NEW YORK STATE COMMISSION OF CORRECTION

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

TO: Commissioner Joseph Ponte
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 Bradley Ballard who died on September 11, 2013, 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.

SUMMATION FINDINGS:

1. Bradley Ballard was a 39-year-old African-American male who died on 9/11/13, at 1:31 a.m.. while in the custody of the New York City Department of Correction (NYC DOC) at the Anna M. Kross Center (AMKC). Ballard was discovered in the evening on 9/10/13, to be lying in his cell naked, unresponsive, covered with urine and feces, and in critical condition. [redacted] Ballard went into cardiac arrest shortly after being removed from his cell and was pronounced dead at Elmhurst Hospital. Ballard died from diabetic ketoacidosis (DKA) (serum glucose 1,200mg%)due to withholding of his diabetes medications complicated by sepsis due to severe tissue necrosis of his genitals as a result of a self-mutilation. Between 8/7/13, and 9/5/13, Ballard should have been encountered for finger sticks 58 times but was actually seen on only ten (10) occasions. The medical and mental health care provided to Ballard by NYC DOC's contracted medical provider, Corizon Inc. during Ballard's course of incarceration, was so incompetent and inadequate as to shock the conscience as was his care, custody and safekeeping by NYC DOC uniformed staff, lapses that violated NYS Correction Law and were directly implicated in his death. Had Ballard received adequate and appropriate medical and mental health care and supervision and intervention when he became critically ill, his death would have been prevented.

2. The events that lead to Ballard's death were directly caused by the compounded failures of NYC DOC and its contracted medical provider, Corizon Inc., to maintain care, custody, and safekeeping of this inmate in accordance with New York State Correction Law, NYS Minimum Standards and Regulations for Management of County Jails and Penitentiaries, and Ballard's civil rights. Bradley Ballard was keeplocked in his cell for six days prior to his death and was denied access to his life-supporting prescribed medications, denied access to medical and psychiatric care, denied access to essential mandated services such as showers and exercise periods, and denied running water for his cell. Ballard's deteriorating health and mental status was observed over the course of this six day period by many NYC DOC officers, supervisors, and administrators, together with clinicians employed by Corizon Inc., who showed deliberate indifference to Ballard's serious medical needs by collectively

failing to provide the very basics of medical care and failing to take appropriate action in a timely manner to a medical emergency which resulted in Ballard's death. The assertion by the NYC Department of Health and Mental Hygiene in its response to the Medical Review Board's Preliminary Report to the effect that Ballard likely died from lactic acidosis secondary to genital stricture is wrong. Lactic acidosis is commonly associated with DKA, and in this case, the deceased's blood sugar level was so extreme as to have unquestionably resulted from DKA, Ballard's genital stricture having been isolated from his circulation and as such not contributory to his lactic acidosis. The Medical Review Board concurs the New York City Medical Examiner's ruling that Bradley Ballard's manner of death is a homicide.

FINDINGS RE: BRADLEY BALLARD'S COURSE OF INCARCERATION:

1. Bradley Ballard was born in Houston, TX. His father is deceased and his mother reportedly still resides in Houston. Ballard was the youngest of three boys. Ballard reported having an abusive childhood from his biological father and stepfather. Ballard had no spouse and no children. Ballard had a GED from 1990 but no steady work history. Ballard reported alcohol and cocaine use, the most recent use in March, 2013.

2. [redacted]

3. [redacted]

4. [redacted]

[redacted]

5. Bradley Ballard was extradited from Harris County, Texas by NYS DOCCS - Division of Parole and directly admitted to Otis Bantum Correctional Center on 6/13/13. Ballard was housed in 3-West as a new admission/general population.

6. [redacted]

7. [redacted]

8. On 6/18/13, Ballard was transferred to George R. Vierno Center (GRVC). [redacted]

9. [redacted]

10. [redacted] No member of the clinical or security

staff encountered Ballard with this history of refusals and failures to produce him at clinic to determining the reasons therefor or to counsel him accordingly. This represents substandard medical and mental health treatment.

11. Ballard was involved with a use of force by DOC officers in the evening on 6/30/13. Ballard had begun to display radical changes in his behavior and became assaultive. At 7:00 a.m., on 7/1/13, Ballard was seen in the medical clinic for an injury assessment. [redacted]

12. [redacted]

13. [redacted]

14. [redacted]

15. [redacted]

[redacted]

16. [redacted] No attempt was made to encounter Ballard with regard to the reason for these failures to produce, and there was no inquiry in regard to the failure to produce him by senior Corizon, Inc. or DOC personnel. This represents substandard medical and mental health treatment.

17. [redacted]

18. Ballard was transferred to Anna M. Kross Center's (AMKC) [redacted] on 8/8/13. [redacted]

19. [redacted]

[redacted]

20. [redacted]

21. On 8/12/13, Ballard was re-housed in AMKC's [redacted]

22. [redacted]

23. [redacted]

24. [redacted] The lack of a documented clinical rationale for changing a psychotropic medication for patient with reported efficacy of the current medication regimen supported by a

physician's order and the failure to thoroughly read a patient's medical chart and history constitutes incompetent psychiatric care.

25. [redacted]

26. [redacted]

27. [redacted]

28. [redacted] The lack of follow up for a known chronic condition [redacted] after Ballard had three missed appointments and was present in the clinic for a benign complaint [redacted], constitutes uncoordinated and incompetent medical care.

29. On 8/28/13, Ballard was involved in a fight whereby Ballard was reported to have thrown hot water on two other inmates. [redacted]

[redacted]

30. [redacted]

31. [redacted]

32. [redacted]

33. [redacted]

[redacted]

34. On 8/31/13, Ballard was involved in fight with an inmate in his housing area. Ballard and his assailant refused to stop fighting when ordered by correction officers and chemical agents (OC) was used. [redacted] He was returned to his housing area.

