disABILITY LAW CENTER OF VIRGINIA

Protection & Advocacy for Virginians with Disabilities

Falling Through the Cracks

An Investigation into the Death of Irvo Otieno

Image Description: *An empty hospital bed in a hospital room*

August 2024

Table of Contents

Executive Summary

A mental health crisis should not be a death sentence.

Irvo Otieno was a 28-year-old man who was passionate about life, his family, and had dreams for his future. Mr. Otieno was a gifted athlete in high school, playing football and basketball, and even attended college in California for a bit. He loved creating music and aspired to make a career in the industry. His goals were not just of fortune and fame – he wanted to help his relatives back in his native country, Kenya. He was known for being warm, inviting, and a good listener.

Mr. Otieno had a mental health crisis in the community and needed treatment. Too often individuals who need psychiatric help face many barriers to receiving treatment, especially people of color. What he received was policy brutality, arrest, incarceration, unreasonable restraints, and ultimately death.

disAbility Law Center of Virginia (dLCV) investigated the death of Irvo Otieno in March 2023. From his initial encounters with police and the hospital emergency room to his incarceration and transfer to Central State Hospital, dLCV discovered a complete breakdown of Virginia's mental health crisis system, compounded by a culture of criminalizing individuals with mental illness, particularly communities of color. The system that was *supposed* to help Mr. Otieno utterly and completely failed him.

To prevent such tragedies from occurring in the future, dLCV recommends the following to address the multiple system failures illuminated by Mr. Otieno's death:

- Preventing the Criminalization and Unnecessary Incarceration of People with Disabilities
- Implementing Adequate Health and Behavioral Standards in Jails
- Protecting the Rights of Patients in Hospital Settings to Ensure Necessary Care
- Strengthening Police Oversight and Regulating the Use of Prone Restraint

Introduction

On March 6, 2023, 28-year-old Irvo Otieno died at Central State Hospital after Henrico County Sheriff's deputies and hospital staff restrained him. Three days before, he had a mental health crisis in the community and Henrico County police officers took him to Parham Doctor's Hospital for a psychiatric evaluation, which recommended inpatient treatment; however, before transferring him to a psychiatric hospital for recommended treatment, Henrico County police arrested him and took him to Henrico County Regional Jail West. For the three days in jail, he was subjected to hours in an emergency restraint chair and the jail failed to provide him with any psychiatric treatment.

After another psychiatric evaluation, the local community services board (CSB) again recommended Mr. Otieno for in-patient treatment. Henrico County Sheriff Office's deputies transferred him from the jail to Central State Hospital. During the admission process, ten people (seven deputies and three hospital staff) pushed him face down onto the floor and physically restrained him. After twelve minutes, the deputies and staff removed themselves from the non-responsive Otieno and began life-saving measures, which ultimately failed.

disAbility Law Center of Virginia (dLCV) is the federally-mandated Protection and Advocacy System for Virginians with disabilities, tasked with protecting their legal, human, and civil rights. For decades, we have worked to improve the lives of people with mental health conditions and disabilities in the community and institutional settings. After dLCV learned of Mr. Otieno's death, we opened an investigation into his initial encounter with police, treatment at Parham Doctor's Hospital, arrest, incarceration, and death.

What dLCV uncovered is a cascade of systemic failures that led to Mr. Otieno's death, a death that could have been prevented if it weren't for the complete breakdown of Virginia's mental health crisis system and the Commonwealth's culture of criminalizing individuals with mental illness.[i]

[i] dLCV's findings are based on extensive review of records from Central State Hospital, Henrico Community Services Board, the Office of the Chief Medical Examiner, and the Virginia Department of Health.

Background

Research has found that the best way to improve outcomes for people with mental illness is to provide robust community-based services and crisis interventions designed and staffed by clinicians and social workers.[1] Though roadmaps of a better system are available, Virginia still grapples with a system that increases the risk of unnecessary incarceration, poor treatment outcomes, violence, and death for this vulnerable population.

People who live with mental illness are at increased risk of abuse and neglect in institutional settings.

Decades of research from across America has long identified what our crisis systems are just beginning to acknowledge: that states are more likely to police mental illness than treat it. A 2024 Pew Research poll estimated that people with mental illness are twice as likely than those without mental illness to be arrested and that more than two million people with serious mental illness are booked into jails each year.[2] One 2006 study found that, in a ten-year period, 27% of individuals receiving mental health treatment from the state's Department of Health were arrested at least once for largely minor crimes, such as trespassing, disturbing the peace, and motor and drug offenses.[3]

When society criminalizes psychiatric symptoms while failing to provide appropriate community supports, it's hardly a surprise that a person with a serious psychiatric illness has a far higher likelihood of spending a night in jail than being admitted to an inpatient psychiatric hospital.[4] Tragically, law enforcement often becomes involved in situations involving people with disabilities, not because of reports of a crime, but because family, neighbors, or other bystanders reported a person having a mental health crisis.[5]

Despite representing only 20% of the population, people with disabilities make up 30-50% of individuals subject to police "use of force" and constitute an estimated 33%-50% of the people killed by police.[6] Furthermore, Black Americans make up 13.4% of the population, but account of 22% of fatal police violence.[7] Nationally, Black people are 2.9 times more likely to be killed by the police than White Americans.[8] This brutality at the hands of police often stems from both misunderstandings related to mental illness or other disabilities and racial biases.[9]

People with mental illness and other disabilities are disproportionately subjected to State violence.

While fewer than 1 in 14 arrests of a person with mental illness involved a violent charge, people with mental illnesses are more likely to receive a jail sentence for misdemeanors and receive longer sentences.[10] People in mental health crises are often charged with "Assault Against Law Enforcement" due to the acute symptoms

they are facing. University of Virginia researchers estimated that in 2002, 10% of all Virginians charged with assaulting an officer had a history of mental illness spanning a decade or more; these individuals also spent an average of 94.8 days in jail, compared to the 79-day average for those without mental illness.[11]

Risks are especially high for Black and Brown Virginians with disabilities. Research on implicit bias has evidenced that racial bias exists in risk assessments, in which law enforcement and clinicians interpret ambiguous behaviors as riskier when displayed by Black or Brown individuals.[12] In 2017, Black emerging adults (20 – 24 years old) were killed by police at more than triple the rate of white emerging adults.[13] These biases only increase further into the criminal justice process, as one out of every three Black boys born today can expect to be sentenced to prison.[14].Black defendants are also 22% more likely to have convictions involving police misconduct that eventually result in exoneration.[14] When these racial biases are compounded with disability, they paint a harmful and concerning picture for Black Americans with disabilities -- more than half of whom have been arrested by law enforcement by age 28.[15]

In a report from 2023, 22.36% of inmates in Virginia jails were known or suspected to have a mental illness.[16] Of those individuals, 52.56% were diagnosed with a serious mental illness, which includes schizophrenia, bipolar disorder, major depressive disorder, or post-traumatic stress disorder. Despite the high number of people in Virginia jails with serious mental health conditions, the amount of treatment they receive is staggeringly scant.

