	Male
Incident Type:	Unresponsive inmate in cell
Booking Date:	12/13/2019
Date of Death:	12/30/2019
Time of Death:	0749
Date of Incident:	12/30/2019
Time of Incident:	0725
Housing Unit:	2F
Medical Transport:	No
911 (EMS) Request:	Yes, unknown arrival time
CPR:	Yes
AED:	Unknown
Staff Use of Force:	No
Cause of Death:	Coronary artery disease with high blood pressure
Manner of Death:	Natural causes

Incident details

███ was housed in unit 2F, cell 117. He and other inmates were called to come to the dayroom to see the nurse for███. Upon completing the checks, it was discovered ███ had not come to the nurse. The unit officer, knowing ███ had some ███ difficulty, went to the room with the nurse and found him unresponsive in his cell at 0725 hours. A medical emergency was broadcast, and staff performed CPR. It was not noted whether an AED was used. EMS was requested and responded to the facility. ███ was pronounced dead on scene at 0749 hours by EMS.

███ had a history of ███ while in custody. No other significant details about this incident were available.

███	**DOC#███**
Age:	51
Gender:	Male
Incident Type:	Unresponsive inmate in cell
Booking Date:	2/26/2020
Date of Death:	4/11/2020
Time of Death:	Unknown
Date of Incident:	4/11/2020
Time of Incident:	1212
Housing Unit:	3E, cell 110
Medical Transport:	No
911 (EMS) Request:	Yes
CPR:	Yes

AED:	Unknown
Staff Use of Force:	No
Cause of Death:	Atherosclerotic cardiovascular disease
Manner of Death:	Natural causes

Incident details

[REDACTED] was housed in unit 3E, room 110. He was found unresponsive in his cell by the housing unit officer. A medical emergency was called, CPR was initiated, and EMS was requested. He was pronounced dead on site by the medical services physician assistant and was not transported to the hospital. It is not clear if EMS arrived on scene or not based on the details provided.

Per report details, inmates housed in the rooms next to his had heard him singing the night before but had not heard anything from him that morning.

[REDACTED]	**DOC#**[REDACTED]
Age:	36
Gender:	Male
Incident Type:	Suicide
Booking Date:	4/11/2020
Date of Death:	5/25/2020
Time of Death:	1711 Hours
Date of Incident:	5/25/2020
Time of Incident:	1638
Housing Unit:	2B
Medical Transport:	No
911 (EMS) Request:	Yes, arrived at unknown time, no documentation
CPR:	Yes
AED:	Yes
Staff Use of Force:	No
Cause of Death:	Asphyxiation by hanging
Manner of death:	Suicide

Incident details

Inmate [REDACTED] was housed in unit 2B, cell 206. He was found hanging from his [REDACTED] by ACJ staff. Not many details on the incident were in the file, but one of the captains had cut him down and lifesaving measures including CPR and AED were used. It was not noted if [REDACTED] was transported to the hospital. He was pronounced dead at 1711 hours.

[REDACTED] notes in the file indicated [REDACTED] had previously been on a [REDACTED] and was cleared for general population on 4/20/2020. He had a previous medical assessment for [REDACTED] on 4/30/2020 and had at least one [REDACTED] condition. [REDACTED] had recently broken up with his girlfriend of seventeen years prior to his arrest but had refused an appointment to see the [REDACTED] scheduled for 4/16/2020.He used the [REDACTED] to secure [REDACTED] as a ligature.

[redacted]	**DOC#** [redacted]
Age:	29
Gender:	Male
Incident Type:	Medical emergency
Booking Date:	9/20/2020
Date of Death:	10/1/2020
Time of Death:	0143
Date of Incident:	9/20/2020
Time of Incident:	1510
Housing Unit:	Intake
Medical Transport:	Yes
911 (EMS) Request:	Yes
CPR:	No
AED:	NO
Staff Use of Force:	No
Cause of Death:	Central brain herniation, bacterial endocarditis due to IV drug use
Manner of Death:	Not found in information reviewed

Incident details

Inmate [redacted] was booked into the ACJ on 9/20/2020. At approximately 1510 hours a medical emergency was initiated and EMS requested, due to [redacted] having elevated [redacted]. He was transported to the hospital and had multiple [redacted] after admission. He died on 10/1/2020 after family removed him from [redacted].

Very minimal details are available on this individual as he was only in custody for a short time.

[redacted]	**DOC#** [redacted]
Age:	63
Gender:	Male
Incident Type:	Unresponsive inmate in cell
Booking Date:	11/7/2020
Date of Death:	11/26/2020
Time of Death:	1046
Date of Incident:	11/26/2020
Time of Incident:	1022
Housing Unit:	[redacted]
Medical Transport:	No
911 (EMS) Request:	Yes
CPR:	Yes
AED:	Yes
Staff Use of Force:	No
Cause of Death:	Atherosclerotic cardiovascular disease
Manner of Death:	Natural causes

Incident details

[redacted] was found unresponsive in his cell by officers. Staff made entry into the cell, broadcast a medical emergency, and initiated CPR. Medical personnel responded, took over lifesaving efforts and used the AED. EMS was requested to respond to the facility. The AED recommended [redacted] and

compressions were continued. EMS arrived on scene at 1042 hours. EMS pronounced [redacted] dead at 1046 hours.

[redacted]	**DOC#** [redacted]
Age:	40
Gender:	Male
Incident Type:	Unresponsive inmate in cell
Booking Date:	11/20/2020
Date of Death:	11/30/2020
Time of Death:	1200 hours
Date of Incident:	11/20/2020
Time of Incident:	2015
Housing Unit:	Processing cell 6
Medical Transport:	Yes
911 (EMS) Request:	Yes, arrived at unknown time
CPR:	Yes
AED:	Yes
Staff Use of Force:	No
Cause of Death:	Opioid toxicity, pulmonary hypertension
Manner of Death:	Accident

Incident details

[redacted] was booked into the ACJ on 11/20/2020 and housed in processing cell 6. He was found unresponsive in his cell by ACJ officers and lifesaving measures (CPR, [redacted], and AED) were initiated by officers and medical personnel. AED advised [redacted] and directed compressions to continue. A 911 response was requested. The time of arrival of EMS was not noted, but they transported [redacted] to the hospital and arrived by 2055 hours. [redacted] by 2125 hours and admitted to the intensive care unit.

[redacted] had previously been housed with other inmates and this information was turned over to investigators so that they could ensure no incidents had occurred that could have led to [redacted] issue. A few hours prior to being found unresponsive, reports indicated he had been given [redacted] by ACJ medical staff. Other details indicated medical personnel found a possible [redacted] and an [redacted] blood sugar was checked, and a pulse was obtained prior to transport. A note also indicated he had elevated [redacted] and the doctor at the hospital indicated he "had been [redacted] for a long time."

[redacted] was placed on [redacted] and remained in the hospital for 10 days. He was taken off [redacted] by his family and he was pronounced dead on 11/30/2020 at approximately 1200 hours.

[redacted]	**DOC#** [redacted]
Age:	55
Gender:	Male
Incident Type:	Unresponsive inmate in cell
Booking Date:	6/23/2021
Date of Death:	7/3/2021
Time of Death:	1758
Date of Incident:	7/3/2021

Time of Incident: 1715
Housing Unit: [redacted]
Medical Transport: Yes
911 (EMS) Request: Yes, unknown arrival time
CPR: Yes
AED: Yes
Staff Use of Force: No
Cause of Death: Asphyxia – food obstruction
Manner of Death: Underdetermined

Incident details

At 1715 hours on 7/3/2021, Inmate [redacted] was found unresponsive in his cell in unit [redacted] Custody and health staff approached his cell to administer [redacted]. Staff made entry into his cell, placed handcuffs on him to restrain him for safety reasons, and [redacted] were used with negative response. A medical emergency was announced, and EMS requested. His handcuffs were removed, and lifesaving measures were implemented, including CPR and the use of the AED, which recommended [redacted] When doing CPR, a blockage was removed from his mouth. The blockage was later determined to be food. EMS arrived on scene, took over lifesaving measures, and he was transported to the hospital. [redacted] was pronounced dead at the hospital at 1758 hours.

In this incident, the logbook for the post was not chronological as a guard tour was logged out of time sequence with the medical emergency. This could be due to the officer completing the tour before the information from the medical incident was logged or may indicate entries are being made before they are completed.