35. [redacted]

36. It is noted by the Medical Review Board that Ballard's irritability, agitation, and aggression all significantly increased after being discontinued from [redacted] both contrary to physician orders. No comprehensive clinical review or assessment of Ballard's medication efficacy was documented by any psychiatric provider in relation to his changes in behavior in the face of subtherapeutic and otherwise ineffective therapy not authorized by a physician. This represents inadequate psychiatric care by Corizon, Inc.

37. On 9/3/13, Ballard was transferred to AMKC's [redacted] and placed in an individual cell.

38. [redacted]

39. [redacted]

[redacted] There is no evidence that a review of Ballard's medical chart was completed prior to renewing his medications. This represents inadequate medical care. NYC DOH-MH's assertion that [redacted] was not appropriate for this patient begs the question that Mr. Ballard died from being deprived of needed [redacted] for 11 days, a severe lapse for which there is no explanation and for which no defense is offered.

40. [redacted] The lack of coordinated care for and the mismanagement of Ballard's [redacted] represents grossly negligent medical care by Corizon, Inc., endangered Ballard's life and subsequently caused his death.

41. [redacted] The Medical Review Board found evidence that **LPN A.D.** created a false entry in Ballard's medical chart. Recorded video camera footage for the 24 hour period covering 9/6/13 (as cited in Finding # 18 in Part II of this report) revealed no medical staff were present at Ballard's cell, and Ballard was not removed from the cell at any time. NYC Department of Health and Mental Hygiene in its response to the Medical Review Board's Preliminary Report offered that **LPN A.D.** had taken a written data from another patient, and in error, entered it in Ballard's chart.

42. [redacted] The information documented was completely inconsistent with Ballard's known and established

history and is apparent that a proper and thorough chart review was not completed by **Dr. N.G.**

43. There were no further documented encounters for Ballard with medical or mental health staff from 9/3/13 through the terminal event, eight (8) days later.

RECOMMENDATIONS OF THE MEDICAL REVIEW BOARD RE: BRADLEY BALLARD'S COURSE OF INCARCERATION:

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

1. That the Division shall conduct a quality assurance review of the psychiatric care provided by **NP R.A.** to Ballard on 8/15/13. The focus of the review should include why a sub-therapeutic dosage of an [redacted] medication [redacted] was ordered without documented supporting clinical indication, counter therapeutic to the reported efficacy of the current medication [redacted] and contrary to a prior order of a reviewing psychiatrist.

2. That the Division shall conduct an inquiry with the AMKC clinic director as to why Ballard did not receive the [redacted] laboratory study as ordered for 8/12/13. A comprehensive review shall also be undertaken to examine the laboratory requisition procedure to determine the frequency and circumstances of dropped laboratory orders by Corizon, Inc.

3. The Division shall conduct an inquiry with the AMKC clinic director as to how an order [redacted] for Ballard was dropped on 8/30/13, and was not renewed without clinical evaluation or follow up.

4. The Division shall conduct an inquiry with the AMKC clinic director as to why Ballard was not produced for five separate callouts for specialty clinics for purpose of managing his [redacted] and why follow up explanation by senior Corizon, Inc. and DOC staff did not occur. Further inquiry shall include how providers failed to recognize Ballard was in need of being seen in a specialty clinic when Ballard was readily available at the medical clinic on 8/26/13 for a non-acute complaint.

5. The Division shall conduct an inquiry into the psychiatric care provided to Ballard by **Dr. A.G.** to include the failure to review Ballard's course of changing behavior, his having been referred for causing self-injury, and the failure to correlate this to his change in medication two weeks prior.

6. The Division shall conduct a quality assurance review with **Dr. Y.P.** who failed to thoroughly review Ballard's medical chart prior to

renewing a medication on 9/4/13 whereby missing the fact that Ballard was without a current order for [redacted]

7. The Division shall conduct a quality assurance review with **Dr. N.G.** who conducted a transfer chart review of Ballard on 9/10/13 and failed to properly note his mental health history and current medications. A representative sample of patient chart reviews by **Dr. N.G.** shall be conducted to illuminate his practice pattern in this regard.

8. The Deputy Commissioner shall complete all recommended inquiries and quality assurance reviews and provide a comprehensive report to the Medical Review Board with findings and corrective actions taken on or before **November 21, 2014.**

9. The Deputy Commissioner shall conduct an investigation into the conduct of **LPN A.D.** who entered incorrect medical data for Ballard on 9/6/13. Administrative action should be taken at the completion of the investigation if found to be in violation of policy and procedures.

FINDINGS RE: TERMINAL EVENT:

44. On 9/3/13, Ballard was transferred to AMKC's Quad Lower 4, [redacted] and placed into cell # 23. On 9/3/14, Ballard was let out of his cell for programming and social interaction on the housing unit.

45. Video Footage of Quad Lower 4 on 9/4/13, revealed the following:

- At 12:15 p.m., Ballard is in the day room for Quad Lower 4 socializing with other inmates.
- At 1:35 p.m., Ballard is observed dancing in the day room. Ballard stops and stands still holding his hands upward as if he were praying.
- At 1:50 p.m., Ballard is observed again dancing in the day room.
- At 1:54 p.m., Ballard is observed removing his shirt.
- At 1:56 p.m., Ballard is observed twisting his shirt into a phallic symbol and making a lewd gesture. The gesture was reported to have been done toward a female correction officer.
- At 1:57 p.m., Ballard puts his shirt back on.
- At 2:24 p.m., Ballard is observed holding his hands upward again as if in prayer.

