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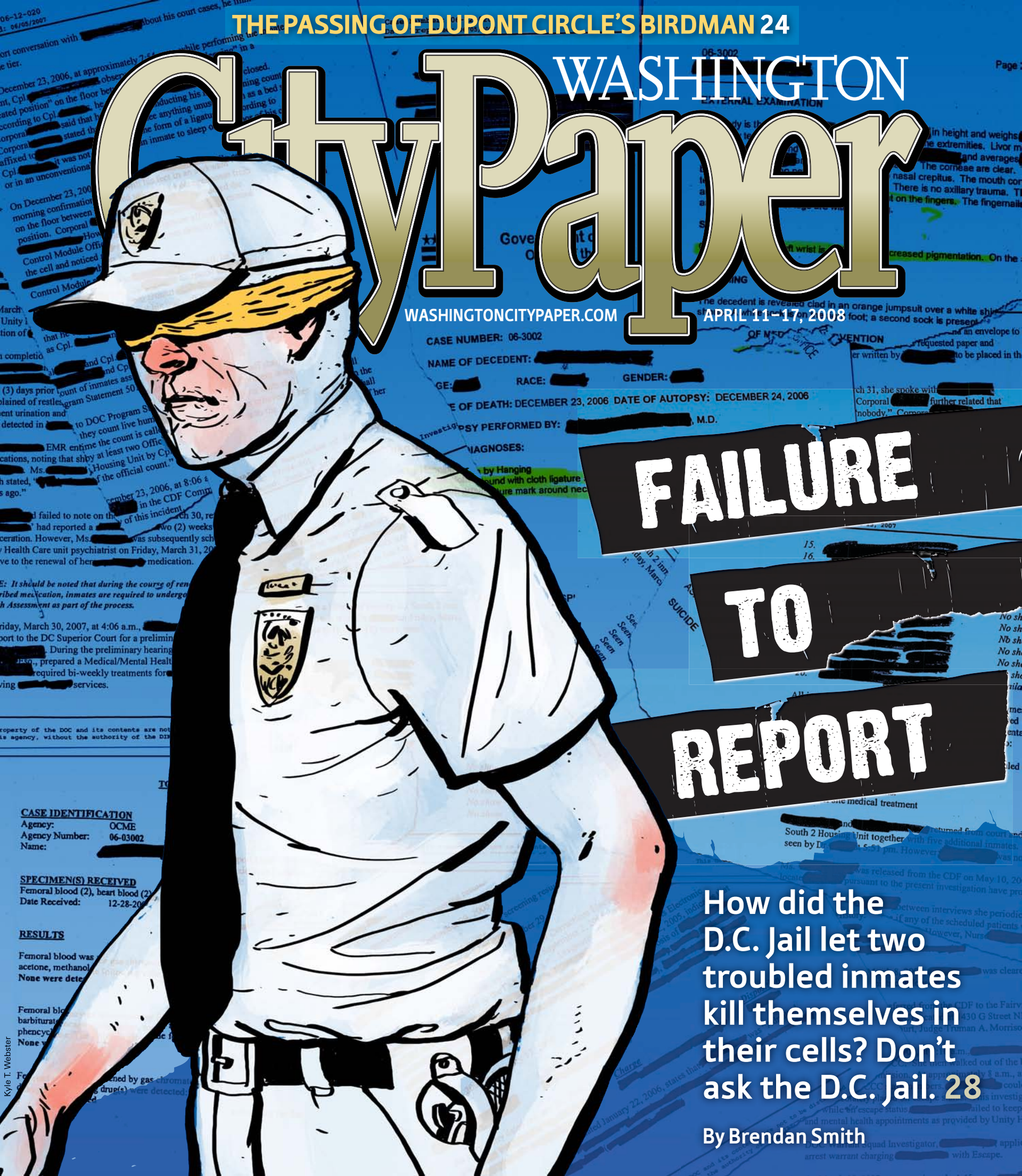

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Failure to Report

How did the D.C. Jail let two troubled inmates kill themselves in their cells? Don't ask the D.C. Jail

By Brendan Smith
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No one noticed when Thomas Alemayehu killed himself in Cell 43 of the D.C. Jail by twisting a torn piece of a bed sheet around his neck and tying it to the top bunk.