In June 2023, Virginia jails reported:

16,618	**10,258**	**1.62**
Hours of mental health treatment provided to inmates	Number of inmates who received mental health treatment	Average amount of hours of inmates received

Jails know that they are not the appropriate provider for someone in crisis. When people in mental health crises are arrested and jailed at far greater rates, they often are immediately sent out again for mental health evaluation and treatment. Forensic patients in need of psychiatric evaluations or treatment accounted for 47% of all admissions to state hospitals in fiscal year 2023.[17] These patients also remain hospitalized for three times longer than their civil counterparts.

People in the midst of a mental health crisis may eventually get treatment, but at the cost of unnecessary incarceration and criminalization, increasing their likelihood to be unemployed, homeless, and re-arrested.

Timeline of Events

During dLCV's investigation, we reviewed records from Parham Doctor's Hospital, Henrico County CSB, and Central State Hospital, as well as news reporting and publicly available records, including security footage.[18] Based on those records, dLCV constructed a timeline of what occurred with Mr. Otieno from March 2nd to March 6th, 2023.

March 2nd

00:00	Police arrived on scene after a neighbor called regarding concerns about Mr. Otieno's behavior. Police did not transfer Mr. Otieno to a hospital and Mr. Otieno remained in the community.

March 3rd

11:30am	Police arrive on scene after Mr. Otieno's mother called, reporting that Mr. Otieno was experiencing a mental health crisis. Police place Mr. Otieno under an Emergency Custody Order (ECO).
1:30pm	Mr. Otieno arrives at Parham Doctor's Hospital.
1:50pm	Henrico CSB conducts prescreening evaluation to determine if Mr. Otieno requires a Temporary Detention Order (TDO) for inpatient psychiatric care. Henrico CSB determines that Mr. Otieno meets TDO criteria.
	Parham Hospital staff administer medications for agitation.
2:30pm	Mr. Otieno becomes agitated towards Henrico Police. Hospital staff and police place "pt back on stretcher, railings in place, handcuffed both hands/ankles."[ii]
3:20pm	Parham Hospital staff administer an anti-psychotic medication for agitation.
5:30pm	Parham Doctor's Hospital staff conduct suicide assessment and note that Mr. Otieno is not engaging in verbal or physical threats or attacking objects or people.
6:30pm	Henrico CSB enter a note stating that Mr. Otieno is to be admitted to Central State Hospital under a TDO. TDO is formally ordered but has not yet arrived at the hospital.
6:40pm	Mr. Otieno becomes agitated. Parham Doctor's Hospital emergency physician orders medications. Parham Doctor's Hospital staff administer

[ii] This is typically called four-point bed restraints.

	medications with physical assistance from Henrico police. Mr. Otieno strikes out, scratching and hitting one of the officers. Henrico police arrest Mr. Otieno for assault on a law enforcement officer, property damage, and disorderly conduct.
10:30pm	Police transport Mr. Otieno to Henrico Regional Jail West where they admit him.
11:30pm	Henrico jail nursing staff examine Mr. Otieno. Jail staff place him into an emergency restraint chair and take him to a cell.

March 4th

10:15am	Henrico County CSB conducts another psychiatric evaluation at the jail for Mr. Otieno due to continued psychiatric crisis. The pre-screener determines that Mr. Otieno continues to meet TDO criteria.
10:30am	Henrico jail nursing staff examine Mr. Otieno. Mr. Otieno's restraints are removed one at a time to allow him to stretch and then replaced. At this point, he has been in a restraint chair for 11 hours.
12:30pm	Henrico County CSB contacts magistrate for new TDO and places Mr. Otieno on wait list for hospital bed.
1:00pm	Henrico County CSB submits Forensic Admission Screening Intake Assessment to Central State Hospital for TDO admission.
4:30pm	Henrico jail nursing staff examine Mr. Otieno. They note aggressive behavior, but are unable to properly assess as he is still in the emergency restraint chair.

March 5th

9:30am	Henrico CSB communication states that there are not available beds for Mr. Otieno at that time.[iii]
3:50pm	Henrico jail staff conduct mental health watch. Mr. Otieno is no longer in the emergency restraint chair. Staff note Mr. Otieno refuses medications and has not eaten. Mr. Otieno remains on level 1 continuous watch with full restrictions.[iv]

[iii] As of March 2023, there were 158 patients on DBHDS' Extraordinary Barriers List (EBL), meaning that they had been clinically ready for discharge for at least 7 days from DBHDS-operated psychiatric facilities across the state. The state hospitals have been at capacity often in the past few years, but this could be remedied by timely discharging patients who are ready for discharge.

[iv] Restrictions include a safety smock and safety blanket, no sharps, and no sheet on the bed.

March 6th

00:00	A Henrico County District Court Magistrate signs the TDO.[v]
2:30pm	Henrico County Sheriff's Department deputies stand outside Mr. Otieno's cell. A struggle breaks out while they attempt to deliver a food tray through the slot. Six deputies enter the cell and tackle Mr. Otieno to the ground. One officer throws multiple punches down.
2:45pm	Six Henrico County deputies carry Mr. Otieno out of the cell and into the carport, where they place him into a white van.
3:10pm	The van with Mr. Otieno leaves the jail carport.
4:00pm	Mr. Otieno and the Henrico County Sheriff's Department arrive at Central State Hospital.
4:19pm	Seven Henrico County Sheriff's deputies carry Mr. Otieno into the admissions suite and place him sitting on the floor. His hands and feet are in restraints.
4:20pm	Henrico County deputies begin attempting to remove Mr. Otieno's leg restraints. At one point, four deputies and three hospital staff are physically restraining Mr. Otieno as he sits on the floor.
4:28pm	Henrico County deputies and Central State hospital staff physically maneuver Mr. Otieno into a prone (face down) position on the ground. Seven deputies and one hospital staff physically hold him down and, at one point, at least two deputies are entirely physically on top of Mr. Otieno.
4:35pm	Central State Hospital medical provider gives a verbal order for medications for agitation.
4:39pm	Central State Hospital staff begin replacing the police leg restraints with hospital restraints.
	One Henrico County Sheriff's deputy shakes Mr. Otieno. Mr. Otieno does not respond. Henrico County Sheriff's deputies and Central State Hospital staff roll Mr. Otieno onto his side. Mr. Otieno is motionless.
4:40pm	One Central State Hospital staff enters the room and injects the medications as ordered for agitation. Mr. Otieno remains non-responsive.
4:41pm	Henrico County Sheriff's deputies and Central State Hospital staff roll Mr. Otieno onto his back.