- At 2:50 p.m., officers confront Ballard in the day room.

- At 2:53 p.m., Ballard is secured in handcuffs by two officers and a captain and escorted back to his cell.
- At 2:55 p.m., Ballard is secured in his cell.

46. There is no notation in the housing area logbook about Ballard being keeplocked in his cell pending disciplinary action or any entry about any disciplinary infraction. This in violation of **9 NYCRR §7003.3 (J)(6) (i – iv)** that requires "any significant events and activities occurring during supervision" be properly documented in the logbook.

47. There is no written misbehavior report documenting for what infraction Ballard was being administratively segregated and no documentation authorizing Ballard's administrative segregation pending a disciplinary hearing. These are in violation of **9 NYCRR § 7006.4 (a)(b)(1-5)** Misbehavior reports which states:

> (a) When a staff member has a reasonable belief that an inmate has committed an offense that constitutes a violation of the facility's rules of inmate conduct, and such violation is not informally resolved, such staff member shall prepare a written misbehavior report.
>
> (b) Each misbehavior report shall include:
>
> (1) the name(s) of the inmate(s) charged with the misconduct;
> (2) the date, time and place of occurrence;
> (3) a description of the incident or behavior involved and the rule(s) allegedly violated;
>
> (4) the date and time the report is written;
>
> (5) the reporting staff member's printed name and signature.

and **§7006.7 (a)(b)(c)** Administrative segregation pending a disciplinary hearing which states:

> (a) An inmate who threatens the safety, security, and good order of the facility may be immediately confined in a cell or room pending a disciplinary hearing and may be retained in administrative segregation until the completion of the disciplinary process.
>
> (b) Within 24 hours of such confinement, the inmate shall be provided with a written statement setting forth the reason(s) for such confinement. Upon receipt of the written statement, the inmate shall be provided with an opportunity to respond to such statement orally or in writing to the chief administrative officer.

(c) The chief administrative officer shall review the administrative confinement within 24 hours of such confinement in order to determine if continued confinement is warranted.

48. Video Footage of Quad Lower 4 on 9/4/13, revealed the following:

- At 4:57 p.m., a meal tray is delivered to Ballard's cell.
- At 5:01 p.m., a beverage container is delivered to Ballard's cell.
- At 11:57 p.m., garbage is observed being pushed out from underneath the cell door by Ballard.

49. Video Footage of Quad Lower 4 on 9/5/13, revealed the following:

- At 12:08 a.m., Ballard is flooding his cell as water is seen coming out from under his cell door. No notation is made in the logbook regarding this incident.
- At 1:03 a.m., a captain is observed at Ballard's cell.
- At 5:57 a.m., the breakfast meal is served but not delivered to Ballard. There is no notation in the logbook that Ballard refused the meal. This is in violation of **NYS Correction Law Article 20 §500 - K Treatment of Inmates** that applies **Article 6 §137 (6) (a)** and states:

  > The inmate shall be supplied with a sufficient quantity of wholesome and nutritious food, provided; however, that such food need not be the same as the food supplied to inmates who are participating in programs of the facility.

- At 12:50 p.m., Ballard appears to be banging on his cell door. An officer stops at his cell and speaks to him.
- At 1:03 p.m., Ballard receives a lunch meal tray.
- At 4:48 p.m., a mental health clinician appears to stop at Ballard's cell and speak with him. The clinician is at Ballard's cell for less than one minute.
- At 6:59 p.m., a dinner meal tray is delivered to Ballard's cell.
- At 7:24 p.m., a mental health clinician is observed making rounds on the unit. The clinician does not stop to speak to Ballard.

50. In the 24-hour period covering 9/5/13, Ballard did not receive any medications delivered to his cell despite current orders for Metformin and Seroquel.

51. During the same 24-hour period of 9/5/13, Ballard was not provided with access to a shower in violation **9 NYCRR §7005.2 (a) Showers** which states:

> Hot showers shall be made available to all prisoners daily. Consistent with facility health requirements, the chief administrative officer may require prisoners to shower periodically.

52. During the 24-hour period covering 9/5/13, Ballard was not afforded any access to exercise in violation of **9 NYCRR §7028.2 (b)(1,2) Exercise periods** which states:

> All inmates who have completed the classification process pursuant to sections 7013.7 and 7013.8 of this Title, except as otherwise provided in subdivision (c) of this section or

section 7028.6 of this Part, shall be entitled to exercise periods which, at the discretion of the chief administrative officer, shall consist of:

> (1) at least 1-1/2 hours during each of five days per week; or
> (2) at least one hour seven days a week.

No specific written determination was made to deny Ballard's exercise access based on any threat to the safety and security of the facility or of others in violation of **9 NYCRR 7028.6 (a)(b)** which states:

> (a) The exercise periods of a prisoner may be denied, revoked, or limited when it is determined that such exercise period would cause a threat to the safety, security, or good order of the facility, or the safety, security, or health of the prisoner or other prisoners.
>
> (b) Any determination to deny, revoke, or limit a prisoner's exercise period pursuant to this section shall be made by the chief administrative officer in writing, and shall state the specific facts and reasons underlying such determination. A copy of this determination shall be given to the prisoner.

53. During the 24-hour period covering 9/5/13, Ballard was not seen by a mental health clinician. This is in direct violation of **NYC Department of Health and Mental Hygiene Correctional Health Services Policy: MH 26 Mental Observation Unit** which states:

> The Mental Health Unit Chief or their designee shall maintain a daily account of the inmates on the mental observation unit and shall track visits to each patient. Mental health staff shall conduct rounds on the MO Unit seven (7) days a week. The rounds conducted will be documented in the "Rounds Logbook".

