NEW YORK STATE COMMISSION OF CORRECTION

In the Matter of the Death of John Moore, an inmate of the Anna M. Kross Center	: : : : :	FINAL REPORT OF THE NEW YORK STATE COMMISSION OF CORRECTION

TO: Commissioner Dora Schriro
NYC Department of Correction
75-20 Astoria Blvd, Ste. 100
East Elmhurst, NY 11370

GREETINGS:

WHEREAS, the Medical Review Board has reported to the NYS Commission of Correction pursuant to Correction Law, section 47(1)(d), regarding the death of John Moore who died on October 15, 2009 while an inmate in the custody of the NYC Department of Correction at the Anna M. Kross Center, the Commission has determined that the following final report be issued.

FINDINGS:

1. John Moore died from a suicidal hanging on 10/15/09 while in the custody of the NYC Department of Correction (NYCDOC) at the Anna M. Kross Center (AMKC). Inadequate mental health and medical care provided by contract provider Prison Health Services, Inc. (PHS), a business corporation holding itself out as a medical care provider, was implicated in Moore's death. Had adequate care been provided, Moore's death may have been prevented.

2. John Moore reportedly lived alone in the Hunts Avenue section of the Bronx, NY. His work and education history were unknown. Moore had a lengthy substance abuse history including heroin beginning at age 27.

3. [redacted] In the instant offense, Moore was arrested by the New York City Police Department (NYPD) on 10/9/09 for Criminal Possession of a Controlled Substance 3rd. He was brought to the Bronx Court Section on 10/10/09 for arraignment and then placed in to the custody of NYCDOC at AMKC on 10/11/09.

4. [redacted]

5. [redacted]

6. Moore was taken into NYCDOC custody on 10/10/09 at the Bronx Court Section. The ADM-330 Suicide Prevention Screening Guidelines were

administered. [redacted] he scored only a "2" on this screening, indicating little or no risk. The screening venue in the Bronx Criminal Court Division at the point of transfer to NYCDOC custody may interfere with effective administration of the screening. Moore was transferred to AMKC on 10/11/09 for admission.

7. [redacted]

8. [redacted]

9. [redacted]

10. [redacted]

11. [redacted]

12. [redacted]

[redacted]

13. Dr. N.N., a new PHS per diem employee, was not adequately oriented or properly prepared to work in and/or manage acute forensic mental health patients in a correctional setting. PHS provided only the most perfunctory of orientations, no training, no mentoring, and no supervision while assigning her to a critical post in a mental health in-patient unit for the sickest inmates. Dr. N.N.'s professional conduct constituted gross incompetence and gross negligence associated with grossly inadequate medical and mental health care by Prison Health Services, Inc. This lack of adequate preparation lead to a misjudgment of Moore's imminent suicide risk and a formulation of a treatment plan that did not sufficiently address his immediate mental health needs. During the Commission's investigation, it was learned that Dr. N.N. was a per diem psychiatrist who was working one day a week at AMKC. She had only been employed a few weeks prior to her clinical encounter with Moore. Dr. N.N. stated she was not familiar with AMKC and the functions of the C-71 mental health observation unit, a critical element in the NYCDOC/Rikers Island mental health care system. According to Dr. N.N., she was not aware that Moore had just been evaluated by Dr. M.S. and did not see a copy of Moore's chart. The Medical Review Board has repeatedly cited PHS, Inc. for conducting patient encounters without the patient record, a violation of PHS's contract performance standards. Dr. N.N. stated she was told to do an assessment on Moore when he was brought to her area. According to Dr. N.N., she had only received one day of orientation prior to beginning work in AMKC. Dr. N.N. left employment with PHS in October of 2009.

14. [redacted] This again suggests that the patient was encountered without benefit of the patient record, a repeated performance standard violation.

15. [redacted]

16. [redacted]

[redacted]

17. [redacted] Once again the repeated failure of PHS, Inc. to make the record available during patient encounters is noted. This is a contract performance standard violation and as such represented inadequate medical care.

18. [redacted]

19. The medical assessment conducted by Dr. K.C. on Moore was inadequate [redacted] Moore was returned to his housing area at 2:20 p.m.

20. [redacted] Since no medical record was made, it may be inferred that Moore was not seen, notwithstanding that patients are routinely encountered without benefit of the patient record.

21. [redacted] The mental health care provided Moore by PHS, Inc. and LCSW J.M. was flagrantly inadequate.