[v] There is no time noted on the court order, only the date issued.

4:42pm	Central State Hospital staff check Mr. Otieno's vitals and begin CPR. Central State Hospital calls Petersburg Emergency Services.
5:08pm	EMS personnel arrive and take over life-saving measures.
5:35pm	EMS personnel cease life-saving measures and declare Mr. Otieno dead.

A Systemwide Failure

What happened to Mr. Otieno is the result of a complete breakdown of the mental health crisis system: from the community, to the emergency room, to the jail, to the hospital admission suite. This series of failures resulted in the circumstances that ultimately led to Mr. Otieno's death.

The Escalating Effect of Law Enforcement

Mr. Otieno was struggling during a mental health crisis. It has been well documented that the presence of law enforcement caused Mr. Otieno to escalate, becoming far more agitated and impulsive both in the community and hospital. The rescue squad noted that Mr. Otieno was only angry with the police and was cooperative with the EMT in getting onto the stretcher. The pre-screener noted that it took several officers to get him in the ambulance to bring him to the emergency room, but that he was never physically aggressive, only resistant. Even while Mr. Otieno showed agitation, he allowed hospital nursing staff to draw his blood. Mr. Otieno only resisted or was antagonistic towards uniformed law enforcement and was compliant in all other circumstances.

While an individual is under an ECO, police must remain on-site during the prescreening process, though not necessarily in the room with the patient. Henrico Police made the deliberate decision to remain in the room, disregarding the detrimental impact their presence had on Mr. Otieno, undermining his stability and impeding his treatment.

> *Parham Doctor's Hospital reported during the Department of Health's investigation that they felt they could have provided the stabilizing care Mr. Otieno needed* ***"but was not able to fully stabilize the patient because our care was interrupted by the intervention of Henrico County police officers."***[13]

The presence of law enforcement can unnecessarily escalate situations with vulnerable individuals. Nearly half of psychiatric patients reported significant psychological distress as a result of being restrained by law enforcement, with the use of such restraint often worsening existing psychiatric symptoms.[19,20] Law enforcement can misinterpret these mental health symptoms as indications of aggression or criminal behavior, especially if those symptoms cause a person to appear hostile, resistant, or impact their ability to respond to commands.[21] Once escalated, these situations can result in further restraint, arrest, or even the use of force—whether lethal or non-lethal.

Virginia's overreliance on law enforcement during the mental health crisis process means that people like Mr. Otieno, who are better supported by non-police entities, are at far greater risk of escalation, increasing their risk of unnecessary arrest and incarceration. Mr. Otieno's alleged assault on police was after he had already been determined to

require inpatient psychiatric care. He was reportedly in four-point restraints on a bed and in the process of receiving treatment. The police inserted themselves into his medical treatment and Mr. Otieno lashed out in fear and frustration. Police arrested him and prevented him from receiving necessary treatment, ultimately leading to his death.

Without a robust mental health crisis system staffed by trained mental health professionals, communities often must rely on law enforcement to respond to mental health crises.

Emergency Room Failed to Provide Stabilizing Treatment

Law enforcement took Mr. Otieno to Parham Doctors' Hospital, which has a crisis receiving center specific to mental health emergencies in their emergency department. However, according to an investigation by the Virginia Department of Health (VDH), the hospital failed to provide necessary stabilizing treatment for Mr. Otieno.[22] He waited in the emergency department for six hours and never once saw a psychiatrist.

Under the Emergency Medical Treatment and Labor Act (EMTALA), private hospitals must provide a medical screening examination (MSE) during an emergency medical condition (EMC).[23] Furthermore, hospitals must provide stabilizing treatment for patients experiencing an EMC or, if they're incapable of stabilizing the patient, they must transfer the patient to a hospital that can.

HCA Healthcare, which owns Parham Doctors' Hospital, states in their policy that "the hospital is responsible for treating the individual within the capabilities of the hospital as a whole, not necessarily in terms of the particular department at which the individual presented."[24] Additionally, they define "stabilized" as "no substantial deterioration of the condition is likely to result from or occur if the individual is transferred from the facility."

Emergency Departments, despite their duty to provide care, are not ideal places for individuals experiencing a mental health crisis.[25] Staff do not always have the skills or resources to provide support. Nearly half of emergency department physicians report that patients with psychiatric complaints are "boarded"[vi] in their emergency department on a daily basis, meaning that they are kept in the emergency department for an extended period of time without psychiatric care because no psychiatric bed is available.[26] A 2015 study by NAMI found that 38% of mental health patients in the ER waited more than 7 hours to see a mental health professional.[27]

Many Virginia providers report that, since 2015, the situation worsened after the passing of the "bed of last resort" legislation.[28] Psychiatric patients boarded in the emergency department often decompensate, significantly increasing the risk for chemical and

[vi] From the ACEP report, "boarding" is defined as "if that patient's ED evaluation is complete and the decision has been made to either hospitalize or transfer the patient, yet the patient remains in the ED, whether because of staffing issues, bed availability, specialized needs of the patient, or other factors"

physical restraints. Psychiatric boarding also increases the risk of patients to be discharged *without* treatment or arrested while waiting for treatment.[29] These risks can be mitigated if appropriate treatment is provided in a timely manner.

Parham Doctors' Hospital boasts a partnership with Henrico's Crisis Intervention Team (CIT), a team comprised of police and mental health workers designated to provide appropriate responses to residents in mental health crisis. Despite this, Parham Doctor's Hospital reported that they *felt incapable* of stabilizing Otieno. This failure escalated Mr. Otieno's mental health crisis, resulting in his subsequent arrest and transfer to jail.

Mistreatment and Lack of Mental Health Care in Jail

Police arrested and transferred Mr. Otieno to Henrico County Regional Jail West. There, 11 officers placed him into the emergency restraint chair. For the two days he was there, Mr. Otieno did not sleep or take any psychotropic medications. Prior to his transfer to Central State Hospital, six deputies entered his cell, bringing Mr. Otieno to the ground, with one officer appearing to punch him several times.[30]

Use of Restraint

Many correctional facilities, including Henrico County Regional Jail West, use the restraint chair as a primary means to restrain individuals who are disruptive, resistant, or aggressive. The Department of Justice's Federal Performance-Based Detention Standards state that any policies regarding the use of restraint should ensure that restraints are removed as soon as possible, with the use of psychiatric restraints limited to times such as 4, 8, or 12 hours, but not to exceed 24 hours.[31] The National Commission on Correctional Health Care (NCCHC), which establishes standards for health care services in correctional facilities, state that restraints should be used in the shortest time possible and generally shouldn't exceed 12 hours.[32,33] Even the manufacturer states that "detainees should not be left in the SureGuard® Correctional Chair for more than two hours."[34]

Restraints have been associated with death by asphyxia and aspiration, even when properly applied. Furthermore, immobilization caused by restraint is considered a risk factor for fatal pulmonary embolisms.[35] Amnesty International has said that poor training and improper supervision during restraint chair use causes pain, injury, and even death, and the United Nations Committee

Against Torture has urged U.S. officials to abolish the chairs entirely.[36]

Upon arrival at Henrico County Regional Jail West on March 3rd at 11:30 PM, jail staff placed Mr. Otieno in the emergency restraint chair and he was still in the restraint chair on March 4th at 4:30pm. It is unclear when he was released, but the first indication he was no longer in the restraint chair was on March 5th at 3:50pm. He was restrained for *at least 17 hours, and possibly up to 40 hours.*[i] This is far outside any recommendations and such use put Mr. Otieno at serious risk for injury and even death.