By the time someone checked on him, his body already was cold and stiffening; rigor mortis doesn't occur until approximately two hours after death.

Alemayehu, a 28-year-old Ethiopian cab driver with a history of mental illness, died two days before Christmas in 2006, but he might have survived if corrections officers had done their job. Two corporals claim they completed mandatory inmate counts every 30 minutes, but surveillance cameras show no one had set foot on the cell block tier for more than two hours, according to a recently released internal-affairs investigation by the D.C. Department of Corrections.

"There is a strong possibility that Mr. Alemayehu was hanging in a position between his bunk and toilet during the times that security checks and official counts were supposed to have been conducted," the DOC report states.

During his initial health screening at the jail four days before his suicide, Alemayehu told medical staff he had tried to kill himself before, which should have triggered a mental-health assessment by a psychiatrist from jail medical-services contractor Unity Health Care.

However, Alemayehu never received the mental-health assessment, and he wasn't placed on suicide watch. Instead, he was forgotten and died alone in a single cell. The internal-affairs investigation found that Unity Health Care's policy for referring inmates for mental-health assessments was "considered nonexistent."

Unity had never worked in a jail before winning a three-year contract in 2006 from the DOC, which didn't seek any other bidders. Under the $83 million contract, Unity provides medical services for inmates and ongoing treatment for former inmates at its local network of community health clinics.

Three months after Alemayehu's suicide, Alicia Edwards, 32, also hanged herself with a bed sheet in a single cell. During her health screening two days earlier, she told Unity medical staff she had attempted suicide before. She said

she needed a prescribed psychotropic medication for bipolar disorder to stop the dangerous swings from major depression to mania that haunted her mind.

Like Alemayehu, Edwards never received a mental-health assessment, and she wasn't placed on suicide watch. She also didn't get the medication that could have prevented a relapse of her mental illness.

On March 31, 2007, after cutting her body down from the makeshift noose, corrections officers found a piece of paper lying near Edwards' body. It was a medical request form. Edwards was asking again for the medication she needed, the internal-affairs report states.

Alemayehu and Edwards weren't hardened criminals. They faced relatively minor charges when they killed themselves. Their suicides exposed major problems with the diagnosis, treatment, and supervision of mentally ill inmates in the D.C. Jail, which holds, on average, more than 3,200 inmates per day.

The Department of Corrections, headed by Director Devon Brown, fought for 10 months to prevent the release of its internal-affairs reports on the suicides. The reports were recently released after several appeals to Mayor Adrian Fenty's office through the D.C. Freedom of Information Act.

Brown has good reason to want to keep the reports secret. The investigations reveal widespread misconduct by corrections officers and medical staff from Unity Health Care that directly contributed to the deaths of Edwards and Alemayehu. Fenty's office allowed the redactions of the names of all of the employees from the reports, although some names slipped past the black pens of the censors.

In the aftermath of the suicides, several corrections officers and a doctor and nurse from Unity all provided false statements to investigators in attempts to cover up their wrongdoing, the internal-affairs investigation found.

The morass of failures that contributed to the suicides also spread outside the jail to include staff at the D.C. Department of Mental Health and D.C. Superior Court, according to the internal-affairs investigation.

Costly Mistakes

The D.C. government ultimately could be on the hook for millions in damages in a pending wrongful-death lawsuit from Edwards' mother. Attorney Stephen Gensemer won't reveal the exact amount in damages that will be sought in the suit.

"We're just trying to get to the bottom of what happened," Gensemer says. "Ms. Edwards wants to find out what happened to her daughter."

Jail officials started covering up the details about Edwards' suicide from the very beginning. On the day of Edwards' death last year, DOC spokeswoman Beverly Young issued a press release that claims Edwards had been housed in the jail's Mental Health Unit because of her history of mental illness. The press

release also says clinical staff was assigned to the unit around the clock, and inspections of the unit "were conducted according to procedures."

The *Washington Post* and the *Examiner* published inaccurate accounts of Edwards' suicide based on the press release, which wasn't true. Edwards was never in the Mental Health Unit, and she wasn't under increased

observation. Like Alemayehu, she died alone in a single cell in housing units used for the general population of inmates.

