Department of Rehabilitation and Correction

Operation Support Center After-Action Review Report

Ariel Castro (A643-371) Self-Inflicted Death

Corrections Reception Center: September 3, 2013

I. Introduction and Background

On Tuesday, September 3, 2013 at 9:18 p.m. Corrections Reception Center (CRC) Officer Caleb Ackley observed inmate Ariel Castro (A643-371) hanging in his cell (#2103) in segregation housing on range Disciplinary Control II during formal institutional count. Staff responders arrived at the scene as well as a MedCare Ambulance EMS. Despite the efforts of responding staff and the paramedics, Castro was pronounced dead at The Ohio State University Wexner Medical Center (OSUMC) at 10:52 p.m. The details of the time frames and other information gathered during the after-action review process will be discussed in the sections that follow.

Consistent with DRC policy and as ordered by Director Mohr, CRC immediately conducted an internal review and then completed its own institutional after-action report on Wednesday, September 11, 2013. Director Mohr also assembled a DRC/OSC after-action review team (the "Team") to review the CRC report and all relevant underlying documents and to prepare the following report of its findings and recommendations. The Team was comprised of:

Ed Banks, Managing Director of Organizational Development (Team Chairperson)
Andrew Albright, Chief of the Bureau of Internal Audits and Standards Compliance
Charles Bradley, Deputy Warden, Ross Correctional Institution
Dr. Kathryn Burns, Bureau of Behavioral Health Services (BOBHS), Chief Psychiatrist
Shawn Carr, Southwest Regional Nurse Administrator
Trevor Clark, Division of Legal Services
Dr. Robyn Hoffman, BOBHS, Southeast Regional Behavioral Health Administrator

II. Areas of Review

After reviewing the CRC after-action report and other relevant evidence, the Team determined that exploration of the topic areas identified below was necessary for a comprehensive review. Each topic area and its relevant facts will be discussed separately so as to concentrate only on those facts relevant to this after-action review. Additionally, any recommendations made by the separate CRC after-action report will be addressed in the area pertaining to that recommendation. The areas of review are:

1. Intake Processes and Special Precautions
2. Facts and Circumstances Potentially Relevant to Self-Inflicted Death
3. Performance of Rounds, Maintaining Logs, Post Orders, Supervisor Reviews
4. Timeliness of Emergency Response
5. Referral to Mental Health Continuous Quality Improvement Process
6. Referral to Medical Continuous Quality Improvement Process
7. Referral for Criminal/Administrative Investigation

III. Items of Review

The documentation, evidence and polices reviewed in the creation of this report are listed in Exhibit A.

IV. Intake Processes and Special Precautions

Relevant Facts: Inmate Castro entered DRC at Lorain Correctional Institution (LorCI) on August 2, 2013 at 6:25 p.m. (See Team Timeline, Exhibit B).[1] Castro receives initial mental health and medical screenings. He is put on a constant mental health watch because of his high notoriety case, not because of any suicidal thoughts, behaviors or other indications such as depression. He was evaluated again by a mental health professional on August 3 and 4, 2013. On August 5, 2013 at 8:43 a.m., he was seen by a mental health professional and watch precautions were discontinued because there were no clinical reasons for same. He was prepared at LorCI for transfer to CRC.

In preparation for Castro's arrival, CRC's Warden, Rhonda Richard, approved two Incident Command Operations Orders dated August 5, 2013 (See Exhibit C). The first Order was specific to the intake process at CRC. The Order contained various tactics for achieving the mission strategies of keeping other inmates from Castro during the intake process, limiting contact to necessary staff and maintaining a supervisory presence through intake and cell assignment. Castro was processed according to policy and recognized as a high priority transfer. He was placed in Security Control, cell alone in cell DCII-2103, pending a Protective Control Investigation. Castro also was to receive initial medical, mental health, substance abuse screening as required by DRC Policy 52-RCP-06 (Reception Intake Medical Screening). CRC medical staff report that the screening was completed on August 5, 2013; however the actual form (DRC Form 5170) could not be located by CRC or the Team. Despite no record of an initial screening, detailed medical and mental health screenings were completed on August 5, 2013, the day of arrival at CRC. Detailed screenings were done as a precaution and not because of any clinical indications. The screenings showed no clinical indications for watch statuses or placement on the mental health caseload. Nevertheless, a comprehensive mental health evaluation was completed in its entirety as a precautionary measure and again, no evidence of serious mental illness or indications for suicide precautions were present. Castro also completed the Segregation Placement Suicide Questionnaire (DRC Form 5404) as required by DRC Policy 55-SPC-02 (Special Management Procedures). He indicated no current suicidal thoughts or past attempts to hurt himself. Castro was not shown the suicide prevention video at LorCI or CRC as is required in the orientation processes set forth in DRC Policy 52-RCP-10 (Inmate Orientation).