Use of Force

While dLCV cannot speak to the criminal nature of any of these events, both our investigation and the public investigations have found that the force used against Mr. Otieno while in Henrico County Jail was particularly egregious.

Irvo Otieno was actively experiencing a mental health crisis, in jail, while subjected to pepper-spray, restraints, potentially struck, then carried out of his cell.[12]

Public health scholars argue that excessive force can extend to a wide variety of practices, such as psychological intimidation, sexual and emotional violence, and verbal assault.[37] A 2000 study from the National Institute of Justice found that use of physical force by law enforcement has a high likelihood of suspect injury, with subjects far more likely to be injured if struck with a fist (81%) than with a baton (64%) or even a handgun (45%).[38] When it comes to correctional settings, use of force is often linked with inmate resistance.[39]

> *The risk of being subject to use of force is higher for people with mental illnesses, whose psychiatric symptoms are often misunderstood and misinterpreted by law enforcement.*[7]

The Henrico County Sheriff's Office Use of Force guidelines state that the use of force is to be restricted to controlling an individual or in cases of self-defense and protection of others.[40] The use of force is to begin at the lowest level and to only advance to a level that is "objectively reasonable." It is perplexing how the use of force, including physical strikes and pepper spray by six deputies, began *at the lowest level***.** It is even more confusing that the use of force advanced solely to control an individual's behavior or the protection of others, particularly when that individual was alone in a cell.

Lack of Mental Health Treatment

The Virginia Code states that all jails must provide 24-hour emergency medical and mental health care services.[41] During a behavioral health screening, if the individual is

having a mental health crisis, the jail should complete a comprehensive behavioral health assessment within 72 hours (excluding weekends or holidays).[42] The standard also requires that immediate behavioral health interventions should be implemented if an individual is in acute mental health distress. Local and regional jails must follow the standards and guidelines to ensure the health, safety, and welfare of incarcerated individuals.[43]

There is little indication that Mr. Otieno received any mental health treatment while incarcerated. During his admission, the jail cited him as having an acute psychosis episode, however the staff completing the initial screening did not refer him for further evaluation.

When Ms. Ouko, Mr. Otieno's mother, visited the jail that Saturday to see her son, the jail told her that they had no medications to treat his mental health issues and that any medications would have to be cleared by a doctor, who would not see him until Monday.[44]

In a 2023 report, Henrico County Jail (East and West) reported that all inmates who exhibited signs of an acute mental health crisis during their mental health screening were assessed within 72 hours.[10] To the contrary, Henrico County Jail *also* indicated that they would have "Extreme Difficulty" complying with policy requiring that all inmates who received a "positive" mental health screen receive a comprehensive mental health assessment within 72 hours.

*In 2023, the average length of time Henrico County Jail inmates waited to receive a comprehensive mental health assessment was **14 days**.*

Custody Confusion between Law Enforcement and Hospital Settings

Mr. Otieno had multiple interactions with law enforcement while in hospital settings: first at Parham Doctor's Hospital, then at Central State Hospital. At times he was in law enforcement custody, and other times he was under the direct care of medical staff. This overlapped in multiple instances, resulting in confusion regarding custody and oversteps by law enforcement, contributing to Mr. Otieno's death.

Parham Doctor's Hospital

Mr. Otieno was under an ECO when Parham Doctor's Hospital admitted him to the emergency department. He was in the custody of Henrico County Police for the sole purpose of transporting him to a hospital to secure a mental health evaluation and receive stabilizing treatment. [45] He was then to remain in police custody until a TDO was issued.

Henrico County Police policy indicates that the officer enforcing the ECO must ensure the individual is in their sight at all times. Officers do not have any additional authority or powers beyond maintaining that custody. Yet, records from Parham Doctor's Hospital indicated that police actively intervened during Mr. Otieno's medical care multiple times. While hospital staff were providing treatment to Mr. Otieno, Henrico County Police physically assisted in the medical intervention, even though they were not employed by the hospital and were not medical staff.[17]

This physical intervention escalated Mr. Otieno, leading him to strike one officer. This is when the police decided to arrest him for assault. In the VDH investigative report, Parham Doctor's Hospital specifically stated that they were unable to provide stabilizing care for Mr. Otieno due to the care being interrupted by Henrico County Police.[46]

Though police overreached their involvement with Mr. Otieno, Parham Doctor's Hospital should never have allowed outside law enforcement to participate in medical interventions. HCA Healthcare and Parham Doctors' Hospital have policies to address how to handle disruptive patients. Trained hospital staff use de-escalation techniques, such as providing the person space, verbal de-escalation, clinical medications, or behavioral restraints, to defuse behavioral and crisis situations directly.[47] They adhere to a code of conduct which the primary edict is to provide safe, effective, and compassionate care, emphasizing patient dignity, privacy, and respect.[48] Law enforcement do not have these responsibilities and they are not held to the same ethical restrictions.

Allowing police to directly intervene in patient care creates a massive conflict of interest, one that creates negative outcomes for the patient.

Police presence in emergency departments can interfere with patient care and compromise patient rights. Police can negatively impact the delivery of medical care by intervening during trauma evaluations and treatment.[49] Trauma patients may intentionally minimize symptoms and withhold accurate information out of fear that healthcare workers would share that information with police.[50] Hospital staff are less likely to be considered independent of police influence, undermining public trust in the emergency department as a safe place to seek care.

Central State Hospital

The Department of Behavioral Health and Developmental Services (DBHDS) located a bed for Mr. Otieno at Central State Hospital. Seven deputies from the Henrico County Sheriff's Office carried Mr. Otieno, with his hands and feet in restraints, into the admissions suite and placed him on the floor. During the removal of restraints, deputies, as well as hospital staff, physically restrained Mr. Otieno while he was seated. Additional hospital staff were in the admissions suite, watching the proceedings and interacting with the deputies.

