NEW YORK STATE COMMISSION OF CORRECTION

In the Matter of the Death of Kevin Brown, an inmate of the Nassau County Correctional Center	: : : : :	FINAL REPORT OF THE NEW YORK STATE COMMISSION OF CORRECTION

TO: Sheriff Michael J. Sposato
Nassau County Sheriff's Office
100 Carman Avenue
East Meadow, New York 11554

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 Kevin Brown who died on February 10, 2014, as a result of circumstances which occurred while an inmate in the custody of the Nassau County Sheriff at the Nassau County Correctional Center, the Commission has determined that the following final report be issued.

FINDINGS:

1. Kevin Brown was a 47-year-old male who died on 2/10/14, of cardiac failure due to hypertensive cardiovascular disease while in custody of the Nassau County Sheriff at the Nassau County Correctional Center (NCCC). Brown entered the jail with known histories of traumatic brain injury, seizures, hypertension, and mental health diagnoses. Medical and mental health care provided to Brown at NCCC by Amor Inc., was deficient resulting in a mismanaged mental health diagnosis, inadequate psychiatric care in response to deteriorating behavior, undiagnosed or managed hypertensive cardiovascular disease, and inadequate medical management of a seizure disorder. This was compounded by a health record that was unorganized, incomplete, and in selected sections, illegible. The Medical Review Board finds that Amor Inc., in its contracted locations in New York State, has engaged in a pattern of inadequate and neglectful medical care and questions their ability to meet and provide for the healthcare needs of jail inmates. Additionally, Brown was found at the terminal event in full rigor mortis indicating that proper supervision in accordance with NYS Minimum Standards was not maintained. The Medical Review Board opines that had Brown received proper medical care and supervision, his death may have been prevented.

2. Brown was born in New York State. He was single with no children and his mother was listed as his only relative. He was unemployed. He reported occasional marijuana and alcohol use. Much of his history is unclear as Brown was not cooperative during his intake. He never gave information regarding his family history or education.

3. Brown was arrested by the Nassau County Police Department on 1/13/14 for Pettit Larceny. The police department took him to Nassau University Medical Center prior to admission to the correctional center because he appeared to be under the influence of a substance. Brown was deemed physically fit for confinement.

4. [redacted]

5. Brown was taken to the Nassau County Correctional Center and admitted at 8:36 p.m. on 1/14/14. Brown appeared to be responding to hallucinations during his intake medical and mental health evaluations. He was returned to Nassau University Medical Center for further assessment. Brown was deemed psychiatrically fit for confinement and returned to the Correctional Center.

6. [redacted]

7. [redacted]

8. [redacted]

9. [redacted] There was no formal referral form that described why the referral was made or documenting any of the clinical indicators. Per Commission's interview with mental health staff during the investigation, the record was to be reviewed by the psychiatric provider to ascertain the reason for referral. The Medical Review Board finds this to be a wholly inadequate system for assuring a proper referral is made to a psychiatric provider.

10. At 11:15 p.m. on 1/14/14, Brown was escorted to his cell [redacted] Brown's supervision records show he slept in intervals through the night. It is also documented that inmate needed several verbal cues to understand directions.

11. Per the supervision log, Dr. [redacted] came on post at 9:32 a.m. on 1/15/14. He was off post at 9:45 a.m. [redacted]

12. [redacted]

13. [redacted]

14. [redacted] The Medical Review Boards finds that the lack of a physician assessment and consideration for transfer to a hospital on a patient experiencing a medical emergency such as a seizure is evident of negligent medical care.

15. [redacted]

16. [redacted]

17. [redacted]

18. [redacted]

19. [redacted]

20. [redacted]

21. [redacted]

22. [redacted]

23. [redacted] Dr. [redacted] was no longer employed by Amor Inc. at the time of the Commission's investigation. Brown remained cleared for general population.

24. [redacted]

25. On 1/23/14, Brown moved to a [redacted] on E01-F Block [redacted]

26. [redacted]

27. [redacted]

28. [redacted]

29. [redacted]

30. At 7:30 a.m., on 1/28/14, corrections staff requested mental health to assess Brown again after being found standing naked in his cell covered with white powder. When asked what he was doing Brown replied, *"Can't you see I just got out of the shower, Stupid."* Brown had no shower in his cell and had not yet been out to shower. [redacted]

31. [redacted]

32. [redacted]

33. On 2/2/14, at 9:35 a.m., Brown was released from his cell to get medications, and he walked directly to the shower. He was noted to be covered with urine and feces. He began showering with his clothes on. He then became violent throwing bars of soap at corrections staff and the nurse. Corrections staff utilized Oleoresin Capsicum (OC) spray and the restraint chair to control Brown. [redacted]

[redacted]

34. [redacted]

35. [redacted] The Medical Review Board finds that the psychiatric care provided to Brown by Armor Inc. was inadequate. Despite having evidence of active hallucinations at admission and increasingly agitated behavior, Brown never was provided with a full psychiatric assessment with appropriate diagnosis.

36. On 2/4/14, constant watch documents showed Brown's only unusual behavior was flushing the toilet repeatedly. [redacted]

37. [redacted]

38. During the investigation interview by Commission staff, Clinical Coordinator [redacted] stated that there are *"informal and formal meetings"* to communicate inmate issues. He stated that he *"usually meets one to one"* with his staff. He stated that he communicates with the psychiatrist *"if an inmate has an issue."* There is no documentation showing any discussion took place regarding Mr. Brown.