54. Ballard was also not seen by any staff from medical during the 24

hours covering 9/5/13, which is in violation of **NYS Correction Law Article 20 §500 - K Treatment of Inmates that applies Article 6 §137 (6)(c)** which states:

> Where such confinement is for a period in excess of twenty-four hours, the superintendent shall arrange for the facility health services director, or a registered nurse or physician's associate approved by the facility health services director to visit such inmate at the expiration of twenty-four hours and at least once in every twenty-four hour period thereafter, during the period of such confinement, to examine into the state of health of the inmate, and the superintendent shall give full consideration to any recommendation that may be made by the facility health services director for measures with respect to dietary needs or conditions of confinement of such inmate required to maintain the health of such inmate.

55. Video Footage of Quad Lower 4 on 9/6/13, revealed the following:

- At 2:49 a.m., an officer and a captain are at Ballard's cell.
- At 3:23 a.m., Ballard is at his cell door and an officer responds.
- At 3:24 a.m., the officer leaves from in front of Ballard's cell.
- At 4:47 a.m., an officer is at Ballard's cell.

56. It is noted at 5:30 a.m. that an officer stationed at a constant supervision post at cell #14 for inmate **M.H.**, abandons his post until 6:22 a.m. This is in violation **9 NYCRR §7003.2 (d)(1,2) Security and Supervision** which states:

> Constant supervision shall mean the uninterrupted personal visual observation of prisoners by facility staff responsible for the care and custody of such prisoners without the aid of any electrical or mechanical surveillance devices. Facility staff shall provide continuous and direct supervision by permanently occupying an established post in close proximity to the prisoners under supervision which shall provide staff with:
>
> (1) a continuous clear view of all prisoners under supervision; and
>
> (2) the ability to immediately and directly intervene in response to situations or behavior observed which threaten the health or safety or prisoners of the good order of the facility.

57. Video Footage of Quad Lower 4 on 9/6/13, revealed the following:

- At 6:13 a.m., the breakfast meal is delivered to Ballard's cell.
- At 7:34 a.m., the constant supervision post at cell #14 is abandoned until 8:46 am in violation of 9 NYCRR §7003.2 (d)(1,2).
- At 9:31 a.m., Ballard is observed to be flooding his cell again.
- At 9:33 a.m., an officer is at Ballard's cell.

58. At 10:24 a.m., Ballard is still flooding his cell. Maintenance staff is observed shutting off the water to Ballard's cell. There is no notation in the logbook as to Ballard's water being shut off in violation of **9 NYCRR §7003.3 (J)(6) (i – iv)**. Additionally, there is no documentation as to who authorized the water deprivation order, how long it was to be in effect, and who was to review it to see if it was still warranted. Although it may be necessary to shut off water to an occupied cell when an inmate is becoming disruptive and flooding the cell, affecting the safety and order of the facility, it must be periodically turned back on for the purposes of flushing the toilet, access to drinking water, and otherwise providing proper sanitation. Ballard's water remained turned off and unchecked for over four and half days through the terminal event. This is in blatant violation of **NYS Correction Law Article 20 §500 – K Treatment of Inmates that applies Article 6 §137 (6)(b)** which states:

> Adequate sanitary and other conditions required for the health of the inmate shall be maintained.

59. Video Footage of Quad Lower 4 on 9/6/13, revealed the following:

- At 1:14 p.m., the lunch meal was delivered to Ballard's cell.
- At 1:25 p.m., an officer opens Ballard's cell door. Ballard tosses out food trays and a cup.
- At 5:48 p.m., the dinner meal tray was delivered to Ballard's cell.
- At 7:00 p.m., a mental health clinician conducts rounds on the unit. The clinician looks in Ballard's cell but does not engage in any conversation with him.
- At 7:22 p.m., rounds were conducted by an Assistant Deputy Warden (ADW; name illegible in logbook). The ADW makes motions that indicate that the area near Ballard's cell was malodorous. There were no orders documented in the logbook to address the situation. The ADW failed to make a command decision and take proper action of an obvious health and safety situation with Ballard's cell which had water shut off to it for over 24 hours.

60. During the 24-hour period covering 9/6/13:

a. Ballard did not have any medications delivered to his cell nor was he seen by any staff from medical which is in violation of **NYS Correction Law Article 20 §500 - K Treatment of Inmates that applies Article 6 §137 (6)(c).**

b. Ballard was not provided with access to a shower in violation **9 NYCRR §7005.2 (a).**

c. Ballard was not afforded any access to exercise in violation of **9 NYCRR §7028.2 (b)(1,2).** Also, no specific written determination was made to deny Ballard's exercise access based on any threat to the safety and security of the facility or others in violation of **9 NYCRR 7028.6 (a)(b).**

d. Ballard was not actually seen by a mental health clinician during mental health rounds. This is in direct violation of **NYC Department of Health and Mental Hygiene Correctional Health Services Policy: MH 26.**

61. Video Footage of Quad Lower 4 on 9/7/13, revealed the following:

- At 5:54 a.m., it appears that Ballard refuses his breakfast meal tray. No tray is delivered.
- At 8:17 a.m., an officer is seen utilizing a deodorizer spray in front of cell #23. Nothing more is noted or documented to address the problem.
- At 12:22 p.m., Ballard's lunch meal tray is delivered.
- At 12:59 p.m., a mental health clinician stops by Ballard's cell and speaks with him briefly. The clinician leaves the area within the minute.
- At 5:00 p.m., Ballard's dinner meal tray is delivered.

