DEPARTMENT OF CORRECTIONS

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May 15, 2020

Sheriff Ernie Beitel
Beltrami County Sheriff's Office
613 Minnesota Avenue Northwest
Bemidji, MN 56601

Re: Hardel Sherrell death

Sheriff Beitel:

As you may be aware, after the initial review of the death of Mr. Hardel Sherrell, the Department of Corrections (DOC) received additional information related to the death of Mr. Sherrell, who died in your facility on September 2, 2018. On December 3, 2019, DOC Commissioner Paul Schnell ordered the Inspection and Enforcement Unit to re-review jail standards compliance with regard to the death of Mr. Sherrell. Based on the Commissioner's directive, I requested all documentation you had originally provided for review of the incident, as well as additional documentation dating back to when Mr. Sherrell entered the facility. The Commissioner's concern was related to the fact that the previous review by the Inspection and Enforcement Unit included review of data for only the 12-hour period immediately preceding Mr. Sherrell's death. We have now completed the updated review covering the nine day timeframe encompassing Mr. Sherrell's incarceration in the Beltrami County Jail, including 476 hard copy documents and approximately 828 video clips.

The result of our review is a finding of regular and gross violation of Minnesota Jail standards as set forth in chapter 2911 of the promulgated rules. While it is beyond the scope of our authority to determine whether or not compliance with the rules would or could have resulted in a different outcome, the deterioration of Mr. Sherrell's condition over his nine-day term of incarceration in the Beltrami County Jail is notable and disturbing. Below you will find a description of some of our findings. It should be noted that we did not document each specific violation of well-being checks or other requirements. However, our review did find that policy failures were pervasive and likely stemming from the incorrect belief that Mr. Sherrell was demonstrating symptoms of malingering versus a bonafide medical condition.

We understand that you were not the Beltrami County Sheriff at the time of Mr. Sherrell's death, and we appreciate your cooperation with this inquiry. As the entity responsible for licensing jails across Minnesota, we feel an obligation to ensure that all reasonable steps are taken to avoid tragedies such as this. Sound policies and strict adherence to those policies, along with full and aggressive compliance with the state's jail standards are intended to minimize risks.

Beyond the obvious problem of non-compliance with jail policies and the corresponding jail standards is the fact that no one seemed to question the assumptions made about Mr. Sherrell's condition. In fact, the treating physician at Sanford Health included in his discharge summary that "worsening weakness, difficulty standing, paralysis, loss of control of the bladder or bowels or difficulty swallowing" should result in immediate medical attention being sought. Based on the information available in the records we were provided, it appears this directive was summarily disregarded contrary to rules or policy. Please know that should we find evidence of continued violations of the provisions set forth below, we will be required to take action up to and including suspension or revocation of the County's license to operate a jail.

The following violations were noted in the Inspection and Enforcement Unit review:

Chapter 2911.2850 INMATE DISCIPLINE PLAN. Subp. 6. Removing clothing and bedding. The facility administrator or designee shall have a policy and procedure for removing clothing and bedding from an inmate. The following shall be included:

A. clothing and bedding shall be removed from an inmate only when the inmate's behavior threatens the health, safety, or security of self, other persons, or property. When appropriate, alternative clothing and bedding shall be issued;
B. clothing and bedding shall be returned to the inmate as soon as it is reasonable to believe the behavior that caused the action will not continue;
C. the decision to deprive an inmate of articles of clothing or bedding shall be reviewed by the officer in charge or the supervisor during each eight-hour period; and
D. the review shall be documented.

Findings: On August 29, 2018, at approximately 4:41 am, staff helped Mr. Sherrell remove his pants so he could use the toilet. His pants were not returned until August 31 at approximately 9:44 am. This did not appear to be neither a behavioral issue nor a disciplinary issue, and therefore is a violation of the rule. Mr. Sherrell was provided with a "Depends" type of undergarment, but was not provided pants, or other appropriate alternative clothing.