The Second Incident Command Operations Order set strategies for Castro to prevent contact with other inmates while incarcerated at CRC, to limit staff contact to those required to address his needs and due process rights and to require supervisor presence at any time he was outside of

[1] Unless otherwise noted, all dates and times referenced in this report are from the Team Timeline prepared by Team members Albright and Bradley.

his cell. Some of the notable tactics included preventing inmates from providing direct service to Castro by specifically excluding them from exchanging things in and out of Castro's cell, securing other inmates in their cells when Castro needed to be moved for any reason and video recording Castro whenever he was moved from his cell.

Conclusions: The Team review by members Albright and Bradley indicates that the Incident Command Operations Orders were complied with by CRC staff (See Exhibit D). Documentation of Castro's initial medical/mental health/substance abuse screening appears to have been lost. Castro's orientation was incomplete in that he was not shown the required suicide video.

Recommendations: CRC should review medical documentation routing procedures to ensure that important medical documentation is placed in the inmate's health record. In this particular circumstance, although the initial intake screening documentation appears to have been lost, it had no effect on later screenings and services because CRC did the follow-up detailed screenings on the same date as the initial screenings.

The Bureau of Behavioral Health Services should review policy language regarding the provision of information to inmates regarding suicide prevention at orientation. Additionally, steps should be taken to remind all staff at reception centers and parent institutions of the importance of ensuring that inmates view the suicide prevention video.

V. Facts and Circumstances Potentially Relevant to Self-Inflicted Death

The Team reviewed several sources of information in an attempt to determine the motivation for the self-inflicted death because Castro left no suicide note and had previously shown no suicidal ideations in multiple levels of assessment. He was found in his cell with a Bible open to John Chapters 2 and 3. Additionally, he had pictures of his family out and arranged in a poster-board fashion. He was hanging from a hinge in the window of his cell by a sheet wrapped around his neck. His pants and underwear were pulled down to his ankles. The relevance of this finding is unclear. These facts, however, were relayed to the Ohio State Highway Patrol for consideration of the possibility of auto-erotic asphyxiation. No other immediate observations about the scene led to conclusions about the motivation for the self-inflicted death.

Team member Hoffman reviewed incoming letters to Castro that were found in his property (not attached) and found no additional information that would lead to conclusions about the motivation for the self-inflicted death. Castro had no telephone records on the inmate phone system to review because he was being housed in a Security Control pending Protective Custody Investigation status. CRC Deputy Warden Heiss reports that to his knowledge no other special calls were arranged for Castro. Castro had visits from family on August 12, 2013 and August 26, 2013. No significant events were reported from these visits.

Team members Banks and Clark reviewed documents found in Castro's cell entitled "Informal Complaints," (not attached) which were never officially submitted to the formal grievance

process. In those documents, Castro generally complains about verbal harassment from other inmates and staff; however, he did not provide any names or detailed facts sufficient for the Team to conduct a further investigation into these allegations. These documents also contain multiple references to Castro's fear that someone was tampering with his food. Team members Banks and Clark interviewed segregation supervisor Lt. Brandi Ackley regarding food delivery procedures for Castro. Lt. Ackley indicated that food was prepared for all of segregation in the food service area of CRC's compound and brought over on carts for all segregation inmates *en masse*. Castro's tray was not specially marked and was randomly selected by the supervisor. The tray was then hand-carried by the supervisor or by an officer in direct supervision by the supervisor to Castro's cell. The delivery of the food was generally monitored by the existing block cameras. There was no opportunity to tamper with Castro's food. According to these documents, Castro's paranoia about his food led him not to eat some of his meals. There were also claims by him that he was flushing his food down the toilet. He also complained that not eating was causing him health problems. These complaints coincide with two visits by medical staff on August 14, 2013 in response to complaints by Castro for chest pains, dizziness, nausea and concerns about his food not properly being prepared. Notably, Castro did receive his evening meal on September 3, 2013 at 5:29 p.m. from a supervisor. Castro then returned his meal at 6:00 p.m. From the review of the procedures established for food delivery, these complaints from Castro appear to be unjustified.