Additionally, the sergeant on scene ordered the camera turned off before entry into the cell per a report by Officer Gorham. It isn't clear why this was done when making entry into the cell, other than the supervisor may have anticipated having to restrain [redacted] when making entry due to his prior behavior toward staff. The reason for the camera being shut off should have been articulated. In most incidents, the camera is left on and still frame photos are included with critical incident packets.

Inmate [redacted] was previously diagnosed and treated for [redacted] while not in custody, and had been on [redacted] at some time prior to his death.

[redacted] **DOC[redacted]**
Age: 48
Gender: Male
Incident Type: Unresponsive inmate in cell
Booking Date: 11/7/2020
Date of Death: 9/12/2021
Time of Death: 0600
Date of Incident: 8/23/21
Time of Incident: Unknown
Housing Unit: Unknown
Medical Transport: Yes
911 (EMS) Request: Yes, unknown arrival time
CPR: No
AED: No

Staff Use of Force: No
Cause of Death: COVID-19 pneumonia
Manner of Death: Natural causes

Incident details

Inmate was diagnosed with on 8/16/2021. He called his wife (per public information sources) and told her he was diagnosed with On 8/28/2021, his wife was called by ACJ officials and told was hospitalized. She was given further information the following day from hospital staff that he had been in the intensive care unit at Allegheny General Hospital for approximately 10 days.

On 9/5/2021, public information indicates he was placed on a at the hospital. His wife was contacted on 9/11/2021 and told he was not expected to survive through the night. She was permitted a visit with that evening. died that evening at an unknown time.

We found limited documentation on in the packet regarding housing. However, e-mails stated he was sent to the hospital via EMS 8/20/2021 due to
Documentation was not clear on the exact time of the transport.

DOC#
Age: 48
Gender: Male
Incident Type: Medical emergency
Booking Date: 9/17/2021
Date of Death: 9/20/2021
Time of Death: 0143
Date of Incident: 9/17/2021
Time of Incident: 2145
Housing Unit: Intake
Medical Transport: Yes
911 (EMS) Request: Yes, unknown arrival time
CPR: No
AED: No
Staff Use of Force: No
Cause of Death: Hemorrhagic shock – ruptured spleen
Manner of Death: Accidental

Incident details

housed in the intake unit and was observed having a at approximately 2145 hours. A medical emergency was called, and EMS was requested. He was noted in reports as exhibiting during the transport to the hospital. He became at the hospital and had emergency on 9/18/21. was placed on on 9/19/2021 and passed away on 9/20/2021 at 0143 hours.

Minimal information was available on as he was in intake and had not been arraigned yet. No reports indicated any behavioral issues, altercations with other inmates, or force used by staff.

An internal investigation, including review of facility video, showed no incident occurred in-custody where a blunt force trauma-related injury could have occurred while in ACJ custody. Also notable was that the public information release that gave the cause of the death did not mention the ruptured spleen.

[redacted]	**DOC#** [redacted]
Age:	36
Gender:	Male
Incident Type:	Unresponsive inmate in cell
Booking Date:	9/16/2021
Date of Death:	9/23/2021
Time of Death:	Unknown
Date of Incident:	9/18/2021
Time of Incident:	Unknown, no details
Housing Unit:	Processing cell CH-6
Medical Transport:	No
911 (EMS) Request:	Yes, unknown arrival time
CPR:	Unknown
AED:	Unknown
Staff Use of Force:	No
Cause of Death:	Acute bilateral aspiration pneumonia, opioid withdrawal
Manner of Death:	Accidental

Incident details

[redacted] was booked into the ACJ on 9/16/2021 at 1552 hours. He was screened by health staff and housed in cell H-8 with one other arrestee at 1613 hours. He was moved to CH-6 at 1846 hours and his health assessment was conducted at 2109 hours. He was returned to his cell at 2113 hours.

[redacted] remained in the processing area until he was found unresponsive in his cell on 9/18/2021. The time of the medical emergency, and details, were not in the information received by the review team. The timeline noted he was transported from the facility by EMS at 1050 hours. There were no further details.

A review of video indicated [redacted] had [redacted] several times while he was held in cell CH-6. There was no medical information. We found no notes on [redacted] being placed on a [redacted] by medical personnel within the custody reports.

[redacted]	**DOC#** [redacted]
Age:	55
Gender:	Male
Incident Type:	Medical emergency
Booking Date:	9/11/2021
Date of Death:	10/9/2021
Time of Death:	1826 hours
Date of Incident:	10/9/2021
Time of Incident:	1723
Housing Unit:	[redacted]

Medical Transport:	Yes
911 (EMS) Request:	Yes, arrived at 1733
CPR:	Yes
AED:	Yes
Staff Use of Force:	No
Cause of Death:	Bronchial asthma
Manner of Death:	Natural causes

Incident details

was housed in unit . He had previously been the subject of a emergency in housing unit 2C at approximately 1620 hours on the same date. reported he had trouble while in 2C and reported his was not working. ACJ officers transported to housing unit on a stretcher as he had issues walking due to . Upon arrival in medical staff administered was not responsive to treatment, a medical emergency was declared, and CPR/AED was initiated. EMS arrived at the facility and took over lifesaving measures. was transported to the hospital by EMS at 1806 hours and pronounced deceased at 1826 hours.

Medical notes and information in the incident file indicated was previously on a he had a housing status with a lower bunk/lower tier restriction, and that he had received earlier that same day at the before being cleared for return to the ACJ by the

	DOC#
Age:	74
Gender:	Male
Incident Type:	Unresponsive inmate in cell
Booking Date:	10/21/2021
Date of Death:	12/22/2021
Time of Death:	1634
Date of Incident:	12/22/2021
Time of Incident:	1555
Housing Unit:	
Medical Transport:	No
911 (EMS) Request:	Unknown
CPR:	Yes
AED:	Yes
Staff Use of Force:	No
Cause of Death:	Atherosclerotic cardiovascular disease
Manner of Death:	Natural causes

Incident details

was housed in unit was occurring in the housing unit and upon completion, it was discovered that he had not come to receive . A unit officer and nurse went to his cell and found him unresponsive at 1555 hours. A medical emergency was broadcast, and CPR and AED lifesaving measures were initiated. The AED advised

[REDACTED] was pronounced dead by the ACJ doctor at 1634 hours. He was last observed alive by housing unit officers during the 1500 count process.

We noted the unit logbook was not in chronological order, nor did it match the timeline of the video review for guard tours. The 1545 guard tour does not appear to have been done based on the logbook and supervisor's timeline of events seen on video. [REDACTED] would have been occurring during the 1545 tour, which may limit the ability to do the tour until after [REDACTED] occurs, but it was logged in the book as if it had been done. The medical emergency was not in chronological order in the logbook, indicating the tours were logged before they were completed. Documentation was not clear regarding the precise time EMS was requested or when they arrived on scene.

[REDACTED]	**DOC#[REDACTED]**
Age:	74
Gender:	Male
Incident Type:	Unresponsive inmate in cell
Booking Date:	1/4/2022
Date of Death:	1/30/2022
Time of Death:	Unknown
Date of Incident:	1/22/2022
Time of Incident:	0905
Housing Unit:	4F, cell 110
Medical Transport:	Yes
911 (EMS) Request:	Yes
CPR:	No
AED:	No
Staff Use of Force:	No
Cause of Death:	Blunt force trauma to head
Manner of Death:	Accidental

Incident details

[REDACTED] was housed in unit 4F and had been called to come to the dayroom for a [REDACTED], but he did not respond. When the officer and nurse went to his cell, they found him on the ground unresponsive. EMS transported him to the hospital. At some point between the date of the incident and the date he died, the court released him from custody. He died on 1/30/22 at the hospital. The medical examiner found the cause of death was blunt force trauma to the head and his death was ruled accidental.

[REDACTED]	**DOC[REDACTED]**
Age:	26
Gender:	Male
Incident Type:	Medical emergency
Booking Date:	3/21/2021
Date of Death:	3/6/2022
Time of Death:	1412
Date of Incident:	3/6/2022
Time of Incident:	1220
Housing Unit:	2C, upper tier near showers

Medical Transport:	Yes
911 (EMS) Request:	Yes
CPR:	Yes
AED:	Unknown
Staff Use of Force:	No
Cause of Death:	Bilateral pulmonary embolism
Manner of Death:	Natural causes

Incident details

At 1220 hours, was on a video visit and abruptly left the visit. Within a short time, he was near his room on the upper tier and collapsed to the ground. Staff responded as several inmates were trying to assist him. The inmates were sent to their rooms and the officer broadcast a medical emergency. Medical staff responded and attempted to assess who was not responsive. EMS was requested and CPR was initiated by medical personnel. EMS arrived at the facility at 1235 hours. CPR continued for an extensive period and a pulse was restored. was transported to the hospital at 1337 hours. He was pronounced dead at 1412 hours.