Eventually, Henrico County Sheriff's Office deputies, as well as Central State Hospital staff, restrained Mr. Otieno in a prone, face-down position. During this restraint, a physician ordered medications to reduce agitation. After twelve minutes, the deputies and hospital staff removed themselves from Mr. Otieno, who was lying unresponsive on the ground. A Central State Hospital nurse then administered the medication to a motionless Mr. Otieno. A minute or so later, hospital staff checked Mr. Otieno's vitals and began performing CPR.

When an incarcerated individual is placed under a TDO, a law enforcement agency is named in the order, their sole charge being to provide transportation to the treatment facility and maintain custody during transportation.[51] According to Henrico County Sheriff's Office policy, deputies are not to interfere with hospital staff during treatment, are to follow instructions from hospital staff regarding room environment for the person's care and recovery, and are to address offender behavioral issues in accordance with facility rules and regulations.[52] This policy makes it clear that hospital staff, *not the Henrico County Sheriff's Office,* must oversee an inmate and their care.

Despite this, Henrico County's Sheriff's Office continually interfered with Mr. Otieno's admission and treatment process and initiated all the physical restraints of Mr. Otieno, including the one that resulted in his death.[53] The blatant and willful disregard of their own policies puts the public at greater risk of harm.

Central State Hospital was responsible, per the TDO, to provide Mr. Otieno with mental health treatment to stabilize his psychiatric condition.[54] Instead, they ill-advisedly allowed outside law enforcement to intervene, whose civic duty is not patient care but public safety. Allowing law enforcement to take charge of a hospital admission confuses the transfer of custody. In this case, the consequences were deadly.

The Use of Prone Restraint

Mr. Otieno's autopsy confirmed that his death was caused by "positional and mechanical asphyxia with restraints."[47]

The dangers of prone restraint have been well-documented for decades.[55] Restraining someone in a face down position for an extended period of time disrupts the flow of oxygen, increasing the risk of losing consciousness and potentially cardiac arrest.[56,57] Due to the high risk of injury and death, many Virginia agencies ban the use of prone restraint, such as public schools, private schools, assisted living facilities, and all licensed mental health providers.[58,59,60,61]

Law enforcement has been aware of the risks of prone restraint since the 1990s and cautioned against its use for decades.[62] The International Association of Chiefs of Police

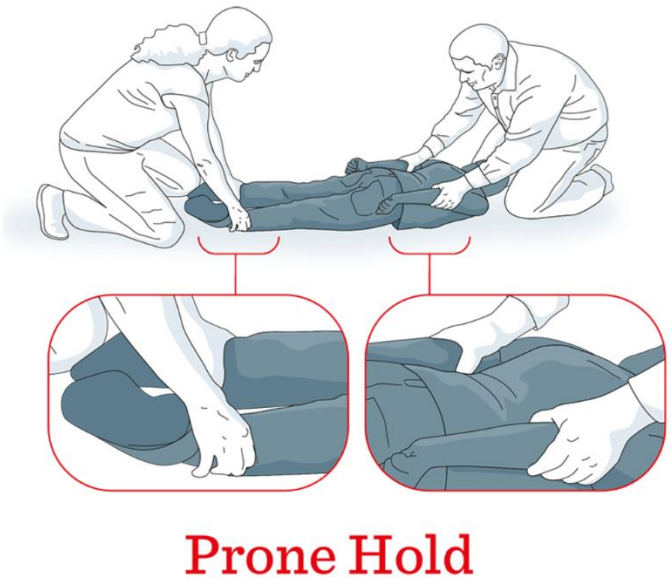


Image credit: Alberto Cairo/ProPublica

acknowledged the fatal risks of prone restraint and cautioned against its use.[63] Legal scholars and law enforcement agencies continually emphasize the risk of prone restraint, with the U.S. Department of Justice entering into agreements with police agencies specifically recommending the use alternative methods of restraint that do not compromise a person's breathing.[64]

Despite decades of awareness and education on the risks of prone restraint, law enforcement still frequently use this risky practice. From 2012 to 2021, more than 1,000 people died after police used physical force or other "non-lethal" means; 740 of those deaths involved the use of prone restraint.[65]

Henrico County Sheriff's Office policies do not specifically regulate the use of prone restraint. Deputies have complete discretion as to when and for how long they use prone restraint. This unfettered discretion led to seven deputies piling on Mr. Otieno, who was lying face down in arm and leg restraints, for twelve minutes.

When law enforcement placed Mr. Otieno in a prone restraint, Central State Hospital staff joined in that restraint, even though restraining someone face down violates the Human Rights Regulations. Unfortunately, this was not just a violation of his human rights, but an action that, tragically and avoidably, ended Mr. Otieno's life.

Human Rights Regulations

Central State Hospital, as a DBHDS-operated facility, is required to follow the Human Rights Regulations, detailed in 12VAC35-115-10 et seq. The Regulations detail very specific standards for the use of restraint, such as:

- Providers shall not use seclusion or restraint for any behavioral, medical, or protective purpose unless other less restrictive techniques have been considered
- Providers shall ensure that only staff who have been trained in the proper and safe use of seclusion, restraint, and time out techniques may initiate, monitor, and discontinue their use
- Providers shall not use a restraint that places the individual's body in a prone (face down) position[66]

Recommendations & Conclusion

The entire system failed Mr. Otieno, contributing to his tragic death. To prevent such tragedies from occurring in the future, dLCV recommends the following to address the multiple system failures illuminated by Mr. Otieno's death.

Prevent the Criminalization and Unnecessary Incarceration of People with Disabilities

- Create and expand intervention programs, such co-responder teams, crisis intervention teams, and mobile crisis teams, led by clinicians and social workers trained to stabilize individuals in crisis
- Create and expand prevention programs and crisis stabilization units designed to prevent or deescalate behavioral health crises
- End the practice of arresting and prosecuting an individual for assaulting a law enforcement officer if that individual is currently in a mental health crisis
- Revise Virginia law to ensure that individuals under a TDO are not diverted from treatment due to incarceration, instead always being sent to an appropriate care provider

Implement Adequate Health and Behavioral Health Standards in Jails

- Officially implement the Minimum Standards for Behavioral Health Services in Local Correctional Facilities as drafted by the 2019 HB 1942 advisory group[67]
- Strengthen jail healthcare standards including: adequate healthcare staffing, access to medications, timely hospital transfer and continuity of care, and improved screening
- Create a strict standard for the use of mechanical restraints in jails to reflect clinical best practices and restrictions
- Ensure that individuals receive timely access to medical and mental health appointments, including the immediate ability to request medical and psychiatric services
- Create a local and regional jail ombudsman to handle complaints by inmates, staff, and the public
- Amend the Virginia Code to explicitly state that the Board of Local and Regional Jails has the authority to sanction facilities that fail to meet minimum standards or engage in egregious conduct