On September 3, 2013, Castro had his hearing regarding Protective Control placement at 1:29 p.m. CRC staff members were interviewed by Team members Banks and Clark as to the content of this hearing because it was not audio recorded.[2] Staff reported that Castro showed interest in Protective Control. He asked questions about where it was located and how far that would be for his family. He appeared happy that the placement would be closer for his family. He asked questions about other potential placements, and CRC staff explained that those placements would not be safe for him. He also asked questions about getting mail. The hearing ended without any significant issues or events, and Protective Control placement was recommended to the Warden. Warden Richard signed off on the Protective Control documentation (not attached) that same day. Castro was returned to his cell from this hearing at 1:52 p.m.

Team members Banks and Clark reviewed a letter to Warden Richard from a confidential inmate source (not attached) claiming to have knowledge of other facts and circumstances surrounding Castro's death – specifically, the corrections officers did not properly call for mental health intervention for Castro on September 3, 2013. This information was previously forwarded to the Ohio State Highway Patrol and will be forwarded to the Chief Inspector's office with this report for further investigation.

Conclusion: There appears to be no known, substantiated motivation for the self-inflicted death.

[2] Policy does not require audio recording of this hearing. It is frequently not recorded due to the sensitive nature of Protective Custody investigations.

Recommendations: This section is informational. There are no Team recommendations because a conclusion could not be reached. All appropriate notifications have been made to the Ohio State Highway Patrol.

VI. Performance of Rounds, Maintaining Logs, Post Orders, Supervisor Reviews

Relevant Facts: DRC Policy 55-SPC-02 requires that, "[c]orrection officers assigned to special management housing areas shall make security rounds and personally observe all special management inmates at least every 30 minutes on an irregular schedule." [redacted]

[redacted]

In order to verify that rounds were being timely completed in segregation housing areas, [redacted] By memorandum dated May 7, 2013 from CRC Deputy Warden of Operations Heiss, [redacted]

During the Team investigation of this incident, it was made clear to Team members Banks and Clark through interviews with Deputy Warden Heiss and Captain D. Wilson that the May 7, 2013 memorandum was not properly distributed to all shift supervisors. This caused some confusion in how high security rounds were to be verified. [redacted] Instead, they were randomly selecting a time for each high-security pod to visually verify one round per shift. [redacted] As will be explained below, these practices were clarified following September 3, 2013; however, this was the practice in place at the time of Castro's self-inflicted death.

Team members Albright and Bradley reviewed the post log books and remote eye video to determine the occurrence of rounds on September 3, 2013 between 2:00 p.m., the start of second shift, and the time Castro was found hanging in his cell – 9:18 p.m. The Team reviewed the spider alarm reports (not attached); however, because of the uncertainty in the accuracy of these records, Team members determined that the best way to verify rounds was to utilize and compare both the post log books and remote eye video to do a visual verification on each round. According to the timeline (Exhibit B), this is how rounds were conducted:

September 3, 2013 - 1:52 pm	Castro returned to his cell from PC committee	Remote eye video.
September 3, 2013 – 2:15 pm	DC II Range check by CO Murphy	Remote eye video 2:12 pm
September 3, 2013 – 2:40 pm	DC II Range check by CO Murphy	Remote eye video 2:54 pm
September 3, 2013 – 3:03 pm	No Remote eye support – FALSIFIED LOG	Remote eye video
September 3, 2013 – 3:32 pm	No Remote eye support – FALSIFIED LOG	Remote eye video
September 3, 2013 – 4:00 pm	DC II Range check by CO Murphy & Ackley	Remote eye video 4:03 pm
September 3, 2013 – 4:03 pm	Captain Wilson documents his review of rounds on the Daily Shift Log; however, this was just a visual verification of the 4:00 p.m. round due to the confusion in verification instructions noted above.	Daily Shift Report 9/3/2013 *spider alarm printout shows round deficiencies & 1st Shift CO White did not use spider alarm for rounds
September 3, 2013 – 4:30 pm	DC II Range check & count by CO Murphy & Ackley	Remote eye video 4:34 pm
September 3, 2013 – 5:00 pm	No Remote eye support – FALSIFIED LOG	Remote eye video
September 3, 2013 – 5:29 pm	Lt. Antle & Shasteen to Castro's cell with food tray – NO RANGE CHECK completed.	Remote eye video
September 3, 2013 - 6:00 pm	Inmate Castro refused evening meal.	DRC4118 form
September 3, 2013 – 6:00 pm	DC II Range check by CO Ackley	Remote eye video 6:05 pm
September 3, 2013 – 6:30 pm	DC II Range check by CO Ackley & Lt. Antle for Castro's meds	Remote eye video 6:39 pm
September 3, 2013 – 6:55 pm	CO Ackley on range but did not go to Castro's cell	Remote eye video
September 3, 2013 – 7:23 pm	Both CO's on bottom range of DC II, NO TOP RANGE CHECK (Castro's Range)	Remote eye video
September 3, 2013 – 7:45 pm	No Remote eye support – FALSIFIED LOG	Remote eye video
September 3, 2013 – 8:15 pm	No Remote eye support – FALSIFIED LOG	Remote eye video
September 3, 2013 – 8:45 pm	DC II Range check by CO Ackley	Remote eye camera 8:54 pm

September 3, 2013 – 9:18 pm	Castro found hanging from window bars with sheet around neck in cell 2103 during 9:15 pm count by CO Ackley.	Incident Report & remote eye camera.

The remote eye video indicates that no rounds were done on Castro's cell at 3:03, 3:32, 5:00, 5:29, 6:55, 7:23, 7:45 and 8:15 p.m. The post log books indicate falsified logs at 3:03, 3:32, 5:00, 7:45 and 8:15 p.m. The 8:45 p.m. round and the 9:15 p.m. round were properly conducted within DRC Policy and CRC Post Order guidelines.

Conclusion: Rounds were not properly completed. Post log books were falsified. There was no satisfactory verification process in place. Shift supervisors were not given clear direction on verfication procedures and expectations. Not all staff were following spider station directive. Corrections officers were utilizing fire escape doors as shortcuts between segregation pods and floors.

Recommendations: Following the incident on September 3, 2013, CRC took immediate action to clarify procedures for rounds verification and documentation. These recommendations encompass many of the recommendations that would have been made by the Team. CRC issued four separate memoranda (Exhibit G) containing the following directives:

[redacted]

CRC also addressed previous communication defects by ensuring that these above requirements were given to all shift supervisors. The officers were notified during roll call at the beginning of

each shift. Discussions with Major Smith and DWO Heiss as well as an interview with Captain D. Wilson confirm this.

In addition to the procedures recently put into place by CRC, the Team recommends that a quality assurance check at the Major/DWO level be implemented to verify that shift supervisors are properly verifying rounds. The current procedures require a report when a shift supervisor determines a descrepancy in rounds, but there are no checks to determine whether a shift supervisor has met the requirements of the directives above. The Team recommends that, at a minimum, the Major/DWO randomly select spider station reports to verify round compliance and supervisor verfication compliance. CRC should review this recommendation and initiate other quality assurance processes as it deems appropriate.

The Team also recommends that CRC review and account for all segregation duties and their distribution among the shifts to ensure an appropriate balance.

VII. Timeliness of Emergency Response[3]

Relevant Facts:

9:18 p.m. - Corrections Officer Ackley at Castro's cell – Castro found hanging from window bars with sheet around his neck and his shorts around his ankles.

9:19 p.m. – Corrections Officer Murphy arrives to assist Ackley in getting inmate Castro down from the window bars. They are able to rip the sheet and lower the inmate to the ground but cannot get sheet off inmate's neck. Murphy goes to get cut down tool.