A report from the housing unit officer indicated had told him his left leg was hurting earlier in the shift, but did not want medical to respond to check him when he was asked. Medical personnel indicated they felt may have possibly per some documentation we were able to review.

The medical examiner found the cause of death to be bilateral pulmonary embolism.

	DOC#
Age:	48
Gender:	Male
Incident Type:	Unresponsive inmate in cell
Booking Date:	3/1/2022
Date of Death:	4/28/2022
Time of Death:	Unknown
Date of Incident:	4/28/2022
Time of Incident:	1624
Housing Unit:	
Medical Transport:	No
911 (EMS) Request:	No
CPR:	Yes
AED:	Unknown
Staff Use of Force:	No
Cause of Death:	Cardiomegaly
Manner of Death:	Natural causes

Incident details

was housed in the housing unit due to known, A medical emergency was broadcast at 1624 hours when he was discovered unresponsive in his cell. Officers implemented CPR and medical staff responded to the housing unit. Dr. Winters of the ACJ pronounced deceased shortly after arrival, but no specific time was listed in the custody reports.

showed signs of rigor per Dr. Winters, he was cold to the touch, eyes dried over, and had no pulse or respiration at any time during lifesaving efforts. Based on his appearance, the doctor felt he had been dead since earlier in the day. Video review showed officers having some sort of interaction with at 1503 hours, and inmates reported he had been yelling obscenities at approximately 1100 the same day. A still shot from video when officers entered the cell shows him lying on his bunk with his arms crossed over his chest and legs crossed over one another, and he appeared to be sleeping. s was also at the time of his death. The medical examiner had not issued a final cause of death as of the time of this report.

	DOC#
Age:	39
Gender:	Male
Incident Type:	Unresponsive inmate in cell
Booking Date:	7/12/2022
Date of Death:	7/13/2022
Time of Death:	2013
Date of Incident:	7/13/2022
Time of Incident:	2008
Housing Unit:	4A, cell 108
Medical Transport:	No
911 (EMS) Request:	No
CPR:	Unknown
AED:	Unknown
Staff Use of Force:	No
Cause of Death:	Multidrug toxicity (fentanyl, methamphetamine)
Manner of Death:	Accidental

Incident details

appeared to be asleep in his room on the upper bunk. He was discovered unresponsive in his bunk during when he failed to respond to receive . Staff moved him to the floor of the room from the bunk for medical assessment and determined he had signs of rigor, was cold to the touch, and appeared to have been deceased for some time. His roommate said he had not spoken to all night. was pronounced dead by ACJ medical staff at 2013 hours.

was in his bunk, appearing to be asleep. We noted no deficiencies with respect to the times guard tours were conducted.

	DOC#
Age:	79
Gender:	Male
Incident Type:	Medical emergency
Booking Date:	7/18/2022
Date of Death:	8/14/2022
Time of Death:	1530 hours
Date of Incident:	8/14/2022
Time of Incident:	1512

Housing Unit: [redacted]
Medical Transport: No
911 (EMS) Request: Yes, arrived at 1526
CPR: Yes
AED: Yes
Staff Use of Force: No
Cause of Death: Ventricular fibrillation
Manner of Death: Natural causes

Incident details

[redacted] had been at the [redacted] and was returned to the ACJ at approximately 1430 hours. According to reports, he appeared to be [redacted] and had to be assisted to the ground while officers waited for a wheelchair. Due to the conditions, [redacted] was moved to the intake bench after his restraints were removed. While in the intake area, he slid down from the bench to the floor, and he [redacted] and [redacted]. He was placed in a wheelchair and was seen by the RN assigned to intake. [redacted] was sent directly to [redacted] from intake for [redacted] at 1502 hours.

Upon arrival in [redacted] was assigned to a room. Officers moved him to his assigned room, [redacted] and noted he was unresponsive. A medical emergency was called, and he was moved to the floor. CPR was initiated and the AED was used. A [redacted], so compressions continued. EMS arrived at 1526 hours and [redacted] was pronounced dead on scene at 1530 hours.

Numerous health record notes indicated [redacted] and other [redacted]. He had been ordered to be [redacted] until 8/17/22, presumably due to [redacted] He was back at the ACJ for less than an hour after being discharged from the [redacted] when a medical emergency was declared by ACJ staff.

[redacted] **DOC#** [redacted]
Age: 57
Gender: Male
Incident Type: Medical emergency
Booking Date: 9/10/2022
Date of Death: 9/22/2022
Time of Death: Unknown
Date of Incident: 9/21/2022
Time of Incident: 2246
Housing Unit: [redacted]
Medical Transport: Yes
911 (EMS) Request: Yes
CPR: No
AED: No
Staff Use of Force: No
Cause of Death: Medical examiner's finding is pending
Manner of Death: Medical examiner's finding is pending

Incident details

was housed in unit He had just arrived in the unit earlier that day. At approximately 1950 hours, the unit officer was locking the unit down for count and did not respond or move from the chair he was sitting in. He had difficulty and was . Another inmate assisted with getting him to his cell and he said he had . A medical emergency was called. He was seen by medical personnel and cleared to remain on the unit. The emergency was cleared at 2010 hours and was housed in his cell.

Medical personnel continued to come to the housing unit throughout the shift to check on . Medical was requested to assess him at 2218 hours and cleared him. At 2235 hours, during a guard tour, was unresponsive and was pulled out of his cell on his mattress, which he was laying on top of on the floor of the cell and another medical emergency was broadcast. EMS was requested to respond to the facility. EMS arrived at 2240 hours, and he was transported to the hospital at 2255 hours. He died the following day at the hospital. Prior to his death, he was released from custody.

His cause of death has not yet been determined by the medical examiner.

ANALYSIS OF FINDINGS

We conducted a thorough review of in-custody deaths between 2017 and 2022. The total number of deaths was 27, seven of which were suicides. Some in-custody deaths occurred after a patient was released, but because they were in custody at the time of the medical event, they were considered an in-custody death for purposes of this review.

The causes of the deaths in custody between January 2017 and October 2022 are varied, with some due to trauma, suicide, overdoses, blood clots and, according to the medical examiner, natural causes.

Characteristics Related to Mental Health for All Deaths, Part 1 (n=27)											
Year of Deaths	**Number of Deaths n (%)**	**History of Mental Health Issues n (%)**		**Seen by QMHP Within 1 Week Prior to Death n (%)**			**Received Psychiatric Consultation n (%)**			**History of Suicide Attempts n (%)**	
		Yes	**No**	**Yes**	**No**	**NA**	**Yes**	**No**	**NA**	**Yes**	**No**
2017	3 (11.11)	3 (11.11)	0 (0)	2 (7.41)	1 (3.70)	0 (0)	0 (0)	3 (11.11)	0 (0)	2 (7.41)	1 (3.70)
2018	4 (14.81)	3 (11.11)	1 (3.70)	2 (7.41)	2 (7.41)	0 (0)	2 (7.41)	1 (3.70)	1 (3.70)	1 (3.70)	3 (11.11)
2019	3 (11.11)	1 (3.70)	2 (7.41)	1 (3.70)	2 (7.41)	0 (0)	1 (3.70)	1 (3.70)	1 (3.70)	0 (0)	3 (11.11)
2020	5 (18.52)	4 (14.81)	1 (3.70)	1 (3.70)	2 (7.41)	2 (7.41)	2 (7.41)	0 (0)	3 (11.11)	1 (3.70)	4 (14.81)
2021	6 (22.22)	2 (7.41)	4 (14.81)	1 (3.70)	3 (11.11)	2 (7.41)	1 (3.70)	5 (18.52)	0 (0)	1 (3.70)	5 (18.52)
2022	6 (22.22)	4 (14.81)	2 (7.41)	2 (7.41)	4 (14.81)	0 (0)	2 (7.41)	2 (7.41)	2 (7.41)	1 (3.70)	5 (18.52)
Total n (%)	**27 (100)**	**17 (62.96)**	**10 (37.04)**	**9 (33.33)**	**14 (51.85)**	**4 (14.82)**	**8 (29.63)**	**12 (44.44)**	**7 (25.93)**	**6 (22.22)**	**21 (77.78)**