Protect the Rights of Patients in Hospital Settings to Ensure Necessary Care

- Revise Virginia law to ensure that medical providers are able to use their discretion to protect patients and their rights even in the presence of law enforcement

- Organize local hospital and law enforcement partnerships to workshop protocols and guidelines to reduce custody confusion, ensure patient care, and maintain public safety
- Have the Virginia Department of Health create and dispense a toolkit to guide hospitals in developing clear policies for interaction with law enforcement centered on patient privacy and care
- Create a standard that ensures patients experiencing a mental health crisis in the Emergency Department are triaged and provided stabilizing treatment within a prompt timeframe

Strengthen Police Oversight and Regulate the Use of Prone Restraint

- Revise Virginia law to ban the use of dangerous restraint techniques that have contributed to the deaths of people in custody, including prone restraint
- Establish a statewide use of force standard for law enforcement with penalties such as discipline and decertification, ensuring that law enforcement only authorize the minimal amount of force necessary to accomplish a lawful objective and only after exhausting alternatives to use-of-force
- Create a legislative standard for lethal force that explicitly prohibits deadly force against a person who only poses a risk to themselves or property and that incorporates express de-escalation requirements
- Expand Virginia's data collection of use-of-force by police to include disability as a demographic factor
- Task the Attorney General's office to prioritize public complaints of police misconduct during the ECO/TDO process

Mr. Otieno was in the middle of a mental health crisis. He needed treatment and care to stabilize his condition and rejoin his community. Instead, law enforcement and providers created road blocks to recovery every step of the way, from the officers who arrested him and prevented him from getting the care he needed, to the jail failing to treat him and physically assaulting him, to his death at the Central State Hospital Admissions unit.

Irvo Otieno deserved better. This tragedy shows how fragile and precarious it is to be a person with a mental illness in the state of Virginia. This will happen again and keep happening until Virginia makes meaningful changes and those in power prioritize human dignity over control.

Appendix

1 Balfour, M. *Cops, Clinicians or Both? Collaborative Approaches to Responding to Behavioral Health Emergencies*. October 2021. Psychiatric Services, Vol 73 (6). https://doi.org/10.1176/appi.ps.2020007

2 Pew Research. *Adults with Mental Illness are Overrepresented in the Probation Population*. January 2024. https://www.pewtrusts.org/-/media/assets/2024/01/adults_with_mental_illness_are_overrepresented_in_probation_population_report_final_jan10-2024.pdf

3 Fisher WH, Roy-Bujnowski KM, Grudzinskas AJ Jr, et al. *Patterns and prevalence of arrest in a statewide cohort of mental health care consumers*. November 2006. Psychiatric Services, Vol 57 (11). https://doi.org/10.1176/ps.2006.57.11.1623

4 Morrissey JP., Cuddeback G., Meyer P. *Extending assertive community treatment to criminal justice settings: origins, current evidence and future directions*. October 2007. Community Mental Health Journal, Vol 43 (5). doi: 10.1007/s10597-007-9092-9

5 Lowery, W., Kindy, K., Alexander, K., et al. *Distraught People, Deadly Results*. June 2015. Washington Post. https://www.washingtonpost.com/sf/investigative/2015/06/30/distraught-people-deadly-results/

6 Perry, D. M., & Carter-Long, Lawrence. *The Ruderman White Paper on Media Coverage of Law Enforcement Use of Force and Disability: A Media Study (2013–2015) and Overview*. March 2016. Ruderman Family Foundation. https://rudermanfoundation.org/wp-content/uploads/2017/08/MediaStudy-PoliceDisability_final-final.pdf

7 Korhonen, V. People shot to death by U.S. police, by race 2024. Statista. https://www.statista.com/statistics/585152/people-shot-to-death-by-us-police-by-race/

8 Sinyangwe S., McKesson D., Elzie J. *Mapping Police Violence Database*. https://mappingpoliceviolence.org/

9 Vallas, R. *Disabled Behind Bars: The Mass Incarceration of People with Disabilities in America's Jails and Prisons*. July 2016. The Center for American Progress. https://cdn.americanprogress.org/wp-content/uploads/2016/07/15103130/CriminalJusticeDisability-report.pdf

10 Compton, M. T., Graves, J., Zern, A., et al. *Characterizing Arrests and Charges Among Individuals with Serious Mental Illnesses in Public-Sector Treatment Settings*. April 2022. Psychiatric Services, Volume 73 (10). doi: 10.1176/appi.ps.202000581

11 Masters, K. *One in 10 Virginians charged with police assaults have a history of mental illness*. June 2022. Virginia Mercury. https://virginiamercury.com/2022/06/

14/one-in-10-virginians-charged-with-police-assaults-have-a-history-of-mental-illness/

12 Sreenivasan, S., DiCiro, M., Rokop, J., & Weinberger, L. E. (2022). *Addressing Systemic Bias in Violence Risk Assessment.* The journal of the American Academy of Psychiatry and the Law, 50(4), 626–635. https://doi.org/10.29158/JAAPL.220031-21

13 Edwards, F., Lee, H., & Esposito, M. (2019). *Risk of being killed by police use of force in the United States by age, race-ethnicity, and sex.* Proceedings of the National Academy of Sciences of the United States of America, 116(34), 16793–16798. https://doi.org/10.1073/pnas.1821204116

14 *Criminal justice fact sheet.* NAACP. (2022, November 4). https://naacp.org/resources/criminal-justice-fact-sheet

15 McCauley E. J. (2017). *The Cumulative Probability of Arrest by Age 28 Years in the United States by Disability Status, Race/Ethnicity, and Gender.* American journal of public health, 107(12), 1977–1981. https://doi.org/10.2105/AJPH.2017.304095

16 Virginia Compensation Board. *Mental Illness in Jails Report*. 2023. https://www.scb.virginia.gov/docs/2023mentalhealthreport.pdf

17 Joint Legislative Audit and Review Commission. *Virginia's State Psychiatric Hospitals*. December 2023. https://jlarc.virginia.gov/pdfs/reports/Rpt584-4.pdf

18 Bergazzi, M. *What happened to Irvo Otieno? Full security video shows final moments*. March 2023. WTVR. https://www.wtvr.com/news/local-news/irvo-otieno-security-video-released-march-21-2023

19 Frueh B.C., Knapp R.G., Cusack K.J., et al. *Patients' reports of traumatic or harmful experiences within the psychiatric setting*. September 2005. Psychiatric Services, Vol 56 (9). https://doi.org/10.1176/appi.ps.56.9.1123.