Edwards, who also was suffering stomach cramps, body aches, and other symptoms from heroin withdrawal, was scheduled for a mental-health assessment on March 30, but the Unity Health Care psychiatrist left the jail after seeing only eight of the 26 inmates scheduled for appointments that day, the internal-affairs report states.

Edwards was one of the inmates left behind, and she couldn't get the medication she needed without first seeing the psychiatrist. She had faced misdemeanor charges for shoplifting and skipping court hearings, along with a felony escape charge for absconding from a halfway house three weeks before her suicide.

In the hours before Edwards' suicide, a corporal spoke several times with her through the door of Cell 32. She seemed despondent and was scratching her wrist with a pen, so the corporal confiscated the pen and told a lieutenant and a Unity nurse that Edwards needed help, the internal-affairs report states.

More than 30 minutes passed, but the nurse still hadn't checked on Edwards when an officer found her body at 2:46 p.m. Officers cut her down, but it took seven minutes before anyone started performing CPR. A doctor and nurse from Unity gave up on resuscitation efforts a short time later, the internal-affairs investigation found.

Then the lies started piling up.

A doctor and a nurse from Unity lied about resuscitation efforts, with the doctor claiming they performed CPR for an additional 25 minutes after overhearing radio transmissions that an ambulance crew was turned away, the internal-affairs report states. The investigation found the doctor already had declared Edwards dead, so a captain told the ambulance crew they weren't needed. The crew already had responded to the jail, but they never reached Cell 32.

A corporal also lied to investigators about escorting the ambulance crew, the internal-affairs report states. At the time of Edwards' death, the corporal wasn't even in the jail because she had tacked an extra hour onto her 40-minute lunch break.

Neither Edwards' mother, Patsy, nor any other family members could be reached for comment about Edwards' life or her death in the jail.

Vincent Keane, Unity's president and CEO, says the Unity doctor didn't turn the ambulance crew away because the doctor "has no control over that." Despite Unity's lack of prior experience working in a jail, its medical staff has always provided quality health care to D.C. inmates, he says.

"The environment is definitely a different environment," he says. "I think soldiers are prepared to go to war. It's a different thing when they go to war."

Keane says there has been "an incredibly fast learning curve" for medical staff at the jail and there is "tremendous accountability" under Unity's contract with the DOC.

"A suicide-free environment is absolutely essential to us," he says.

A Life Derailed

Alemayehu lived up to his name, which means “I Saw the World” in Amharic. He traveled thousands of miles from his home in Addis Ababa, Ethiopia, to the United States and eventually settled in D.C. because of its large Ethiopian community and family living in the area.

Alemayehu got a green card, rented a cab, and saved enough money to buy a dilapidated row house for $115,000 on Holbrook Street in Northeast. But the problems with his new home triggered a downward spiral that ultimately would end with his suicide.

While Alemayehu was on a trip to Ethiopia, a contractor left the rear door unsecured at the row house, which Alemayehu was renovating as four apartments. The mistake was a costly one. Looters stripped the house down to the walls and floors, even ripping the sinks and toilets from their fixtures.

When Alemayehu returned home, he found his house empty and flooded with more than a foot of water, says Wondwosan Temesgen, Alemayehu’s cousin and a D.C. cab driver as well. “People came in and took everything,” Temesgen says. “After he lost the house, he just disappeared.”

The bank foreclosed on the house in 2005. When Alemayehu resurfaced months later, he was a different man. He always wore the same dirty clothes and refused to eat anything except rice, spinach, and bread. When he visited Temesgen’s home for a meal, he would spit food out onto his plate, Temesgen says.

Alemayehu, who was single and had no children, sometimes cried in incoherent phone calls to Temesgen and then would disappear for weeks at a time. He would sit catatonic in Temesgen’s home before sudden, angry outbursts. After slamming his fist into the coffee table or smashing a phone on the floor, he would apologize and act as if he didn’t know what had just happened, Temesgen says.

“When you see him, you know he’s not good. He’s sick,” Temesgen says.