Note: All characteristics may not add up to 100% due to missing data

Characteristics Related to Mental Health for All Deaths, Part 2 (n=27)											
Year of Deaths	**Number of Deaths n (%)**	**History of Substance Abuse n (%)**		**Participation in the MAT Program n (%)**		**History of Overdose n (%)**		**Previous Psychiatric Hospitalization n (%)**		**Mental Health Policies and Procedures Followed n (%)**	
		Yes	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**
2017	3 (11.11)	3 (11.11)	0 (0)	0 (0)	2 (7.41)	0 (0)	2 (7.41)	2 (7.41)	0 (0)	3 (11.11)	0 (0)
2018	4 (14.81)	3 (11.11)	1 (3.70)	2 (7.41)	2 (7.41)	1 (3.70)	3 (11.11)	1 (3.70)	3 (11.11)	4 (14.81)	0 (0)
2019	3 (11.11)	1 (3.70)	2 (7.41)	0 (0)	3 (11.11)	0 (0)	3 (11.11)	0 (0)	3 (11.11)	3 (11.11)	0 (0)
2020	5 (18.52)	4 (14.81)	1 (3.70)	0 (0)	6 (22.22)	3 (11.11)	2 (7.41)	2 (7.41)	3 (11.11)	5 (18.52)	0 (0)
2021	6 (22.22)	4 (14.81)	2 (7.41)	0 (0)	5 (18.52)	0 (0)	5 (18.52)	2 (7.41)	4 (14.81)	6 (22.22)	0 (0)
2022	6 (22.22)	3 (11.11)	3 (11.11)	1 (3.70)	6 (22.22)	1 (3.70)	5 (18.52)	1 (3.70)	5 (18.52)	6 (22.22)	0 (0)
Total n (%)	**27 (100)**	**18 (66.67)**	**9 (33.33)**	**3 (11.11)**	**23 (85.19)**	**5 (18.52)**	**20 (74.07)**	**8 (29.63)**	**18 (66.67)**	**27 (100)**	**0 (0)**

Note: All characteristics may not add up to 100% due to missing data

Characteristics Related to Mental Health for Suicides, Part 1 (n=7)										
Numbe r of Deaths n (%)	**In Custody Less Than 2 Weeks**	**History of Mental Health Issues n (%)**		**Seen by QMHP Within 1 Week Prior to Death n (%)**		**Received Psychiatric Consultation n (%)**			**History of Suicide Attempts n (%)**	
		Yes	**No**	**Yes**	**No**	**Yes**	**No**	**NA**	**Yes**	**No**
7 (100)	2 (28.57)	5 (71.43)	2 (28.57)	2 (28.57)	5 (71.43)	1 (14.29)	4 (57.14)	2 (28.57)	3 (42.86)	4 (57.14)

Note: All characteristics may not add up to 100% due to missing data

Characteristics Related to Mental Health for Suicides, Part 2 (n=7)										
Number of deaths n (%)	**History of Substance Use n (%)**		**Participation in the MAT Program n (%)**		**History of Overdose n (%)**		**Previous Psychiatric Hospitalization n (%)**		**Psychological Autopsy Completed n (%)**	
	Yes	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**
7 (100)	6 (85.71)	1 (14.29)	1 (14.29)	5 (71.43)	1 (14.29)	5 (71.43)	3 (42.86)	3 (42.86)	6 (85.71)	1 (14.29)

Note: All characteristics may not add up to 100% due to missing data

Medical History Statistics for All Deaths by Year (n=27)							
Year of Death	**Number of deaths n (%)**	**History of chronic health issue, including substance use n (%)**		**History of chronic health issue, excluding substance use* n (%)**		**Seen by an MD within 1 week of death n (%)**	
		Yes	**No**	**Yes**	**No**	**Yes**	**No**
2017	3 (11.11)	3 (11.11)	0 (0)	0 (0)	3 (11.11)	No data	No data
2018	4 (14.81)	4 (14.81)	0 (0)	3 (11.11)	1 (3.70)	1 (3.7)	3 (11.11)
2019	3 (11.11)	2 (7.41)	1 (3.70)	2 (7.41)	1 (3.7)	0 (0)	3 (11.11)
2020	5 (18.52)	5 (18.52)	0 (0)	1 (3.7)	4 (14.81)	1 (3.7)	2 (7.41)
2021	6 (22.22)	5 (18.52)	1 (3.70)	3 (11.11)	3 (11.11)	3 (11.11)	No data
2022	6 (22.22)	5 (18.52)	1 (3.70)	3 11.11)	3 (11.11)	3 (11.11)	3 (11.11)
Total	**27 (100)**	**24 (88.89)**	**3 (11.11)**	**12 (44.44)**	**15 (55.56)**	**8 (29.63)**	**11 (40.74)**

Note: All characteristics may not add up to 100% due to missing data
**Includes chronic conditions that are co-occurring with substance use, as applicable*

As seen in the table "Medical History Statistics for All Deaths by Year," almost 90% of individuals had a diagnosed chronic health issue when a history of substance use is included in the metric. In the second column, we note that the prevalence of chronic health issues drops to almost 44% when substance use is excluded. This suggests that substance use may contribute to a large part of the chronic disease burden among this sample.

The CDC provides strong evidence that long-term effects of alcohol abuse can lead to high blood pressure, cardiovascular disease, stroke, liver disease, high levels of fats and cholesterol increasing the risks of blood clots, cancer (mouth, throat, esophagus, liver), and weakening of the immune system. Additionally, chronic heroin users can develop Hepatitis C, pulmonary infections, kidney disease, and infections of valves in the heart. Long-term effects of using methamphetamine can include heart damage, high blood pressure, and liver failure.

Natural causes are defined as internal factors that cause the body to shut down such as cancer, heart disease, stroke, liver or kidney failure, or diabetes. Contributing factors to an organ or system failure can be secondary to lifestyle choices such as, but not limited to, alcohol abuse, illegal drug use, and smoking. Several inmates who died while in custody had a history of alcohol and drug abuse that played a part in their overall health.

Regardless of the causation, some overarching themes existed among these deaths, that although they might not have contributed to the demise of these individuals, need to be addressed. Individuals identified with poorly controlled chronic conditions upon entering the jail should be seen by a provider in a timelier manner - within 7 days of incarceration. Providers should adopt evidence-based clinical protocols when treating chronic conditions. Documentation of all chronic care visits should include condition and status and should have a scheduled follow-up.

Parameters and nursing protocols for abnormal vital signs should be followed by all nurses and documentation of the disposition and follow-up should be included in the health record.

Individuals with wounds should be seen by a provider as soon as possible. Wounds needing provider assessment can be defined as crushing or open, visibly infected, contaminated, thermal or chemical

burns, painful, pressure ulcers, non-healing, and diabetic leg or foot wounds. Pictures should be taken of the wound at intake and then over the course of the treatment.

Individuals presenting to intake with a history of alcohol, opioid, or any substance abuse should be started on the detoxification protocol and managed immediately regardless of arrest status. Once treated at intake, nursing should assess individuals held in intake/receiving every 4 hours using the COWS or CIWA assessment scale.

Individuals admitting to a history of suicide attempts, psychiatric hospitalization, and/or a recent personal loss should be seen by a QMHP within 14 days.

Policies for medication refusals should be followed in all cases, with documentation by a provider acknowledging the patient's noncompliance and disposition.

All man-down incidents that require transport to an emergency room should be discussed in a debrief with the staff who participated in the event. The use of the emergency encounter form should be completed at that time.

Polypharmacy is a concern when a number of providers are treating the individual. An outside pharmacy audit should be completed every quarter to ensure patients are not being overmedicated and that the best medications are being used to treat these individuals.

Causes of in-custody deaths

We were asked to conduct this analysis of all deaths as they relate to the operation in an attempt to identify any trends or issues that could relate to the number of deaths. Because the deaths occurred over a 5-year period, there have been many changes to the operations of the ACJ since the initial deaths and suicides occurred. Therefore, it is important to note that findings from older cases may indicate gaps, physical plant defects, and/or policy and procedure failures that have already been addressed since those incidents occurred.