20 Wong AH, Ray JM, Rosenberg A, et al. *Experiences of individuals who were physically restrained in the emergency department*. January 2020. Journal of the American Medical Association, Vol 3 (1). https://doi.org/10.1001/jamanetworkopen.2019.19381.

21 Kerr, A., Morabito, M., & Watson, A. *Police Encounters, Mental Illness and Injury: An Exploratory Investigation*. January 2010. Journal of Police Crisis Negotiations, Vol 10 (1-2). https://doi.org/10.1080/15332581003757198

22 Powell, L. *Investigation Faults Parham Doctors Hospital for Otieno care*. December 2023. Richmond Times Dispatch. https://richmond.com/news/local/crime-courts/irvo-otieno-crisis-parham-hospital/article_7cd4a898-9eb1-11ee-90e7-63f5424affea.html

23 Center for Medicare & Medicaid Services. *Emergency Medical Treatment & Labor Act*. Retrieved July 16, 2024. https://www.cms.gov/medicare/regulations-

guidance/legislation/emergency-medical-treatment-labor-act

24 HCA Healthcare. *Policy: EMTALA – Definitions and General Requirements*. September 2019. https://hcahealthcare.com/util/forms/ethics/policies/legal/llem001-a.pdf

25 Stefan, S. *Hospital Psychiatric Inpatient Units Refusal to Accept Psychiatric Patients from Emergency Departments: EMTALA Violation or Not?*. January 2008. Center for Public Representation. https://www.tascnow.com/wp-content/uploads/2019/03/Hospital_Psychiatric_Inpatient_Units_Refusal_to_Accept_Psychiatric_Patients_for_Emergency_Dept_CPR_FINAL1-18-08.pdf

26 American College of Emergency Physicians. *The Impact of Boarding Psychiatric Patients on the Emergency Department: Scope, Impact and Proposed Solutions*. October 2019. https://www.acep.org/siteassets/new-pdfs/information-and-resource-papers/the-impact-of-psychiatric-boarders-on-the-emergency-department.pdf

27 Jones-Sanborn, B. *As emergency rooms fail in treating mental health, systems create new plans, centers*. April 2016. Healthcare Finance. https://www.healthcarefinancenews.com/news/emergency-rooms-fail-treating-mental-health-health-systems-create-new-treatment-plans

28 Caterine, JW. *More patients in crisis falling through cracks of state psychiatric commitment system.* June 2023. Virginia Mercury. https://virginiamercury.com/2023/06/26/more-patients-in-crisis-falling-through-cracks-of-state-psychiatric-commitment-system/

29 Pinals, D. *The Vital Role of a Full Continuum of Psychiatric Care Beyond Beds*. April 2020. Psychiatric Services, Vol 71 (7). https://ps.psychiatryonline.org/doi/10.1176/appi.ps.201900516

30 Robertson, C. *New Video Shows Virginia Officers Overpowering and Punching Irvo Otieno in Jail Cell*. March 2023. The New York Times. https://www.nytimes.com/2023/03/23/us/irvo-otieno-videos-virginia.html

31 United States Department of Justice. *Federal Performance-Based Detention Standards Handbook*. February 2011. https://www.justice.gov/archive/ofdt/fpbds02232011.pdf

32 National Commission on Correctional Health Care. *Correctional Mental Health Care, Standards and Guidelines for Delivering Services (ed 2).* 2003. Chicago: National Commission on Correctional Health Care.

33 Champion, M. K. *Commentary: Seclusion and Restraint in Corrections—A Time for Change*. December 2007. Journal of the American Academy of Psychiatry and the Law, Vol. 35 (4). https://doi.org/10.29158/JAAPL.220082-22

34 Safety Restraint Chair INC. *SureGuard Correctional Chair: Instructions*. Retrieved July 16, 2024. https://restraintchair.com/pdfs/SureGuard-Instructions.pdf

35 Mohr, W. K., Petti, T. A., & Mohr, B. D. *Adverse Effects Associated with*

Physical Restraint. June 2003. The Canadian Journal of Psychiatry, 48 (5). https://doi.org/10.1177/070674370304800509

36 Alang, S., McAlpine, D., McCreedy, E., & Hardeman, R. *Police brutality and Black health: Setting the agenda for public health scholars*. April 2017. American Journal of Public Health, Vol 107 (5). https://doi.org/10.2105/AJPH.2017.303691

37 Office of the Sheriff, Henrico County. *Section: Search and Seizure, Subject: Use of Restraints*. May 2021.

38 Alpert, G.P. & Dunham, R.G. Analysis of police use of force data. July 2000. National Institute of Justice. https://www.ojp.gov/pdffiles1/nij/grants/183648.pdf

39 Henry, P., Senese, J. D., & Smith-Ingley, G. Use of Force in America's Prisons: An Overview of Current Research. July 1994. Corrections Today, Vol 56 (4). https://www.ojp.gov/ncjrs/virtual-library/abstracts/use-force-americas-prisons-overview-current-research

40 Hauck, G. Illinois Answers Project. *The U.N. calls restraint chairs torture; Illinois jails use them every day*. July 2024. Capital News Illinois. https://capitolnewsillinois.com/news/the-un-calls-restraint-chairs-torture-illinois-jails-use-them-every-day

41 Virginia Administrative Code. 6VAC15-40-360. *Twenty-four-hour emergency medical and mental health care*.

42 Virginia Code. § 53.1-68. *Minimum standards for local correctional facilities and lock-ups; health inspections, behavioral health services inspections, and personnel*.

43 Virginia Administrative Code. 6VAC15. *State Board of Local and Regional Jails*

44 Jouvenal, J., Vozzella, L., Heim, J., & Rizzo, S. *Irvo Otieno's last days: How a mental health system 'completely failed*. March 25, 2023. The Washington Post. https://www.washingtonpost.com/dc-md-va/2023/03/25/irvo-otieno-mental-health-system-failures/

45 Henrico County Police Department. *Policy: Mentally Ill Persons*. 2018. https://henrico.gov/assets/LP-28-18.pdf

46 Virginia Department of Health and Human Services. *Statement of Deficiencies and Plan of Correction: Henrico Doctors' Hospital; 1602 Skipwith Road, Richmond VA 23229*. Survey completed April 3, 2023. Retrieved July 16, 2024. https://bloximages.newyork1.vip.townnews.com/richmond.com/content/tncms/assets/v3/editorial/5/18/51849d12-aa7b-11ee-a98b-7f11bc3ac0f7/6595cb71ee9fb.pdf.pdf

47 HCA Healthcare. *Policy Description: Use of Force*. April 2021. https://hcahealthcare.com/util/forms/ethics/policies/information-protection/IPPS009-a.pdf