62. During the 24-hour period covering 9/7/13:

a. Ballard did not have any medications delivered to his cell nor was he seen by any staff from medical which is in violation of **NYS Correction Law Article 20 §500 - K Treatment of Inmates that applies Article 6 §137 (6)(c).**

b. Ballard was not provided with access to a shower in violation **9 NYCRR §7005.2 (a).**

c. Ballard was not afforded any access to exercise in violation of **9 NYCRR §7028.2 (b)(1,2)** Also, no specific written determination was made to deny Ballard's exercise access based on any threat to the safety and security of the facility or others in violation of **9 NYCRR 7028.6 (a)(b).**

Although Ballard was seen by a mental health clinician, the round

conducted was observed to be a "drive-by" assessment that took less than one minute. This is insufficient to properly assess the daily status of a patient with serious persistent mental illness.

The water to Ballard's cell remained shut off continuously in violation **of NYS Correction Law Article 20 §500 - K Treatment of Inmates** that applies **Article 6 §137 (6)(b)** which states:

> Adequate sanitary and other conditions required for the health of the inmate shall be maintained.

63. Video Footage of Quad Lower 4 on 9/8/13, revealed the following:

- At 12:22 a.m., an officer is seen speaking to Ballard at his cell.
- At 5:28 a.m., a breakfast meal tray is delivered to Ballard's cell.
- At 6:44 a.m., an officer is observed at Ballard's cell speaking to him.
- At 7:53 a.m., an officer is observed at Ballard's cell speaking to him.
- At 8:31 a.m., an officer delivers a drink carton to Ballard's cell.
- At 9:58 a.m., a captain is observed at Ballard's cell speaking to him.
- At 1:00 p.m., the lunch meal is delivered to Ballard's cell.
- At 5:04 p.m., the dinner meal is delivered to Ballard's cell.
- At 7:23 p.m., a mental health clinician was at Ballard's cell. The clinician leaves the area by 7:24 p.m.

64. During the 24-hour period covering 9/8/13:

a. Ballard did not have any medications delivered to his cell nor was he seen by any staff from medical which is in violation of **NYS Correction Law Article 20 §500 - K Treatment of Inmates** that applies **Article 6 §137 (6)(c).**

b. Ballard was not provided with access to a shower in violation of **9 NYCRR §7005.2 (a).**

c. Ballard was not afforded any access to exercise in violation of **9 NYCRR §7028.2 (b)(1,2).** Also no specific written determination was made to deny Ballard's exercise access based on any threat to the safety and security of the facility or others in violation of **9 NYCRR 7028.6 (a)(b).**

d. Although Ballard was seen by a mental health clinician,

the round conducted was observed to be a "drive-by" assessment that took less than one minute. This is insufficient to properly assess the daily status of a patient with persistent mental illness.

e. The water to Ballard's cell remained shut off continuously in violation of NYS Correction Law Article 20 §500 - K Treatment of Inmates that applies **Article 6 §137 (6)(b)** which states:

> Adequate sanitary and other conditions required for the health of the inmate shall be maintained.

65. Video Footage of Quad Lower 4 on 9/9/13, revealed the following:

- At 2:15 a.m., an officer is observed at Ballard's cell with a flashlight looking in. The officer is there until 2:17 a.m. The officer does not enter the cell. There is no notation in the logbook as to what the officer was observing.
- At 5:37 a.m., an officer delivers a small container (unknown) to Ballard. No actual breakfast meal tray was delivered to Ballard's cell.
- At 6:00 am an officer is at Ballard's cell with an inmate porter. An item (unknown) is tossed into Ballard's cell.
- At 8:12 a.m., an officer is observed at Ballard's cell speaking to him.
- At 8:19 a.m., food items were delivered to Ballard by Officer **C**.
- At 10:33 a.m., a Captain and an ADW are at Ballard's cell. Ballard's cell door is opened and they are speaking to Ballard. Ballard's cell door is re-secured at 10:34 a.m. There is no notation in the logbook about the visit with Ballard. No action was taken on Ballard's continued deprivation of running water in his cell by the Captain or ADW in violation of **NYS Correction Law Article 20 §500 - K Treatment of Inmates** that applies **Article 6 §137 (6)(b)**.
- At 12:40 p.m., a lunch meal tray is delivered to Ballard's cell.

66. While viewing the activity around 12:40 p.m. of meal trays being delivered, the neighboring inmate to Ballard in cell 24 is observed to run out of the cell when it is opened to deliver his food. It was noted from viewing the prior 72 hours of video footage that this inmate had also not been provided access out of his cell for exercise, programs, or a shower. It is indicative from the video footage that the violations noted of **9 NYCRR §7028.2 (b)(1,2) Exercise**, and **9 NYCRR §7005.2 (a) Showers** were not specific to Ballard but are pervasive violations in the management of the housing area.

67. Video Footage of Quad Lower 4 on 9/9/13, revealed the following:

- At 5:06 p.m., a mental health clinician is observed doing rounds in the unit but Ballard is not seen.
- At 5:18 p.m., a dinner meal tray is slid underneath Ballard's door to him.
- At 6:18 p.m., an officer and an inmate are at Ballard's cell delivering what appears to be paperwork.
- At 7:45 p.m., the **ADW** [redacted] and Captain [redacted] are seen touring the unit.
- At 9:04 p.m., it is observed that medications are delivered to cell 24 next door to Ballard. No medications were delivered to Ballard.
- At 10:36 p.m., an officer is observed at Ballard's cell speaking to him.
- At 11:56 p.m., an officer is observed at Ballard's cell speaking to him.