Specifically, Allegheny County and the administration of the ACJ have implemented significant changes to the physical structure, staffing, and training within the facility to enhance efforts to protect the lives of patients housed within their facility. NCCHC Resources completed a detailed report in 2019, and almost all of the recommendations in that report were complied with. Notably, the only recommendations not implemented were due to external factors, and it was not ACJ administration's decision to avoid implementing them. Efforts are ongoing to address those previous recommendations.

Tables outlining our different areas of analysis are provided for review below.

Shift on Duty – All Deaths		
Shift	**Deaths - All**	**Suicides**
7:00 a.m. to 3:00 p.m.	11	1
3:00 p.m. to 11:00 p.m.	14	5
11:00 p.m. to 7:00 a.m.	2	1

Housing Units with Multiple In-Custody Deaths	
5B	4
Intake/Processing	4
5C	3
8D	2
4A	2
2F	2

Analysis of Deaths by Shift and Day of Week (n=27)				
		Shift		
Day of Week	**Number**	**7:00 a.m.-3:00 p.m.**	**3:00 p.m.-11:00 p.m.**	**11:00 p.m.-7:00 a.m.**
Sunday	5	3	2	0
Monday	5	3	1	1
Tuesday	3	1	1	1
Wednesday	2	0	2	0
Thursday	2	1	1	0
Friday	3	0	3	0
Saturday	7	3	4	0

Suicide Analysis (n=7)							
Housing	**Method**	**Gender**	**Age**	**Incident Date**	**Day of Week**	**Shift**	**Days in ACJ**
5B	Hanging	F	33	4/18/2017	Tuesday	11:00 p.m.-7:00 a.m.	87
5B	Hanging	M	39	6/3/2017	Saturday	3:00 p.m.-11:00 p.m.	10
8D	Hanging	M	68	9/8/2017	Saturday	3:00 p.m.-11:00 p.m.	408
4A	Hanging	M	62	9/17/2017*	Sunday	7:00 a.m.-3:00 p.m.	Unk**
5F	Hanging	F	57	4/27/2018	Friday	3:00 p.m.-11:00 p.m.	13
8D	Hanging	M	34	4/07/2019*	Sunday	3:00 p.m.-11:00 p.m.	120
2B	Hanging	M	36	5/25/2020	Monday	3:00 p.m.-11:00 p.m.	44

**These individuals were transported to the hospital and remained there until death; therefore, the date of the incident and date of death are not the same.*

*** Unable to ascertain whether this individual remained in custody while hospitalized.*

In the analysis of in-custody deaths, we noted no significant trends or common factors that would show a particular weakness or gap in operations. A few points should be brought to the attention of the ACJ administration, and will reaffirm many of the beliefs they have about their risks as a central booking facility. Specifically:

- Multiple incidents occurred where policy violations by employees were identified through internal investigations. In incidents where staff were found to have violated policy, ACJ administration took timely disciplinary action against involved staff who violated policy and held the employees accountable.
- In incidents where a policy or procedure contributed to a death of an inmate, we found those policies or procedures were addressed by ACJ administration in a timely manner and changes were communicated to staff members.
- In two incidents a patient appeared to be sleeping and was found to have been deceased for a few hours.

- One incident in particular had a conflict in information where medical staff felt had been deceased for some time, but video shows officers interacting with through the door to his cell a little over an hour before he was found deceased.
- There were no significant investigative findings indicating a criminal offense occurred for any of these cases, whether by other inmates or ACJ staff.
- None of the deaths were the result of a use of force by ACJ personnel, or by the actions of other inmates.
- The Allegheny County medical examiner reports were provided to the team for all cases. One of the 2022 cases is still pending a finding by the medical examiner. Three of the findings had causes of death that were not explained by the documentation provided.
  - One cause of death was hemorrhagic shock due to a ruptured spleen. was in the receiving area when he was sent for medical treatment and nothing was documented that related to a use of force, any attempts by to self-harm, or fights with other inmates that could have caused this injury to occur while in ACJ custody.
  - Once cause of death was blunt force trauma to the head and ruled accidental. It appears this incident occurred due to a fall from bunk.
  - One cause of death was asphyxiation due to food obstruction, which was ruled accidental. There were what appeared to be abnormalities on this case in that the sergeant ordered the camera to be turned off before entering the cell, which appears to be outside of normal practice as the video is used to obtain still photos of the cell. The report also indicates staff immediately restrained when making entry, and their purpose of going to the cell was to administer an , so it is possible they felt he was trying to draw them into the cell to potentially attack staff. It was not explained clearly why the camera was turned off. had made by various methods prior to coming to the ACJ, and the autopsy found the manner of this death undetermined.

Analysis points of note are as follows:

- All days of the week, in one way or another, experienced either a suicide or in-custody death. The low days were Wednesday and Thursday (2), and the high day was Saturday (7).
- All shifts experienced a suicide or in-custody death.
- The overnight shift (11:00 p.m. to 7:00 a.m.) was by far lower than the other shifts.
- The day shift (7:00 a.m. to 3:00 p.m.) and swing shift (3:00 p.m. to 11:00 p.m.) were close to equal in deaths between them.
- None of the deaths involved staff at the ACJ using force or a force tool (such as pepper spray or the restraint chair) before the death occurred.
- Four deaths involved patients who were arrested within 24 hours of the incident that led to their death.
- None of the deaths in the receiving area were the result of a suicide.
- Guard tours were largely completed correctly, with only a few exceptions that resulted in termination of officers. However, the quality of the guard tours is not clear. While on site we observed guard tours in several units and while the officers walked by each cell, it is not evident they are checking for signs of life when doing so, especially in units where 15-minute checks are required.
- Housing units with multiple deaths and/or suicides were all higher acuity housing units, such as intake and medical, or higher security level inmates facing serious charges.
- Six of seven suicides were successful in the same higher risk, higher acuity units. Only one of the seven occurred in a general population housing unit.

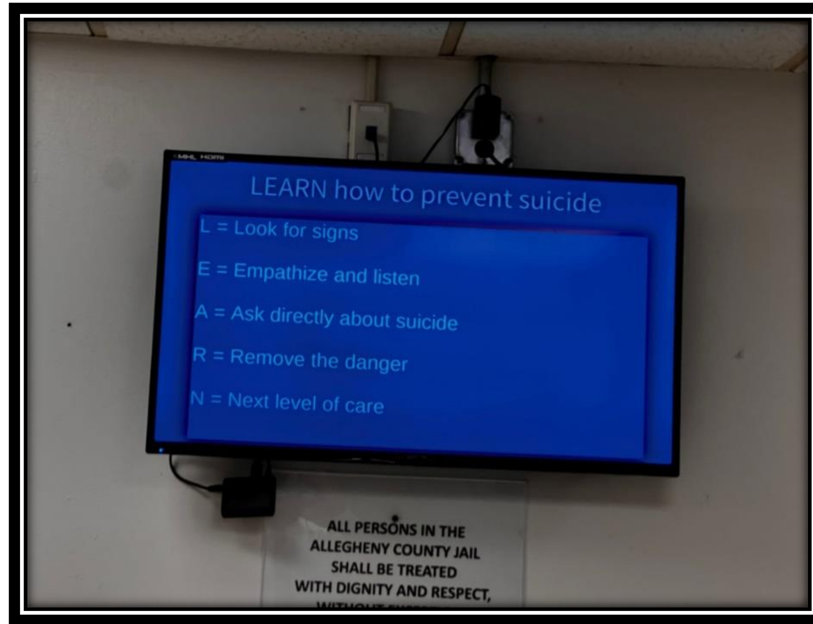
- While in processing on the morning of 11/3/2022, we observed a hostile and agitated patient in a holding cell who attempted to tie off from the [redacted] Using his jacket, he was able to get the jacket [redacted] and pulled down to confirm it held weight. He appeared to be trying to potentially hang himself from the [redacted]. Staff maintained visual observation of him the entire time, requested a supervisor, maintained communication, and appeared to be ready to take immediate action if he did attempt to hang himself.