48 HCA Healthcare. *Code of Conduct*. 2020. https://hcahealthcare.com/util/forms/ethics/2020-Code-of-Conduct-a.pdf

49 Harada, M., Lara-Millan, A., & Chalwell, L. *Policed Patients: How the Presence of Law Enforcement in the Emergency Department Impacts Medical Care*. December 2021. The Practice of Emergency Medicine, Vol 78 (6). https://doi.org/10.1016/j.annemergmed.2021.04.039

50 Liebschutz J, Schwartz S, Hoyte J, et al. *A chasm between injury and care: experiences of black male victims of violence*. December 2010. Journal of Trauma and Acute Care Surgery. Vol 69 (6). https://doi.org/10.1097/TA.0b013e3181e74fcf

51 Virginia Code. § 37.2-810. *Transportation of person in the temporary detention process*.

52 Office of the Sheriff, County of Henrico. *Section: Transportation; Subject: Hospital Security Policy*. May 2021.

53 Rankin, S. *Autopsy finds cause of death for Irvo Otieno was asphyxia*. Associated Press. April 2023. https://apnews.com/article/irvo-otieno-death-autopsy-asphyxia-d7175e541e76b24cc5ff1eff759c4706

54 Virginia Code. § 37.2-809. *Involuntary temporary detention; issuance and execution of order*.

55 Steinberg, A. *Prone restraint cardiac arrest: A comprehensive review of the scientific literature and an explanation of the physiology*. February 2021. Medicine, Science, & The Law; Vol 0 (0). https://doi.org/10.1177/0025802420988 3

56 Helander, M., & McNeil Brown, A. *The Public Health Crisis of Law Enforcement's Over-Use of Force*. July 2020. Lerner Center for Public Health Promotion. https://surface.syr.edu/cgi/viewcontent.cgi?article=1023&context=lerner

57 Disability Rights California. *The Lethal Hazard of Prone Restraint: Positional Asphyxiation*. April 2002. https://www.disabilityrightsca.org/system/files?file=file-attachments/701801.pdf

58 Virginia Administrative Code. 8VAC20-750-30. *Prohibited actions*.

59 Virginia Administrative Code. 8VAC20-671-650. *Prohibitions*.

60 Virginia Administrative Code. 22VAC40-73-710. *Restraints*.

61 Virginia Administrative Code. 12VAC35-115-110. *Use of seclusion, restraint, and time out*.

62 U.S. Department of Justice, Nat'l Law Enforcement Tech. Ctr. *Bulletin: Positional Asphyxia—Sudden Death*. June 1995. https://www.ncjrs.gov/pdffiles/posasph.pdf

63 National Police Accountability Project. *State Police Use of Force Legislation and Public Safety*. June 2022. https://www.nlg-npap.org/wp-content/uploads/2021/12/Use-of-Force-White-Paper-FINAL.pdf

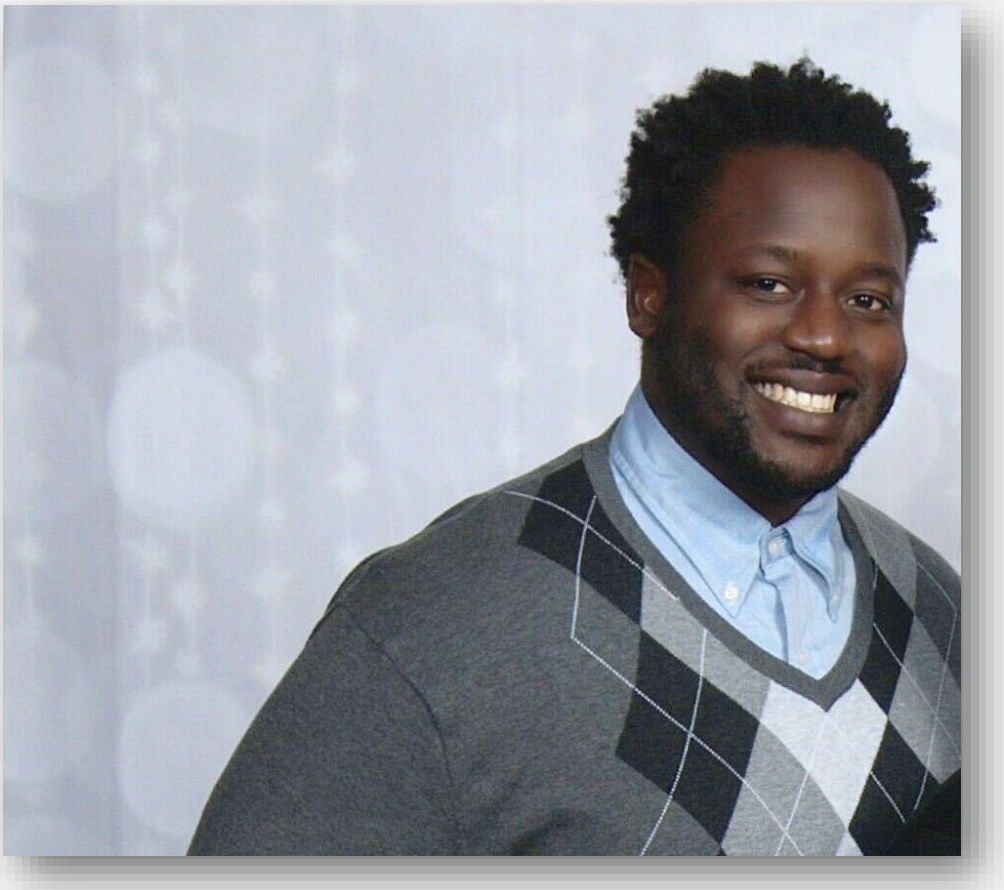
64 Brief of Policing Scholars as Amici Curiae Supporting Petitioners, Lombardo, et al., v. City of St. Louis, et al. 38 F.4th 684 (2022) (no. 20-391). https://www.supremecourt.gov/DocketPDF/20/20-391/158828/20201026155943826_2

020.10.26%20Policing%20Scholars%20Amicus%20Brief.pdf

65 The Associated Press. *Lethal Restraint: An investigation documenting police use of force*. May 2024. https://apnews.com/projects/investigation-police-use-of-force/

66 Virginia Administrative Code. 12VAC35-115-110. *Use of seclusion, restraint, and time out*.

67 Board of Corrections. Minimum Standards for Behavioral Health Services in Local Correctional Facilities (HB 1942). November 2019. https://rga.lis.virginia.gov/Published/2020/RD137/PDF



We dedicate this report to Irvo Otieno and his family. May we honor your memory by fighting for a world where people with mental illness and people of color are safe, cared for, and respected.

> *“If there was anything I could have did, I would have did it. Rest in peace to all our loved ones – may they never be forgotten.”*
>
> - *God’s Grace* (2023), Young Vo (Irvo Otieno)