When he was arrested four days before his suicide, Alemayehu weighed only 140 pounds. In the dead of winter, he was wearing a pair of sandals, Lee dungarees, a navy shirt, and a purple-and-white Columbia jacket stained brown from dirt.

Assefa Feleke, one of Alemayehu’s few friends, says Alemayehu spoke often about the futility of his life.

“I said, ‘Come on. You’re young.You have your whole life ahead of you,’” says Feleke, a fellow Ethiopian immigrant who owns a tow-truck company in Southeast D.C. “I tried so hard to make him go home [to Ethiopia]. I pushed him so hard he didn’t want to talk to me for awhile.”

Both Feleke and Temesgen say Alemayehu never told them he had tried to kill himself before, and they didn’t know he was in jail until after his suicide. Feleke says he tried to help his friend, but Alemayehu wouldn’t listen.

“It was like hitting a brick wall,” he says. “I talk, he listens, but no response.”

Going to Jail

On Dec. 19, 2006, Alemayehu was arrested for skipping a court hearing on a charge of driving his cab with a suspended driver’s license. He couldn’t afford the $1,000 bond, so he stayed in jail.

Two days later, he received a mental competency screening from Robert Benedetti, a psychologist from the D.C. Department of Mental Health. The screening, which is separate from mental-health assessments done at the jail, helps determine whether a defendant is competent to stand trial.

Even though Alemayehu's friends and family say his mental illness was obvious, Benedetti didn't notice anything was wrong. After a 50-minute interview, his two-page report states that Alemayehu showed no signs of "suicidal/homicidal ideation or intent" or any evidence of mental illness. Benedetti also found Alemayehu was mentally competent to plead guilty or stand trial, and he "seemed to have the capacity to make reasoned choices regarding plea options," the report states.

That analysis was contradicted the very next day when a plea hearing broke down because of Alemayehu's bizarre behavior in court. Alemayehu only had to plead guilty to a couple minor traffic charges, and he would have been released on probation under the terms of a plea deal. Instead, he launched into a rambling, incoherent speech to Magistrate Judge Ronald Goodbread.

"I'm pleading guilty for something I'm aware of," Alemayehu said, according to a transcript of the hearing. "So, I'm still guilty, but I'm not going to be guilty for something that is discussed now, if it's not inside what I plead guilty before."

Alemayehu's court-appointed attorney immediately requested an outpatient mental examination and Alemayehu's release from jail, but Goodbread wasn't ready to spring him from jail because of his history of skipping court hearings.

"If he just wants to wander the streets waiting to remember to go back in for treatment, I can't do that," Goodbread said before sending Alemayehu back to jail.

Goodbread ordered that a full mental exam be conducted within 45 days by the Mental Health Department, but neither the department nor the jail received the order. Officials at D.C. Superior Court violated the court's own administrative orders by failing to transmit the mental exam order after Alemayehu's hearing, the internal-affairs report states.

"As a result, DOC had no knowledge and no notice that inmate Alemayehu was considered to be a possible mental health risk by the court," the report states.

D.C. Superior Court spokeswoman Leah Gurowitz said last year that the mental exam order was not transmitted by the court as was required after Alemayehu's hearing. (Even properly handled paperwork may not have saved Alemayehu, who killed himself the next day.) Gurowitz refused to comment about whether any changes have been made at Superior Court over the past year to prevent similar errors with the transmission of court orders from occurring again.

Within 24 hours after his return to jail, Alemayehu was dead. On the morning of Dec. 23, 2006, surveillance camera footage revealed that no one set foot on the tier in the Northwest 3 Housing Unit from 5:46 a.m. until 7:54 a.m., the internal affairs report states. Vernie Young, who is named in the report, and an unnamed corporal also had skipped inmate counts from 2 to 4 that morning.

At 7:54 a.m., Cpl. Cleveland Sanders, a 24-year DOC veteran, conducted an inmate count, but he kept walking down the cell block after seeing Alemayehu slumped over next to the toilet in Cell 43. He didn't stop to see if

Alemayehu was alive, a violation of DOC procedures, the internal-affairs report states.

Neither Sanders nor Young could be reached for comment.