9:20 p.m. – Lt. Antle and other staff responders arrive. Cut down tool used to remove sheet. Corrections officers initiate CPR.

9:22 p.m. – CRC medical staff arrive on scene and take over CPR and placement of AED unit. Correctional medical staff continue CPR on inmate until ambulance personnel arrive on scene. AED was used, but did not advise to shock.

9:25 p.m. – MedCare Ambulance called from control center.

9:49 p.m. – CRC reports MedCare Ambulance called again from control center.

9:59 p.m. – MedCare Ambulance arrives at CRC

10:05 p.m. – MedCare Ambulance staff arrive at scene in segregation

10:18 p.m. – MedCare Ambulance begins transport to OSUMC.

[3] The times noted in this section are from remote eye video of the range (Exhibit B), incident reports authored by CRC staff (Exhibit H) and EMS run report (Exhibit I).

10:18 p.m. to 10:46 p.m. – MedCare Ambulance stops on Interstate 71 N to pick up additional MedCare Ambulance staff to assist with life saving measures.

10:46 p.m. – MedCare Ambulance arrives at OSUMC

10:52 p.m. – Inmate Castro pronounced dead at OSUMC

Conclusion: Emergency response by custody staff was timely and appropriate. Emergency response by Inmate Health Services was timely and appropriate. The response by MedCare Ambulance was significantly delayed. Relevant portions of DRC's contract with the EMS provider require a response within 15 minutes of call from the institution (Exhibit J). MedCare Ambulance took 34 minutes to respond and failed to contact another provider to make the run if they could not, which is also required by the contract. As a result, Castro was not en route to OSUMC until nearly an hour after he was discovered. There is no indication, however, that the delay had an effect on the ultimate outcome.

Recommendations: CRC has already received two letters from MedCare Ambulance which are exception reports required by contract for failing to meet the 15 minute response requirement (Exhibit K). The first letter, dated September 19, 2013, indicates that the closest MedCare Ambulance at the time of the call for assistance was at OSUMC. This is the ambulance that responded. The second letter, dated September 23, 2013, indicates that MedCare Ambulance does not use a station based ambulance plan and instead uses a System Status Plan where ambulances are positioned dynamically based upon historic demand. MedCare Ambulance indicates it is continuously reviewing its plan to improve service. The Team recommends that Bureau of Medical Services staff meet with MedCare Ambulance to receive assurances that their plan will include proper response times to the Orient Correctional Complex. If this contractor cannot demonstrate a sufficient plan, the Team recommends exploring a termination of the contract and securing a new EMS contractor.

VIII. Referral to Mental Health Continuous Quality Improvement Process

The details of quality assurance reviews performed by the institutions and the Bureau of Behavioral Health Services are confidential by statute, which would include a detailed review of the mental health records. See O.R.C. 5120.211. Initially and generally, no major areas of concern were identified in the mental health interactions specific to Inmate Castro. The complete institutional mortality review and Bureau of Behavioral Health Services mortality review will be completed in due course.

IX. Referral to Medical Continuous Quality Improvement Process

The details of quality assurance reviews performed by the institutions and the Bureau of Medical Services are confidential by statute, which would include a detailed review of the medical records. See O.R.C. 5120.211. Initially and generally, no areas of concern were identified in the

medical services interactions specific to Inmate Castro. The complete institutional mortality review and Bureau of Medical Services mortality review will be completed in due course.

X. Referral for Criminal/Administrative Investigation

Relevant Facts: It appears from the full investigation of the incident by CRC and DRC/OSC that Officers Ackley and Murphy did not timely perform all rounds as required by Post Orders. Additionally, it appears that officers did falsify the post log book for their rounds. No interviews of these employees were conducted by CRC after-action or DRC/OSC after action teams. Both employees are on administrative leave, and all relevant facts were reported to the Ohio State Highway Patrol by CRC for a criminal investigation. That investigation is pending at this time.

Recommendation: In addition to the report made by CRC to the Ohio State Highway Patrol, this matter should be referred to the Chief Inspector's Office at the conclusion of the Patrol's investigation for a full administrative investigation for potential discipline/termination of employment.