Facility policy meets the requirements of the rule. However, based on this review, it appears staff did not act according to policy.

Corrective Action: All facility staff shall be re-trained on the policy requirements. Training shall be documented. Provide training verification to the DOC no later than July 1, 2020.

2. 2911.4500 SUPERVISION OF MEAL SERVING.
Meals shall be served under the direct supervision of staff.

Findings: Video footage from the dormitory area shows inmates delivering meal trays into the dormitory with no direct staff supervision. Additional video footage of a different location shows an inmate loading meal trays from one cart to another, and then he delivers those trays to various locations while under no direct supervision of staff.

Policy is clear that meals must be served under direct supervision of staff.

Corrective Action: Staff must directly supervise distribution of meal trays in all areas of the facility. Provide documentation that staff have been re-trained and have signed off on facility policy. Documentation of training and policy sign-off must be submitted to the DOC no later than July 1, 2020.

3. 2911.5000 POST ORDERS; FORMAL INMATE COUNT; WELL-BEING CHECKS.

Subp. 5. **Well-being.** A facility shall have a system providing for well-being checks of inmates.
A written policy and procedure shall provide that all inmates are personally observed by a custody staff person *at least once every 30 minutes.* Thirty-minute checks should be staggered. If a well-being check does not occur due to an emergency, it must be documented in the jail log and have supervisory review and approval.

More frequent observation is required for those inmates of a special need classification who may be harmful to themselves. Examples of inmates of a special need classification include those classified as potentially suicidal, those classified as mentally ill, or those experiencing withdrawal from drugs or alcohol.

Findings: Unit staff reviewed hours of video footage of Mr. Sherrell while he was housed in the dormitory area (2nd Floor Room 207). During the first day in which Mr. Sherrell was housed in this area (August 24, 2018), there were nine violations of the well-being check rule. According to video footage, the time between some checks was in excess of fifty (50) minutes. Based on video review, on August 25, 2018, from 1800 hours (6:00 pm) until 2400 hours (midnight), there were four more checks that exceeded thirty minutes. Video review from August 24 through August 25, 2018 shows there were no less than thirteen well-being checks that exceeded the 30 minute well-being check requirement. The remainder of the video review focused on other rule requirements, as it was clear that well-being check violations were pervasive.

Review of written documentation also verifies violations of well-being checks. Written documentation on August 24, 2018, indicates two of the well-being checks logged were approximately sixty minutes between checks. Documentation indicates that there were at least four checks logged on August 26, 2018, which exceeded the thirty minute requirement. The well-being checks documentation reflect a range of 33 minutes to 60 minutes between the required checks. Well-being check documentation reviewed for August 28, 2018 indicates nine checks that exceeded the rule requirements. Documentation notes reflect a range from 33 minutes to 60 minutes between the required checks.

There is clear evidence from video and written documentation review to verify the regular violation of the rule requiring that well-being checks to be completed every thirty-minutes or less and for those checks to be staggered. In addition, staff provided no documentation that a facility emergency interfered with their ability to perform the required checks as provided in the rule.

Facility policy (508.2) and Well-being Checks procedure (508.3) appear to set forth clear expectations for staff in terms of completing and documenting well-being checks. Based on review of video, facility logs for well-being checks, and facility policy and procedure, staff did not complete and document well-being checks according to facility policy and procedure.

Corrective Action: All staff shall be re-trained on facility policy and procedures related to proper well-being checks and proper documentation of well-being checks.

Additionally, facility administration must develop and implement policy and procedures to audit and document reviews of well-being checks.

Documentation of training and new policy and procedure must be submitted to the DOC no later than July 1, 2020.

4. 2911.5800 AVAILABILITY OF MEDICAL AND DENTAL RESOURCES. Subpart 2. Health care. Medical, dental, and mental health matters involving clinical judgments are the sole province of the responsible physician, dentist, and psychiatrist or qualified psychologist respectively; however, security regulations applicable to facility personnel also apply to health personnel.