68. During the 24-hour period covering 9/9/13:

a. Ballard did not have any medications delivered to his cell nor was he seen by any staff from medical which is in violation of **NYS Correction Law Article 20 §500 - K Treatment of Inmates** that applies **Article 6 §137 (6)(c).**

b. Ballard was not provided with access to a shower in violation of **9 NYCRR §7005.2 (a).**

c. Ballard was not afforded any access to exercise in violation of **9 NYCRR §7028.2 (b)(1,2).** Also, no specific written determination was made to deny Ballard's exercise access based on any threat to the safety and security of the facility or others in violation of **9 NYCRR 7028.6 (a)(b).**

d. Ballard was not actually seen by a mental health clinician during mental health rounds. This is in direct violation of **NYC Department of Health and Mental Hygiene Correctional Health Services Policy: MH 26.**

e. The water to Ballard's cell remained shut off continuously in violation of **NYS Correction Law Article 20 §500 - K Treatment of Inmates** that applies **Article 6 §137 (6)(b)** which states: Adequate sanitary and other conditions required for the health of the inmate shall be maintained.

69. Video Footage of Quad Lower 4 on 9/10/13, revealed the following:

a. Review of the video footage beginning on 9/10/13, revealed that the constant supervision post at cell #14 for inmate **M.H.** is abandoned multiple times. From 1:29 a.m., to 1:37 a.m., (8 minutes), from 1:37 a.m. to 2:13 a.m. (36 minutes), and from

2:14 a.m. to 2:58 a.m. (44 minutes). These are all violations of **9 NYCRR §7003.2 (d)(1,2) Security and Supervision.**

b. Between 2:15 a.m. and 3:15 a.m., no general supervisory tour of the housing area was conducted by the assigned officer. Officer [redacted] was assigned as the "C" post officer for the 11:00 p.m. to the 7:31 a.m. tour. Officer [redacted] made false entries into the housing logbook by signing as having conducted tours at 2:30 a.m. and 3:00 a.m. This is also in violation of **9 NYCRR §7003.2 (a)(1,2)(b)** which states:

(a) Supervisory visit shall mean:

(1) a personal visual observation of each individual prisoner by facility staff responsible for the care and custody of such prisoners to monitor their presence and proper conduct; and
(2) a personal visual inspection of each occupied individual prisoner housing unit and the area immediately surrounding such housing unit by facility staff responsible for the care and custody of prisoners to ensure the safety, security and good order of the facility.
(b) General supervision shall mean the availability to prisoners of facility staff responsible for the care and custody of such prisoners which shall include supervisory visits conducted at 30-minute intervals.

70. At 2:30 a.m., Captain [redacted] signed the logbook for the "C" post indicating a tour of the area was completed; however, the video revealed that no officers walked through the unit for at least an hour. Captain [redacted] made a false entry in the "C" post logbook.

71. At 3:29 a.m., the constant supervision officer left his post and walked down to cell #23 to check on Ballard. The officer remained there until 3:32 a.m.

72. Video Footage of Quad Lower 4 on 9/10/13, revealed the following:

- At 3:30 a.m., the ADW toured the area and signed the log book.
- From 3:35 a.m. to 4:11 a.m., the officer conducting the constant supervision at cell #14 abandoned his post.
- At 3:45 a.m. and 4:00 a.m., Officer [redacted] made two more false entries in the logbook for conducting rounds of the C post. No rounds were observed being conducted on the video.
- At 4:55 a.m., a second security inspection is documented as being done by Officer [redacted] This is also a falsified logbook entry as no security inspection is observed having been conducted on the housing area video.
- At 5:25 a.m., the breakfast meal begins being delivered and Captain [redacted] conducted a tour of the area.

73. At 5:29 a.m., Ballard's cell is opened to deliver a breakfast meal tray. The inmate delivering the tray pulls his shirt up over his nose and mouth indicating that the conditions in Ballard's cell were grossly unsanitary and malodorous. The meal tray was not taken by Ballard. There was no notation in the logbook about the unsanitary conditions in Ballard's cell. Both officers and a supervisor (Captain [redacted]) were in the immediate area to observe this but took no action. This is a violation of **NYS Correction Law Article 20 §500 – K Treatment of Inmates** that applies **Article 6 §137 (6)(b).**

74. Video Footage of Quad Lower 4 on 9/10/13, revealed the following:

- From 5:14 a.m. to 5:55 a.m., the officer conducting the constant supervision at cell #14 abandoned his post.
- From 6:10 a.m. to 7:00 a.m., the officer conducting the constant supervision at cell #14 abandoned his post.
- At 9:22 a.m., Officer [redacted] delivers what appears to be a towel to Ballard's cell.
- At 9:49 a.m., a mental health clinician is seen on the unit but Ballard is not seen.
- It is observed that officers walking by Ballard's cell keep reacting to the malodorous condition coming from it; however, no action is taken.
- At 12:46 p.m., an officer and a civilian are observed at Ballard's cell.
- At 12:57 a.m., a lunch meal tray is delivered to Ballard's cell.
- At 3:00 p.m., Officer [redacted] assumed supervision of the C post for the 3:00 p.m., to 11:00 p.m. tour.
- At 4:18 p.m., an inmate standing near Ballard's cell is observed to be covering his mouth and nose with his shirt.
- At 5:28 p.m., a mental health clinician conducts rounds in the unit but does not see Ballard.
- At 5:35 p.m., an officer opened Ballard's cell and delivered a dinner meal tray.
- At 5:45 p.m., a mental health clinician was observed doing rounds on the unit. Psychiatrist **Dr. N.** is documented as leaving the housing area at 6:45 p.m. Ballard was not seen by the clinician. Ballard had not had a therapeutic clinical encounter with mental health or psychiatry since 9/2/13.
- At 8:21 p.m., an officer is at Ballard's cell checking on him. An inmate standing nearby can be seen covering his nose.