  At one point, the jacket came out of the [redacted]. When their supervisor arrived moments later, there was a brief discussion and it appeared they were pre-planning prior to making entry. However, the patient complied with verbal commands prior to the staff making entry into the cell, and staff were able to handcuff him through the food port in the door without further incident. The patient continued to be verbally abusive to staff after being moved from the cell. Staff performed professionally during this incident and prevented a potential use of force by using communication and de-escalation techniques.
- All suicides were accomplished by hanging, typically from a [redacted]
- Suicides have been reduced significantly since 2019. Only one suicide, in 2020, has occurred since suicide prevention efforts were implemented.
- There were two housing units where multiple suicides (two each) occurred. Those units were [redacted] (acute care housing) and 8D (elevated security level due to charges and/or institutional behavior).
- Most of the deaths that occurred were due to preexisting medical conditions and considered “natural” in nature, or due to drug ingestion.
- Only one death has been attributed to COVID-19, indicating the facility has made significant efforts to manage and control the disease, especially considering almost all arrestees come in directly from the street.
- The one case still pending a final cause of death was known to be [redacted] at the time of death.
- The seven individuals who committed suicide in ACJ custody ranged in age from 33 to 68, yielding an average age of 47.28.
- Time-in-custody for inmates who committed suicide ranged from 10 days to 408 days.
- Three of the seven who committed suicide did so within 2 weeks of being booked into the ACJ, though one was transferred to ACJ from another jail.

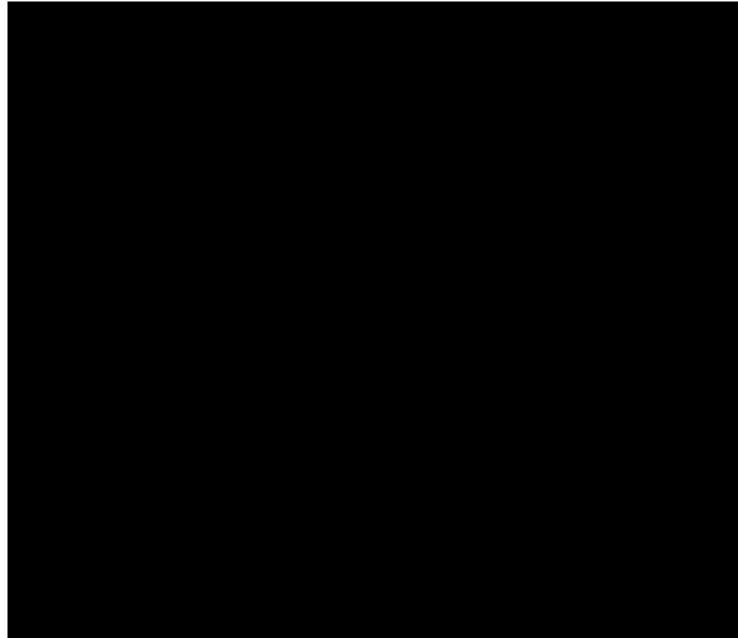
Suicide prevention efforts

It is commendable that the ACJ has implemented so many of the previously recommended suicide prevention options, and it is undoubtedly making suicide more difficult to accomplish while in the facility. This is evidenced by the reduction of successful suicides since our prior analysis in 2019.

While on site we noted the prominence of suicide awareness messaging for staff members. In the secure staff areas, ACJ administration have posted monitors that display rotating messages discussing suicide prevention and recognition of suicidal ideation. We noted the display below just outside of the staff dining area in the main hallway. These efforts serve as further reinforcement of the training and commitment to reducing suicide within the facility.



However, two prominent gaps remain that could lead to a suicide today. Both are known gaps, but funding issues have prevented closing those gaps. To truly remove the opportunity to commit suicide in the ACJ, they need to be addressed immediately. We will address these issues later in the report, under the discussion for Standard J-B-05.



Comparison to similar facilities

Obtaining an accurate number of individuals dying in custody is a challenge as jurisdictions have different methods of gathering data. Some account for all deaths arising or occurring while in custody, thereby including those individuals remaining on life support until family can be located. Others count only the deaths that occur within the confines of the jail, so that if the individual is transported to the hospital and dies, these are not considered in-custody deaths. Allegheny has accounted for all deaths, with six of the individuals in the hospital at their time of death.

Additionally, it is important that we compare "like environments" and for this purpose, the 2021 publication by the US Department of Justice, "*Mortality in Local Jails, 2000-2019 Statistical Tables*" should be used as a reference. According to that study, from 2000 to 2019 the overall mortality rate was 142 deaths per 100,000 jail inmates. Chronic illness was the leading cause of death in the study with the majority of those related to heart disease. The study notes that suicide is the second most common cause of death among incarcerated individuals, with 48 per 100,000 inmates, compared to the rate among non-incarcerated persons of 22 per 100,000.

This fits with NCCHC Resources' review, which identified 85% of those individuals dying in Allegheny County's custody as having a chronic condition as well as a history of substance abuse. Many individuals admitted to multi-substance use with a combination of alcohol, heroin, methamphetamine, and/or fentanyl.

Although official federal data is unavailable past 2019, it is recognized that there have been increases in in-custody deaths across the nation since then. Using publicly available data, we have been able to find several other large jails and their frequency of in-custody deaths in 2022:

In-Custody Death Frequency – 2022		
Agency	**Deaths in 2022**	**Approximate Population**
Harris County, TX	27	9,850
New York, NY	19	5,900
San Diego County, CA	19	2,900
Riverside County, CA	17	3,800
Oklahoma County, OK	16	1,624
Fulton County, GA	14	2,800
Pima County, AZ	10	1,850

The loss of life while in custody is tragic and should be taken seriously. Allegheny County has been proactive in their suicide prevention program and by enlisting NCCHC Resources to review the deaths occurring in their jail from 2017 to 2022. They have demonstrated a willingness to identify issues, change processes when indicated, and provide quality care with the future goal of NCCHC accreditation.

RECOMMENDATIONS

The recommendations below are based on the NCCHC Resources team's operational review of deaths in custody between 2017 and 2022. These recommendations are realistic and the warden and his administrative staff are motivated to improve services. Based on the warden's commitment, many of these recommendations can be implemented within a short period of time. These recommendations have been placed in order of importance.

Priority 1

- Change the operational procedure at processing.
  - A nurse should do a thorough assessment of all individuals entering the jail.
    - This process should include nurses identifying individuals with abnormal vital signs, inmates pending detoxification, and abnormal blood sugars.
    - Initiate detoxification monitoring and medication at the time of intake.
    - Nurses must manage patients by reassessing those who remain in intake every 4 hours (or more frequently, if applicable).
  - Implement an audit system to ensure accountability (see Attachment).
- Improve identification of those individuals at risk of self-harm by noting whether this is their first time in jail, whether they are being admitted on serious charges, reviewing their past history in TechCare (the facility's electronic health record), reviewing past history of suicide attempts, and looking for previous admissions to a psychiatric inpatient unit.
- Institute hands-on man-down drills for all staff.

Priority 2

- Implement a criterion-based chronic care housing unit for those individuals who are more medically fragile and staff it with a registered nurse on day shift Monday through Friday.
  - Initially identify poorly controlled diabetics, uncontrolled hypertension, and patients with ejection fraction less than 40%.
- Complete detoxification assessments every day and every shift.
- Require nurses to debrief after critical incidents and complete the emergency man-down form.
- Consult with a pharmacist regarding the issues with polypharmacy and work with prescribers to discontinue all but one medication from the same family.
- Require a mortality review on all deaths within 30 days, led by the medical director and having each discipline represented.
- Require an in-depth psychological autopsy on all suicides within 30 days.

Priority 3

- Institute collaborative briefings after weekends and prior to the following weekend to identify patients on the radar as being at risk or difficult.
- Initiate interdisciplinary meetings discussing psychiatric and administrative segregation patients.
- Implement a policy that all calls to medical from family members expressing their concerns for an incarcerated family member must be elevated to the DON or ADON.
- Ensure the MD is receiving a report from the hospital on all inmates upon discharge. Require the MD to document the discharge disposition in the health record and notify the DON.

ADDITIONAL AREAS OF POTENTIAL IMPROVEMENT

As part of our team's survey of the facility, we also noted a few areas that could be improved. These do not directly relate to NCCHC accreditation and are offered as observations for your consideration.

Administration

With respect to the reviews of in-custody deaths, the documentation was inconsistent among the packets we reviewed. Although changes have been made since the earlier death reviews, there were still inconsistencies in the packets that made it difficult to get a clear picture of the incident and the individual's in-custody behavior and activities. A few of the packets had great information and organization, from including the inmate's locator card (which contains a lot of critical information) to having a more systematic approach to the content of the packet.