Alemayehu's body wasn't discovered until after an 8 a.m. shift change. There was no point in trying to resuscitate him because he had been dead for approximately two hours. His autopsy report, which found no legal or illegal drugs in his system, notes there was "no evidence of emergency medical intervention."

A Unity Health Care doctor who responded to the cell moved Alemayehu's body to the jail infirmary before D.C. police officers arrived, a violation of crime-scene preservation procedures, the internal-affairs report states.

Temesgen says he doesn't blame the corrections officers because they didn't know Alemaeyhu was suicidal, but he is angry with Goodbread for sending his cousin back to jail when he should have been in the hospital. "That's not right. If he's acting crazy, they've seen it [in court]," Temesgen says.

Temesgen also doesn't understand why Benedetti failed to recognize Alemayehu's mental illness and why Unity medical staff didn't perform a mental-health assessment or place Alemayehu on suicide watch.

"This is not Ethiopia. The government doesn't care about their own people there. If this thing happened in Ethiopia, I'm not surprised," Temesgen says. "But here in America, people care about each other. The government cares about people. That's why I stay here."

Benedetti and Goodbread, who has retired from the bench, couldn't be reached for comment.

Stephen Baron, director of the Department of Mental Health, said last year that he stood behind the accuracy of the mental competency screening for Alemayehu, even though he killed himself two days after receiving a clean bill of mental health from Benedetti.

"I met with the psychologist who did it. He's extremely skilled and competent," Baron said. "I'm not being a Monday morning quarterback."

"Fleas That Come With the Dog"

The Fraternal Order of Police D.C. Lodge No. 1, which represents more than 700 DOC officers and nonuniformed personnel, disputes many of the findings of the internal-affairs reports, says union local vice-chairman John Rosser.

"In each of [the suicides], all of the officers were doing their part. If all you're looking for is someone to blame, we're there," he says. "It's not *Shawshank Redemption*. It's real life."

Rosser says officers' constitutional rights are being violated because DOC Director Devon Brown and the Fenty administration are more likely to side with inmates than officers and are quick to pull the trigger with firings if there is a whiff of scandal.

"The front-line corrections force is up against the management of the city, who have never worn the uniform," he says. "The jail is not a mental-health institution. It's not. The correctional force, whose duty is security, are not the fail-safe for mental-health issues."

Rosser, a corporal with 18 years of service with the DOC, says the jail is understaffed on the graveyard shift, making it difficult for officers to perform all inmate counts. He says Edwards' body was discovered only eight minutes after the last cell check.

Rosser, who says officers need more training and increased staffing levels, says suicides aren't preventable, and officers "are not doctors and psychologists and psychiatrists."

"All jails have suicides, but you don't see firings in other jails because [suicides] are part of the territory, the fleas that come with the dog," he says.

A history of poor health has plagued the D.C. Jail. From 1995 to 2000, a court-appointed receiver oversaw medical care at the jail after the DOC was held in contempt for repeatedly violating court orders to improve medical services.

Lindsay Hayes, an expert on inmate suicide prevention who works for the National Center on Institutions and Alternatives, served as a consultant during the receivership. Hayes says he helped develop new DOC training procedures after nine inmates killed themselves in one year.

"It was an incredible rash of incidents where the officers or medical staff were ill-prepared, ill-equipped, or outright refused to do CPR after the suicide victim was found hanging," he says.

Rosser's complaint that inmate suicides can't be prevented is a common refrain that Hayes hears from corrections officers across the country when he conducts suicide-prevention trainings. "When you have that kind of attitude in your jail system, you have this complacency and denial to take the issue seriously," he says.

Nationwide, the suicide rate in jails is four times higher than for the general public. Most inmates who kill themselves do so within 24 to 72 hours of being incarcerated. "There is a great period of uncertainty when someone enters the jail system, possibly for the first time," Hayes says. "There is the uncertainty of the future, and they don't know if anyone cares about them."

The nationwide jail suicide rate has been falling over the past two decades because of increased awareness and suicide prevention training at some city and county jails. The training doesn't require much additional work by corrections officers, Hayes says.

"Correctional officers are there 24/7. They are the ones who see the inmates the most," he says. "All they are asked to do is be good observers."