Findings: On 8/30/2018, there is a notation on the MEND "Medical Staff Narrative Note" at 0740 hours that indicates Dr. Todd stated they were to send the patient to the ER for evaluation. At 1330 hours there is a notation that indicates "Jail Administrator Calandra stated they would not be pt to ER for evaluation." Additional notations state "Medical has been given information that may indicate a possible escape attempt."

Subsequent to the orders given on August 30, 2018, Mr. Sherrell was eventually transported to Sanford Health Fargo on August 31, 2018. Upon completion of evaluation by Sanford Health, and upon release from Sanford Health Fargo, discharge instructions for Mr. Sherrell were provided. Those discharge instructions provide the following direction:

- Should seek immediate medical attention if exhibiting any of the following:
    - Confusion, coma, agitation (becoming anxious or irritable).
    - Fever (temperature higher than 100.4 degrees F / 38 degrees C), vomiting.
    - Severe headache.
    - Signs of stroke (paralysis/numbness on one side of the body, drooping on one side of the face, difficulty talking).
    - Worsening weakness, difficulty standing, paralysis, loss of control of the bladder or bowels or difficulty swallowing.

Upon return to the Beltrami County jail, Mr. Sherrell appeared to exhibit worsening of some of those symptoms listed above while in custody on September 1, and September 2, 2018. There is no documentation available to indicate the facility sought additional medical care as directed.

Additionally, although MEND medical has a policy that would meet the rule requirement, I was not able to find a corresponding policy in the Beltrami County Jail policy manual. Although MEND has the policy in place, Beltrami County should also have a policy in place that governs Beltrami County staff.

The lack of policy and procedures related to this rule provision, and the refusal by Jail Administration to send Mr. Sherrell to the hospital for evaluation as initially directed on August 30, 2018, and the lack of action to seek additional medical attention upon the return of Mr. Sherrell to the Beltrami County jail upon worsening of symptoms, the DOC finds the facility is in violation of the rule listed above.

Corrective Action: Immediately upon receipt of this letter, facility administration shall develop policy and procedure related to the above noted rule provision. Ensure policy meets all requirements set forth in the rules. Policy, procedures, and documentation of training for all staff must be submitted to, and approved by, the DOC no later than July 1, 2020.

Data Reviewed: Documentation included: death memos from the DOC, facility incident reports, numerous jail logs, documents from MEND medical, health insurance forms, inmate classification forms, inmate medical screens, medical pass-on logs, training documentation, door logs, and discharge documents from Sanford Health Fargo. Additionally, the DOC requested all video related to Mr. Sherrell from the time of his being admitted into your facility, until the time of his death. Video reviewed includes, but is not limited to the following dates and locations: August 24, 2018 from the Booking room, and Room 207 (living area dormitory); August 25, 2018 Room 207; August 26, 2018 Room 207; August 29, 2018 from the nursing area; 2nd Floor holding cell 215 from August 29, 2018 through August 31, 2018; 2nd Floor holding cell 214 from September 1, 2018 through September 2, 2018.

I look forward to the opportunity to meet with you and any Command Staff you believe would benefit from gaining a further understanding as to the seriousness of these violations. I believe there is a great deal of value in collaborating to find solutions for these violations moving forward.

As always, staff of the Inspection and Enforcement unit are available as a resource to you and your staff on any questions you may have related to jail inspections and operations.

If you have any questions or concerns please feel free to contact me at 651-361-7147.

Thank You,

Timothy G. Thompson
Inspection and Enforcement Unit Director

Cc: Paul Schnell, Commissioner of Corrections
Curtis Shanklin, Deputy Commissioner
Sarah Johnson, Detention Facilities Inspector, Sr.
Calandra Allen, Jail Administrator
Beltrami County Jail File