All packets should be consistent in their content and organization as this facilitates reviews and the gathering of information. Many agencies have a checklist-type cover sheet that prompts the individual completing the packet to include certain items available for that particular incident, as all incidents are different and not every one will have every element of the checklist. This ensures all available information is preserved with consistency, and should direct the order in which the packet is compiled and organized. Examples of content include, but are not limited to:

- A cover sheet with inmate information, or the inmate's locator card
- A detailed, single report or incident briefing form (usually completed by a supervisor) that contains the timeline of the incident, personnel who responded to the incident (including medical, investigative, EMS, etc.), preliminary details of the incident known at the time of the report, jail video pertaining to the investigation, evidence that may have been collected for ACJ retention (logbooks), photos or video recorded by initial responding supervisors or personnel, debriefing and after-action efforts for staff or witness inmates, and any other documents deemed necessary for such packets.
- Information on whether a scribe was assigned for the incident (a designated officer or supervisor who records everyone coming and going for an event, and a general timeline that is used for reporting).
- Other required documents as determined by the agency.
  - Consideration could be given to the inmate's custody file, such as charge sheets for the initial arrests, added charge sheets for additional criminal charges after arrest, observation sheets (if used), property forms, requests or grievances filed, etc. Medical information should remain in the health record.
- If provided, any investigative paperwork.
- Upon completion, medical examiner findings (if approved by the legal department).
- A copy of the mortality review, which should be a structured report.

We received medical examiner findings, but no findings from criminal investigations completed by Homicide were included, indicating that those criminal investigations found no criminal acts by other inmates or staff. Internal Affairs information, being a personnel-related function, should not be included. There were findings of staff policy violations in a few of the cases, and immediate disciplinary action was taken to hold ACJ staff accountable.

A confounding element of the reporting was the collection of numerous reports from involved personnel that are included in the packet. Having individual reports provides an individual officer or medical staff perspective but could also present issues with respect to contradictions among those individual perspectives that can cause unnecessary questions or scrutiny from others who see those

reports. Many agencies either have an external report that outlines the incident (from the investigative unit and not detention center personnel) or a single internal report, usually completed by a detention supervisor, that includes elements of the incident known at the time of reporting, such as timelines, incident details, actions taken, etc.

Although agency policy ultimately directs how reporting is completed, consideration should be given to the potential for negative perception, confusion, or other unnecessary conflicts that ultimately cause additional work and distrust of the processes used by ACJ staff. From what we saw, the processes used are very good as far as investigation into incidents, so a more streamlined reporting process would help avoid any unnecessarily negative perceptions of those practices.

It is not clear how information is reported to the Jail Oversight Board, other than by email. The emails we saw reported in news media were worded in a way where the content could cause a perception of issues not being reported to the board. We noted that in email reporting that went to the news, messages indicated an inmate was transported to the hospital after an "incident" in custody, and that inmate later died. The issue with this wording is the word "incident." It could as easily mean that a fight occurred or staff used force, as that a medical emergency or COVID-19 complication occurred. "Incident" does not present a clear picture and is open to interpretation, which does not help the administration or staff of the ACJ.

When there is some sort of staff involvement, restricting information would be understandable as additional investigation is ongoing and there may not be conclusions yet, not to mention protecting the staff's rights for investigative purposes. But when a known medical emergency occurs, as was the case on at least one of these deaths, indicating the occurrence of a "medical emergency" versus an "incident" may be more prudent. Several of these deaths have been related to medical conditions that were not a result of staff actions. Information released should be objective, should not assume a finding ahead of a medical examination or investigation, and should provide known details that can be released.

Even stating something like the following is objective and doesn't assume any investigation details:

> *"During scheduled welfare checks, an inmate was found unresponsive in their cell. ACJ uniformed personnel and medical staff provided treatment on scene and the inmate was transported to the hospital, where they passed away. An investigation into the death is being conducted by the Pittsburgh Police Department Homicide Section and actions by ACJ staff are being investigated by Internal Affairs. Further details will be provided when those investigations are completed."*

The relationship with the JOB is very strained, and it seems to be driven more by one member of that board than the process itself. Having a relationship with that board is critical as it is a Pennsylvania law that establishes their authority, and they do have authority and the responsibility for oversight of the facility. This relationship needs to be addressed immediately.

The JOB has a function they are required to carry out. ACJ administration has responsibility for the safety of staff, security of the facility, and the welfare of inmates in their custody. Common factors between the ACJ and JOB should be considered in the relationship, and it is critical to have open communication and transparency between the two entities to counteract the negativity of the one board member who seems to be trying to drive a negative narrative about everything the ACJ does.

It may take some time but having that open relationship (and not just for a formal meeting or formal, required visit to the ACJ) will encourage collaboration between the ACJ and the JOB, which will ultimately make the relationship both more comfortable, and more functional. The ACJ and JOB share the common goals of ensuring the jail is secure, safe for staff and inmates, and runs efficiently. It seems some people on the JOB are reasonable and will consider information objectively. Open communication is unlikely to win everyone over, but everything starts with relationships, and there do seem to be people there who want to have a productive relationship with the ACJ administration.

The relationship with ACJ staff also seems to be strained. This seems to represent frustration more than an actual negative opinion about what ACJ administration is doing. Staff have a need and desire to know what is going on, and it seems some of the negativity occurring with the JOB is impacting internal communication due to the fear of internal information be released to a wider audience. ACJ administration controls all narratives and information by design, but basic information can be made available to staff.

In a large number of these cases, staff did their jobs correctly and yet circumstances beyond their control resulted in a death. They need to hear this from the top when those facts are known. And when someone makes an error and is held accountable, the actions taken don't need to be shared, but the gaps or issue that caused the failure, and especially policy changes made to correct gaps, must be shared and that should also come from the top. The significant information and communication gap should be addressed as soon as possible.

Training

Staff at the facility expressed some concerns when we spoke to them. The main concern was a lack of in-person training being provided over the last few years. Although COVID-19 played a role in this, staff expressed that the lack of in-person training was making it hard to retain some of the aspects of training they are expected to retain. CPR was expressed as a major concern by staff, although documentation indicated that 71% of staff had their CPR training for the current period. It isn't clear what training is being provided for CPR, but this was a concern expressed by both staff and supervisors.

The reliance on PowerDMS was not well received by the personnel with whom we spoke. Many implied they felt it was "checking a box." Some said they felt training was not as effective via remote learning compared to in-person classes. They recognized the challenges of COVID-19, but indicated remote learning was being done before COVID-19. Some indicated video or other media would be helpful with the classes.

Communication

Information pertaining to important operational issues, staff safety, inmate safety, or the safety and security of the facility itself must be communicated. Staff, including line supervisors, indicated they don't hear information on critical incidents, specifically deaths and suicides, or follow up or corrective information. This is a concern, especially with the lack of corrective information. Regardless of the circumstances, if a policy or procedure is discovered as deficient, it must be a point of communication to all staff. Not communicating corrective actions could increase liability as it could appear as deliberate indifference to what occurred.

Staffing

Some areas, especially intake housing in 4A, appear to be staffed below where they should be. This is solely based on the way that unit is currently operating with the COVID-19 quarantine requirement. The

different custody levels, statuses, and detoxification protocol inmates present challenges to conducting housing unit operations. This unit, and the medical/psychiatric units on the 5th floor, should be reassessed for staffing to cover the current duties. Intake seemed to have a large number of custody staff compared to the booking numbers coming in per shift.

If it has not been considered already, 12-hour shifts may be more effective and efficient for staffing of custody operation posts.

Operations

Guard tours may not be as focused on signs of life as they should be. Some tours we observed appeared rushed and did not seem to be focused on the inmate's welfare as much as being seen on camera doing the tour of the unit. This was especially evident in areas with 15-minute checks of units, which tends to be a higher acuity housing unit with a higher risk of critical incidents and self-harm.

Cell searches appear to be minimal and are reactive after something has occurred. While in medical, one inmate was found to have 17 inhalers in his room. Other accumulations of medicine purchased through the commissary were also noted by medical staff. A review of what can be kept on-person, and how medicine is provided, is needed. Over-the-counter medications like Tylenol and Motrin can be abused and even used for self-harm.

Logbooks were found to be out of chronological order in a few of the in-custody death incidents, which could indicate guard tours are being logged before they are completed, or that multiple personnel are creating entries during critical incidents. Late entries were not noted as "late entry" in the logbooks.