75. At 8:25 p.m., an officer and **ADW** [redacted] are observed at Ballard's cell. The ADW kicks at Ballard's cell and is covering his nose. There was no notation of the obvious unsanitary conditions of Ballard and his cell in the ADW 8:30 p.m. logbook entry. There were no orders or

actions taken to address the situation by the ADW. This is in flagrant violation of **NYS Correction Law Article 20 §500 – K Treatment of Inmates** that applies **Article 6 §137 (6)(b)**.

76. At 8:35 p.m., an officer is seen kicking at Ballard's cell door.

77. At 9:47 p.m., while being let out of his cell for medications, the inmate in cell #24 runs out of the cell and begins to immediately assault another inmate who was standing in the hallway. Officer [redacted] separates the two inmates and secures them in their individual cells.

78. Officer [redacted] documented in a report that he observed Ballard laying naked in his cell and having difficulty breathing at 9:30 p.m. and made notification to the A post officer to contact the clinic. The clinic, however, documents that they were not notified until 10:52 p.m.

79. **Dr. A.H.** and **LPN A.D.** responded from the clinic to Quad 4 Lower along with Officer **D.C.** and two inmate clinic workers. They arrived at Ballard's cell at 10:56 p.m. At 10:57 p.m., Ballard's cell is opened. Neither the medical staff nor the correction officers enter into Ballard's cell. [redacted] Officer [redacted] documented he asked Ballard if he could get up on his own. Ballard attempted to get up but then lay back down and said "I need help."

80. At 11:01 p.m., two inmate workers entered the cell and wrapped Ballard in a blanket. Ballard is then carried out and placed on a gurney. At 11:02 p.m., **Dr. A.H.** is observed doing a brief assessment, and then Ballard is escorted on the gurney out to the clinic. Inmates should never be employed to assist in medical emergencies. It is incumbent upon responding clinicians to encounter and handle the patient.

81. [redacted]

82. [redacted]

[redacted]

83. [redacted]

84. [redacted]

85. [redacted]

[redacted]

86. During the day on 9/11/13, video footage revealed inmates and staff entering into Ballard's cell to conduct cleaning. A mattress that appeared to be covered in feces was removed from the cell. The water was observed being turned back on in Ballard's cell at approximately 4:50 p.m.

RECOMMENDATIONS RE: TERMINAL EVENT:

TO THE ASSISTANT ATTORNEY GENERAL FOR CIVIL RIGHTS, U.S. DEPARTMENT OF JUSTICE:

That the Assistant Attorney General for Civil Rights take official notice of the findings of the Medical Review Board in the case cited herein and initiate both individual criminal civil rights investigations and a CRIPA investigation into the New York City Department of Correction's Anna M. Kross Center and their contracted medical provider, Corizon Inc.

TO THE COMMISSIONER OF NYC DEPARTMENT OF CORRECTION:

1. The Commissioner should remove Warden [redacted] assigned to AMKC during Ballard's terminal event from all command duties due to failing to maintain a correctional facility in a safe, stable, and humane manner and in violation of NYS Correctional Law and NYS Minimum Standards and Regulations for Management of County Jails and Penitentiaries.

2. The Commissioner shall conduct an investigation into the conduct of the Assistant Deputy Warden who conducted rounds of Ballard's housing area on 9/6/13, at 7:22 p.m. who failed to take administrative action regarding Ballard's water being turned off. At the completion of the investigation, administrative action shall be taken for any identified misconduct.

3. The Commissioner shall conduct an investigation into the conduct of the Assistant Deputy Warden and Captain present at Ballard's cell on 9/9/13, at 10:33 a.m., who violated NYS Correction Law by failing to take administrative action regarding Ballard's water being turned off. At the completion of the investigation, administrative action shall be taken for any identified misconduct.

4. The Commissioner shall conduct an investigation into the conduct of the Assistant Deputy Warden who was present at Ballard's cell on

9/10/13, at 8:25 p.m., who failed to take any administrative action regarding Ballard's obvious unsanitary living conditions and deteriorating health. The Medical Review Board opines that the ADW should be removed from all supervisory capacity for failing to properly maintain a correctional facility in a safe, stable, and humane manner in accordance with NYS Correction Law and should be the subject of administrative action.

5. The Commissioner shall conduct an investigation and take administrative action regarding the misconduct of Captain [redacted] who:

- Made a false entry in the Quad Lower 4 "C" post logbook on 9/10/13, at 2:30 a.m., when video evidence showed no tour was completed.
- Violated NYS Correction Law by failing to take appropriate action on 9/10/13 at 5:29 am when the captain was present to observe conditions in Ballard's cell that were grossly unsanitary and inhumane.

6. The Commissioner shall conduct an investigation and take administrative action regarding the official misconduct of Officer [redacted], assigned to supervision of Quad Lower 4 housing area on 9/10/13, from 11:00 p.m. to 7:31 a.m., who made false logbook entries for completing supervisory tours when video evidence shows no tour was completed.

7. The Commissioner shall conduct an investigation into the actions of Officer [redacted] on 9/10/13, who failed to notify the medical clinic in a timely manner when Ballard was observed to be in severe distress. At the completion of the investigation, administrative action shall be taken for any identified misconduct.