22. [redacted] At 5:30 a.m., he was seen by Captain L.W. exiting Quad 5 to the hallway

to go to court. Captain L.W. stopped Moore and asked why he was dressed in an orange jumpsuit and not his civilian clothes for court. Moore stated that he needed to return to his cell as he had just defecated on himself. Captain L.W. instructed Moore to return to his cell and clean himself up.

23. At approximately 5:45 a.m., Moore was observed to be sitting on the stairs inside the housing unit and refusing to go to court. Captains L.W. and D.P. approached Moore to inquire as to why he was refusing to go to court. Moore stated he was feeling ill and had just defecated on himself. Captain D.P. spoke with Moore and told him he would feel better if he took a shower and went down and got checked at medical. Captain D.P. made notification to the transportation captain that Moore was not going to be on the first bus out to court. Moore remained in the housing area for the remainder of the day. He was not transported out to court, however, there is no log entry or medical chart note to support that he was ever sent to medical for an evaluation to see if he was fit for court on that date.

24. Moore was also scheduled for [redacted] visit with the doctor at 10:45 a.m. but was not produced for the appointment. [redacted] It is unclear as to why Moore was not produced for the chronic care visit. [redacted] Dr. M. is no longer employed by PHS, Inc.

25. Moore remained on the unit and followed regular daily routine. Officer C.R. was assigned the dayroom post for the 7:00 a.m. to 3:00 p.m. tour. He reported seeing Moore out in the day area conversing with other inmates at approximately 2:00 p.m. Officer C.R. conducted a tour of the area at 2:45 p.m. with nothing unusual noted

26. Officer P.R. was assigned to the Quad Lower 5 C post for the 7:00 a.m. to 3:00 p.m. tour. Officer P.R. conducted a tour of the housing area and completed the inmate lock in at approximately 2:50 p.m. Officer P.R. reported seeing Moore in his cell and he appeared to be okay. Officer P.R. was then relieved by Officer J.S.

27. An inmate observation aide, M.G., reported seeing Moore in his cell at approximately 3:10 p.m. Moore was reportedly lying on his bed looking up and then turned to look at M.G.

28. At approximately 3:15 p.m., Officer J.S. conducted his first tour of the housing area. Upon arriving at Moore's cell, he discovered Moore was hanging from a sheet tied around the bed frame. Officer J.S. called down the tier to Officer P.R. and Officer M.S. to bring the keys, pocket mask, and to notify the clinic. Officer P.R. responded down to the cell and entered with Officer J.S. Moore was lying prone on the floor with a sheet tied around his neck and affixed to the bed frame above him. Officers P.R. and J.S. removed the sheet

from around Moore and began CPR. Officer M.S. made notification to the clinic and medical staff responded.

29. [redacted]

30. [redacted]

RECOMMENDATIONS:

TO THE DEPUTY COMMISSIONER, DIVISION OF HEALTH CARE ACCESS AND IMPROVEMENT, NYC DEPARTMENT OF HEALTH AND MENTAL HYGIENE:

1. The Division shall require PHS, Inc. to conduct a written comprehensive quality improvement review of the psychiatric care provided to inmate Moore by PHS, Inc., while in the custody of the NYC Department of Correction. Specifically, the review shall focus on:

   a. [redacted]

   b. [redacted]

   c. The gross inadequacy of training and orientation provided to the admitting psychiatrist at AMKC's C-71 Mental Health Unit prior to being assigned there, and the impropriety of assigning a new, untrained, disoriented, unsupervised per diem clinician to a post with a critical role in the NYCDOC mental health service array.

2. The Division shall require PHS, Inc. to conduct a comprehensive quality improvement review of medical care provided to Moore by PHS, Inc., while in the custody of the NYC Department of Correction. Specifically, the review shall focus on:

   a. [redacted]

b. Why reported clinical encounters reported as occurring on 10/12/09 and 10/14/09 were not recorded in the medical chart?

c. [redacted]

d. Why Moore was not produced for a chronic care medical appointment despite being available at his housing unit?

e. The repeated failure of PHS, Inc. to provide patient records for clinical encounters in violation of NYCDOC performance standards and the community standard of care.

PLEASE TAKE NOTICE that your evaluation and response to the above-entitled recommendations should be made in writing directly to this office within thirty (30) days.

WITNESS, HONORABLE PHYLLIS HARRISON-ROSS, M.D., Commissioner, NYS Commission of Correction, 80 Wolf Road, 4th Floor, in the City of Albany, New York 12205 this 18th day of March, 2011.

Phyllis Harrison-Ross, M.D.
Commissioner

PH-R:mj
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3/11

cc: Eric Berliner, Executive Director
of Health Services
Lewis Finkelman, General Counsel
Sara Taylor, Chief of Staff
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