An alternative to logbooks should be considered, such as the use of the jail management system, to log tours and on-unit activities. Jail management systems will typically have the capability to enter electronic information, such as guard tours, unit activities, etc. that eliminate the need for a manual logbook, are reviewable and auditable, and become a permanent record that can be searched.

OPERATIONS AND COMPLIANCE WITH NCCHC STANDARDS

In this section we cover standards which apply to the issues encountered during our review, and what changes should be made in order to be fully compliant in the hopes of achieving NCCHC accreditation.

J-A-04 – Administrative Meetings and Reports (Essential)

The documentation provided to the review team was not consistent. Meetings should be held at least quarterly, and minutes or summaries should be retained and available for reference. Administrative meetings are held to ensure communication among all facility staff members to ensure consistency and to facilitate health care delivery. Monthly statistical reports should also be provided to give a measure of services provided. These reports can aid in identifying gaps in providing access to medical services and grievance trends as they relate to custody and/or medical staff. Meetings must be held at least quarterly.

Note that this is not to say the meetings aren't occurring. Only that their documentation and reporting were inconsistent or absent.

J-A-05 – Policies and Procedures (Essential)

While this standard directs requirements for health care policies and procedures, custody is required to ensure their policies and procedures are not in conflict with those of health care. As the facility prepares for accreditation, it will be necessary to go through all applicable policies and procedures to ensure they do not conflict with health care policies and procedures and will include updates as they occur.

J-A-06 – Continuous Quality Improvement Program (Essential)

A CQI program is designed to monitor and improve the delivery of health care in a facility. This standard also ties into J-A-04, noted above. It requires participation of all disciplines to ensure expectations and requirements are met. CQI Committee meetings must be held at least quarterly.

J-A-09 – Procedure in the Event of an Inmate Death (Important)

Allegheny Jail does not do mortality reviews and psychological autopsies are minimal if done at all, not providing the information intended by the standard.

Although this standard is not labeled "essential" it is extremely important, especially considering the environment in Allegheny County. The standard includes compliance indicators that are being met in part but are largely inconsistent in how they are delivered, documented, or communicated. The administrative review of this process pertains to the joint review of the response to an incident. It assesses applicable facility procedures, staff training for those involved, emergency response, and recommendations for changes to policy, training, physical plant, medical/mental health services, and other operational procedures that relate to an incident.

Corrective actions for any inmate death are to be reported to the CQI program and patient safety program, which are responsible for implementation and monitoring of systemic issues and the identification of any staff-related issues, respectively. The same review is required for any deaths that occur off-site, when the facility is responsible for the inmate.

J-B-04 – Medical Surveillance of Inmate Workers (Important)

This standard requires specific health and safety standards for inmate workers within the facility and is typically conducted in conjunction with the facility's classification unit. It was not evident that all compliance indicators are met for this standard, specifically for committee oversight (or equivalent), overseeing associated risks to workers through a medical surveillance program, or if additional medical screening is being done to assess the inmate's suitability for work assignments. Certain requirements may be met through the local public health authority's requirements, but this area of the operation should be assessed for compliance, even if only to ensure best practices are in place.

J-B-05 – Suicide Prevention and Intervention (Essential)

Regarding this standard, ensure policies, procedures, and training are in line with the requirements expressed in this standard as there could be some discrepancies. The debriefing process may also be inadequate as it appears employee assistance program cards are handed out, but it isn't clear if a true debriefing and assessment of involved staff is done on a consistent basis. Having an employee assistance program is not mandatory, but it is possible for law enforcement personnel to develop PTSD from involvement in critical incidents, which could in turn lead to poor performance, mental health issues, or medical issues. It is not unusual for a law enforcement officer to hide their symptoms and decline assistance until they have reached an advanced stage and experience other problems.

There are two prominent issues that remain to be addressed but are outside the control of the ACJ administration. [redacted]. There has been a delay in the contractor completing that work, but it is in progress.

J-B-08 – Patient Safety (Important)

It is not clear if adverse clinical events or near-miss clinical incidents are discussed with ACJ administration based on the information we reviewed. This process involves custody staff discussing incidents that occur because of errors attributed to medical management rather than the patient's medical conditions, or near-miss events where something could have occurred but didn't. This process is part of the overall CQI concept and relates to standard J-A-06.

J-C-04 – Health Training for Correctional Officers (Essential)

A review of this standard is necessary to ensure training is meeting the required standards for accreditation. Some aspects of training were provided, including CPR. This standard requires specific training be provided at onboarding and every 2 years thereafter, and specifies minimum standards for those trainings. This should be relatively easy to accomplish through PowerDMS. The standard requires the compliance of at least 75% of staff on each shift, and all standards must be expressed in the written policy. Policy 608, *Training and Staff Development* should list the specific topics of training in the standard as ongoing training requirements for all uniformed personnel. Narcan (naloxone) should also specifically be included as staff are trained in its use.

J-C-09 – Orientation for Health Staff (Important)

This standard sets a basic orientation requirement that must be provided on or before the first day of on-site service by a health staff member, even if they are brought in from an agency on a per-diem basis,

to allow them to function safely in the facility. Because of the staff shortage issues in Allegheny County Jail, the potential exists for security issues, including manipulation by inmates, if someone is not properly trained before working in a secure facility.

J-D-02 – Medication Services (Essential)

This standard focuses on safe prescribing by the provider. The practice of polypharmacy identified in this review increases the risk of adverse drug effects and drug-drug interactions. It is the responsibility of the prescribing provider to monitor the individual's active medication list and manage tapering/cessation of medications in the same class when needed.

J-D-07 – Emergency Services and Response Plan (Essential)

This standard is not being met at all, as man-down and mass disaster drills are not being conducted. Also referred to collectively as emergency drills, these drills are important activities that assess custody and medical staff's response to incidents and offer the ability to critique and identify potential gaps before a true incident occurs. All shifts are required to participate annually in man-down drills, and once every three years for mass disaster drills. This requirement includes satellite facilities as well. Applicable policies and procedures must also be updated to include the required drill information.

J-D-08 – Hospital and Specialty Care (Essential)

Based on the findings of this review, there does not appear to be adequate communication among the hospital, the Sheriff's Department (which transfers patients from the hospital to the jail), and the jail. Staff state that sometimes an inmate will be returned to the jail and they have not been notified and so cannot anticipate the needs of the patient.

J-E-02 – Receiving Screening (Essential)

The intake process for those who will remain in custody and those who will bail out is two-tiered. The review completed by the NCCHC Resources team found the bifurcation of this process results in serious negative outcomes. The amount of time an individual is kept in intake exceeds most jail practices and places inmates at risk for not being treated or identified as requiring additional care. This practice falls short of NCCHC's standard.

J-E-05 – Mental Health Screening and Evaluation (Essential)

Mental health screening is performed to ensure urgent mental health needs are met. Indicators of this standard include, but are not limited to, screening for previous psychiatric inpatient hospitalizations, detoxification treatment, suicide attempts and current suicidal ideation, sexual abuse, treatment using psychiatric medications, and emotional responses to incarceration. Our review identified missed opportunities to refer patients requiring a timely evaluation.

J-E-07 – Nonemergency Health Care Requests and Services (Essential)

The process for ensuring mental health requests are viewed and triaged is a concern. Records indicated that patient requests for mental health assistance were not dealt with in a timely manner. This practice does not meet the standard.

J-F-01 – Patients with Chronic Disease and Other Special Needs (Essential)

This standard ensures that patients with chronic health conditions are managed using evidence-based clinical treatment practices for optimum outcomes. Our medical record review of patients with chronic conditions identified areas lacking consistency in treatment and follow-up.

J-F-04 – Medically Supervised Withdrawal and Treatment (Essential)

The facility has a “detox nurse” working Monday through Friday (day shift only). This sporadically timed assessment is inadequate for the management of these patients. Our review identified multiple patients whose detoxification was poorly managed.

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ATTACHMENT

Intake Quality Monitoring									
Booking Number	Were Vital Signs Taken?	Were Abnormal Vital Signs Documented with a Plan for Monitoring and Follow-Up?	Is the Inmate Diabetic?	Was a Blood Glucose Check Completed?	Was There Documentation and a Plan for Follow-Up?	Did the Inmate Admit to Substance Abuse?	Did the Inmate Receive Their First Detoxification Dose During the Assessment?	Is There Documentation That This Inmate Was Monitored While They Were in Intake?	Comments
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