8. The Commissioner shall <u>immediately</u> revise and implement procedures for water deprivation orders in special housing situations. Revised procedures must include the following:

- All deprivation orders must be authorized by an Assistant Deputy Warden or higher ranking official.
- Each deprivation order must be reviewed on a daily basis by a Deputy Warden or an Assistance Deputy Warden who is assigned as a watch commander. The review shall be documented by the reviewing Warden.
- Deprivation orders may only be in effect for seven (7) days and must be re-authorized and approved by the Warden.
- Any deprivation order for "mental health" reasons must be approved by an appropriate clinical professional.
- During an active water deprivation order, an inmate's in cell water must be turned on minimally for ten (10) minutes five (5) times a day as follows: approximately 30 minutes prior to

the service of each meal; once during the night shift and once during the evening shift.

- All times water is turned on and off must be appropriately documented in the housing area log book.

9. The Commissioner shall review policy and procedures and take administrative action to assure that staff are in compliance with **9 NYCRR § 7006.4 (a) (b) (1-5) Misbehavior reports and §7006.7 (a) (b) (c) Administrative segregation pending a disciplinary hearing.**

10. The Commissioner shall review policy and procedures and take administrative action to assure that staff are in compliance with **9 NYCRR §7003.3 (J) (6) (i – iv)** that requires "any significant events and activities occurring during supervision" be properly documented in the logbook.

11. The Commissioner shall review policy and procedures and take administrative action to assure that staff are in compliance with **9 NYCRR §7005.2 (a) Showers;** in that inmates who are administratively segregated are given access to showers in accordance with the standard requirements.

12. The Commissioner shall review policy and procedures and take administrative action to assure that staff are in compliance with **9 NYCRR §7028.2 (b) (1,2)** in that all inmates are provided with daily access to outdoor exercise periods and in compliance with **9 NYCRR 7028.6 (a) (b)** in that any determination to revoke or deny an inmate access to exercise must be made by the chief administrative officer with documented justification why such order is in effect.

13. The Commissioner shall review policy and procedures and take administrative action to assure that staff are in compliance with **9 NYCRR §7003.2 (d) (1,2) Security and Supervision** in that constant supervision posts are continuously occupied until properly relieved as required by the standard.

14. The Commission shall provide the Medical Review Board with a comprehensive report on all administrative and corrective actions taken on or before **November 21, 2014.**

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

1. The Deputy Commissioner should consider and determine whether Corizon, Inc., a business corporation holding itself out as a medical care provider, is fit to continue as a New York City service contractor in light of delivery of flagrantly inadequate, substandard and dangerous medical and mental health care to Bradley Ballard.

2. The Deputy Commissioner shall review the conduct of all clinic staff assigned to conduct rounds in the mental health observation housing area between 9/4/13, and 9/10/13. The review shall focus on:

   a. Failure to make daily or adequate contact with mental health clinicians did not occur with Bradley Ballard.

   b. Failure of clinicians to observe, make notification, and otherwise take appropriate action of a patient who obviously was in extremis.

   At the completion of the review administrative, action shall be taken for any identified misconduct.

3. The Deputy Commissioner shall conduct a review with the AMKC mental health unit chiefs as to why Ballard was not scheduled clinical appointments as part of his approved treatment plan between 9/3/13, and 9/10/13. At the completion of the review, administrative action shall be taken for any identified misconduct.

4. The Deputy Commissioner shall conduct an inquiry as to the failure to deliver medical and/or psychiatric medications to Ballard between 9/3/13, and 9/10/13. The Deputy Commissioner shall make administrative changes necessary to assure that patients who are administratively segregated are provided prescribed medications. At the completion of the review, administrative action shall be taken for any identified misconduct.

5. The Deputy Commissioner shall conduct a review of the professional conduct of **Dr. A.H.** and **LPN A.D.** who both failed to immediately attend to and remove Ballard from his cell and inappropriately ordered inmates to perform said rescue measures in their place. The practice of utilizing inmate workers in the medical clinics or at medical emergency scenes to perform work tasks beyond routine sanitation and cleaning or porter duties shall cease immediately. At the completion of the review administrative, action shall be taken for any identified misconduct.

6. The Deputy Commissioner shall conduct a review of the delivery medical services to inmates who are placed in punitive or administrative segregation to assure that inmates are seen by medical staff daily in compliance with **NYS Correction Law Article 20 §500 - K Treatment of Inmates** that applies **Article 6 §137 (6)(c)**. The Deputy Commissioner shall provide the Medical Review Board with a comprehensive report of the review findings and corrective actions taken.

7. The Deputy Commissioner shall conduct a thorough review of delivery of mental health services to patients in mental health observation units in AMKC, and throughout the Department's institutions. The Deputy Commissioner shall implement administrative changes necessary to assure compliance with NYC Department of Health and Mental

Hygiene Correctional Health Services Policy: MH 26 that requires clinicians to conduct daily rounds in the mental health observation units. The Deputy Commissioner shall provide a comprehensive report to the Medical Review Board with findings and corrective actions taken on or before **November 21, 2014.**

WITNESS, HONORABLE PHYLLIS HARRISON-ROSS, M.D., Commissioner, NYS Commission of Correction, Alfred E. Smith Office Building, 80 South Swan Street, 12th Floor, in the City of Albany, New York 12210 this 16th day of December 16, 2014.

Phyllis Harrison-Ross, M.D.
Commissioner

PH-CO:ams
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12/14

cc: Eric Berliner, Deputy Commissioner,
Health Services Unit
Heidi Grossman, General Counsel/Acting Chief of Staff
Sonia Angell, M.D., Deputy Commissioner
Division of Prevention and Primary Care
Department of Health & Mental Hygiene
George Axelrod, Deputy Executive Director,
NYC Department of Health & Mental Hygiene
Homer Venters, Assistant Commissioner
Stuart Delery, Assistant Attorney General
For Civil Rights, US Department of Justice