39. [redacted]

40. [redacted]

41. [redacted] The Medical Review Board finds that medical management of Brown's seizure disorder by Armor Inc. was grossly inadequate and failed to properly address his continued non-compliance with medication and sub-therapeutic levels, an issue that has substantial health risks. The Medical Review Board also finds that changing Brown's seizure medical management without requisite lab values and absent any physical assessment is improper medical practice.

42. [redacted]

43. [redacted]

44. [redacted]

45. The night tour on 2/10/14, was reported to be without any unusual activity by Correction Officers [redacted] and [redacted] When interviewed by Commission staff, [redacted] who was assigned to the supervision of the unit, stated he did rounds every 15 minutes utilizing a flashlight or lantern. According to a review of the security time recording system, rounds were made timely on the unit by Officer [redacted] Officer [redacted] was on a 1:1 constant watch at cell 10 and remained in the area the entire shift.

46. The first four cells on B3D, at the time of terminal event, had plexi glass plates that were on both sets of bars between the walk way and Brown. Officers consistently reported during interviews with Commission staff that the plexi glass was scratched and difficult to see through.

47. At 6:15a.m., Brown did not rise for a standing count conducted by Corporal [redacted] The corporal continued rounds and returned to Brown's cell at 6:20 a.m. Corporal [redacted] attempted to wake Brown but was unsuccessful. The supervisor was notified. Following the arrival of Sergeant [redacted] the cell was opened and Brown was found face down, unresponsive and rigid. Medical staff were notified.

48. [redacted]

49. Upon his discovery at 6:20 a.m., Brown was found with obvious advanced signs of death including the body being in full rigor mortis. This indicates death in excess of four hours when he was discovered. This is in violation of 9 NYCRR §7003.2 (a)(1)(2) which states:

> (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."*

50. Local Emergency Medical Services arrived on scene and pronounced Brown dead at 6:55 a.m.

RECOMMENDATIONS:

TO THE CHIEF EXECUTIVE OFFICER OF ARMOR INC.:

1. Armor Inc. shall establish an organized and uniform health record for inmate health and mental health care documentation. Forms must be completed thoroughly, signed, dated and legible. Forms must be filed by date in clearly labeled sections. All forms must be secured to the record. A consistent format for all inmate records must be adhered to in order for adequate review by providers in order to deliver accurate care.

2. Armor Inc. shall conduct a detailed quality assurance review regarding the medical care provided to Kevin Brown with a focus on the following:

   - Why community provider records were not actively sought after by medical staff [redacted]

- Why Brown's continued non-compliance with medication [redacted] were not more aggressively addressed by providers including any consideration of using liquid medication to achieve compliance?

- Why a provider changed Brown's level of [redacted] without requisite lab values or proper assessment?

- Why Brown was not assessed by a physician and transported to a hospital after having two episodes of seizures on 1/15/14?

- Why a baseline neurologic diagnostic workup was not ordered by the physician for Brown, a patient with a known history of traumatic brain injury and had active seizures?

The results of this review shall be forwarded to the Medical Review Board in response to the Preliminary Report.

3. Armor Inc. shall conduct a detailed quality assurance review regarding the mental health care provided to Kevin Brown with a focus on the following:

   - Why Brown did not receive a full psychiatric assessment despite multiple referrals from clinical staff indicating such was needed?

   - Why Brown's overtly psychotic, disoriented, and aggressive symptoms, that were progressively deteriorating, were not addressed despite being repeatedly referred for evaluation?

4. Armor Inc. shall develop an effective system of communication between mental health care team providers, psychiatry and other members of the interdisciplinary team. The plan must include a referral form from clinical staff to the psychiatrist indicating specific reason for referral, associated behaviors and requests for complete psychiatric evaluations to confirm a *"Rule out"* diagnosis. These referrals must not be limited to inmates who take medications. The plan must also include routine clinical meetings, and procedures for communication to non-mental health staff regarding recommendations to assist with management of inmates with mental illness.

<u>TO THE OFFICE OF THE NASSAU COUNTY SHERIFF</u>:

1. The Sheriff shall review the policy for supervision of inmates to include that security rounds involve checking for the presence of each inmate under their care and assuring signs of life. In cases where visualization of an inmate is impeded by a physical barrier, the officer must take steps to directly observe the inmate. Failure to do so results in a violation of NYS Commission of Correction Standard 7003.2. Additionally, any situation in which visualization is impeded, should be reported to their supervisor for rectification. This is especially important in high risk areas such as Behavior Management Units, Medical Units and other areas of heightened supervision.

2. The Office of the Nassau County Sheriff should conduct an investigation and disciplinary proceedings of Correction Officer [redacted] who failed to comply with 9 NYCRR §7003.2 (a)(1) by not assuring a personal observation of each individual prisoner was conducted.

TO THE PRESIDING OFFICER NASSAU COUNTY LEGISLATURE:

The Nassau County Legislature shall conduct an inquiry into the fitness of Armor Correctional Health Services, Inc. as a correctional medical care provider in the Nassau County Correctional Center. Specific attention shall be directed to Armor's pattern of failing to properly manage patients chronic medical needs, failing to maintain proper and organized patient records, and failing to provide hospitalization for patients when clinically indicated.

WITNESS, HONORABLE PHYLLIS HARRISON-ROSS, M.D., Commissioner, NYS Commission of Correction, Alfred E. Smith State Office Building, 80 South Swan Street, 12th Floor, in the City of Albany, New York 12210 this 15th day of September, 2015.

Phyllis Harrison-Ross, M.D.

Phyllis Harrison-Ross, M.D.
Commissioner

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9/15

Cc: Bruce A. Teal, Chief Executive Officer, Armor, Inc.
Karen Davis, Regional Vice President, Armor, Inc.
Norma L. Gonsalves, Presiding Officer
Nassau County Legislature