DOC officials won't say what the current suicide rate is at the D.C. Jail. At a DOC oversight hearing last October, Brown said 162 corrections officers, from a staff of more than 600, completed suicide prevention training last year. Seventy-seven officers also received additional training to work in the jail's Mental Health Unit. By contrast, the entire corrections force completed sensitivity training.

DOC has fought to conceal the inmate suicide reports not only from the public but also from the D.C. Council. DOC officials initially refused to release the internal-affairs reports to Councilmember Phil Mendelson, even though he chairs the Committee on Public Safety and the Judiciary that oversees the DOC. Mendelson, who eventually received copies of the reports last year, says a lack of public accountability "has been a problem for years" at the DOC.

"I don't like the fact that the department is so closed when it comes to information and reports like this. It doesn't make them look good, and it doesn't help the conversation," he says. "It is my sense there are improvements being made, even though when we ask questions, we don't necessarily get direct answers."

Councilmember David Catania, who chairs the Committee on Health, says he still supports Unity because of the ongoing treatment provided for former inmates at its community health clinics. He says Unity and the DOC improved suicide prevention training after the suicides of Alemayehu and Edwards.

"I'm not going to defend the system as perfect," he says. "I do think it's a work in progress, and we're moving in the right direction. I'm not trying to diminish the tragedies that occurred."

DOC internal-affairs investigators made a long list of recommendations for needed reforms in the suicide reports, but the pages are just long rows of black lines. Fenty's interim general counsel, Andrew "Chip" Richardson III, allowed the redactions of all of the recommendations before releasing the reports, making it impossible to determine if DOC officials have implemented all of the reforms.

Richardson didn't respond to requests for comment.

The Reporters Committee for Freedom of the Press filed a five-page brief in the Freedom of Information Act appeal to force the release of the internal-affairs reports. Executive Director Lucy Dalglish says the D.C. government has a long history of secrecy and concealment of public records, and the situation hasn't improved under Fenty's administration.

"D.C. is certainly in the first tier of city governments where it's difficult to find out what's going on," she says. "Whether that is by intention or by incompetence, sometimes that is hard to tell."

But Dalglish says one thing is per-fectly clear.

"There appears to me to be a bona fide, bone-chilling fear among public officials in the District of Columbia that if they let Congress know how they operate and what's really going on, Congress is going to take the District's independence away," she says.

The Aftermath

Both Fenty and Brown have repeatedly refused to be interviewed about the suicides or any actions that have been taken to prevent more deaths of mentally ill inmates. Fenty also won't say whether he still has confidence in Unity to provide inmate medical services or in Brown to run the DOC.

After recent inquiries by the *Washington City Paper* to Fenty's office, D.C. Interim Attorney General Peter Nickles states for the first time that two corrections officers were fired because of their misconduct in Alemayehu's case.

In Edwards' case, a corrections officer resigned during the internal-affairs investigation, and two others received warning letters. A doctor and nurse from Unity also were banned from working in the jail. Nickles won't identify the employees who were disciplined.

The doctor and nurse who were banned from the jail weren't fired by Unity but were instead transferred to other Unity operations. Keane, Unity's president and CEO, says Unity's own investigation cleared his staff of

wrongdoing, but he refuses to release that report. He says he hadn't seen the DOC internal-affairs reports, which reached the opposite conclusion, finding not only misconduct and deception by Unity's medical staff but also several contract violations by Unity Health Care.

"I think the quality of the care is not what anyone is disputing. I think the quality is good," Keane says. "Does it bother me someone committed suicide? Of course. Do I sleep at night knowing that my providers provide good health care? Yes, I do."

Both Nickles and Keane say training has increased under a new inmate suicide prevention policy, and they say no suicides have occurred in the jail since Edwards' death on March 31, 2007. But both men say they don't know how many inmates have tried to kill themselves over the past year, a figure that DOC officials and Fenty's office also won't reveal.

Despite the misconduct noted in the internal-affairs reports, Nickles says Unity didn't have to pay any fines for the contract violations, and there are no plans to terminate Unity's contract.

"We have no reason to believe they aren't doing a decent job," he says.