Commission of Correction

Final Report of the New York State Commission of Correction:

In the Matter of the Special Investigation into the Care and Treatment Provided to

Antonio Bradley, an incarcerated individual of the Anna M. Kross Center

March 26, 2025

To: Commissioner Lynelle Maginley-Liddie
NYC Department of Correction
75-20 Astoria Blvd., Suite 100
East Elmhurst, NY 11370

Allen Riley
Chairman

Yolanda Canty
Commissioner

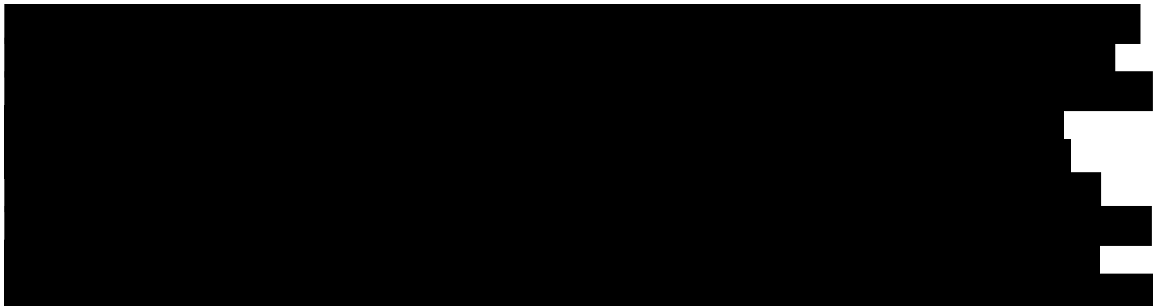
Elizabeth Gaynes
Commissioner

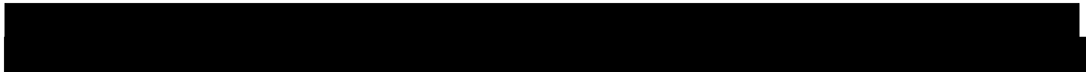
GREETINGS:

WHEREAS, the Medical Review Board has reported to the NYS Commission of Correction pursuant to Correction Law, section 47(1)(e), regarding the care and treatment provided to Antonio Bradley, which occurred while an incarcerated individual in the custody of the NYC Department of Correction, the Commission has determined that the following final report be issued.

FINDINGS:

1. Antonio Bradley was a 28-year-old male who died on 6/18/22 from a suicidal hanging attempt that occurred on 6/10/22 while in the custody of the New York City Department of Corrections (NYC DOC) at the Bronx Hall of Justice after making a court appearance. Bradley had been in custody of NYC DOC at the Anna M. Kross Center (AMKC) during his course of incarceration. Bradley was released from custody from NYC DOC while hospitalized after the incident. The Medical Review Board has found there were significant failures by Correctional Health Services (CHS) to provide Bradley with acceptable levels of medical, mental health, and psychiatric treatment during his incarceration. The Board opines that had Bradley received proper care including proper medication management, proper risk assessments and referral for in-patient hospitalization, his death may have been prevented. The Board has also found that chronic staffing issues at NYC DOC during 2021 lead to the inability to provide adequate safety and supervision for incarcerated individuals as Bradley had numerous instances of needing to be on suicide watch but had no staff supervising him.

2.  In August 2019, Bradley was charged with Assault 3rd Degree which was abated by his death. In June 2020, Bradley was charged with Acting in a Manner Injurious to a Child less than 17, Menacing 3rd Degree, and Criminal Mischief 4th Degree. The charges were abated by his death. In January 2021, Bradley was charged with Robbery 3rd Degree and was arraigned for Petit Larceny and Criminal Possession Stolen Property (CPSP) 5th Degree which were abated by his death. In June 2021, Bradley was charged with Robbery 1st Degree, Assault 2nd Degree, Criminal Mischief, and Criminal Possession Weapon 4th Degree which were abated by his death. In October 2021, Bradley was charged with two counts Criminal Possession Weapon 2nd Degree, three counts Criminal Possession Weapon 3rd Degree, Assault 2nd Degree and 3rd Degree, Criminal Possession Firearm, Unlawful Possession of a Large Capacity Ammunition Feeding Device, Resisting Arrest, General Violation Local Law, Harassment 2nd Degree, and Criminal Possession Weapon 4th Degree. The charges were abated by his death.

3. 

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4. On 10/15/21, Bradley was received at the NYC DOC at Eric M. Taylor Center (EMTC). The arraignment and classification risk screening form was not signed by the receiving supervisor. This is a violation of 9 NYCRR §7013.7(a) which states:

   Each inmate upon admission to a facility shall undergo an initial screening and risk assessment which shall consist of a screening interview, visual assessment and review of commitment documents. Such screening and risk assessment shall occur immediately upon an inmate's admission.

   This is also a violation of 9 NYCRR §7013.7(b)(11) which states: *A screening instrument(s) shall be utilized to elicit and record information on each inmate relating to the following: any other relevant information concerning the safety or welfare of the inmate*.

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7. On 10/17/21 at 1:04 p.m., Bradley was not produced by DOC staff

8. On 10/18/21 at 12:35 p.m., Bradley was not produced by DOC staff At 4:40 p.m., Bradley was not produced by DOC staff . At 8:42 p.m., Bradley was not produced by DOC staff .

9. On 10/19/21 at 12:32 p.m., Bradley was not produced by DOC staff as he was at court. At 11:39 p.m., Bradley was not produced by DOC staff for .

10. On 10/20/21 at 9:28 a.m., Bradley was not produced by DOC staff [redacted].

11. On 10/22/21, 10/23/21, 10/26/21, 10/27/21, 10/29/21, 11/3/21, and 11/4/21 Bradley was not produced by DOC staff [redacted].

12. On 10/25/21, 11/2/21, and 11/5/21, Bradley was not produced by DOC staff [redacted]

13. [redacted]. The Medical Review Board finds that the repeated pattern of failing to produce individuals for scheduled appointments is an unacceptable practice and is tantamount to denying incarcerated individuals access to health care.

14. [redacted]

15. [redacted]

. The Medical Review Board opines that there was an unacceptable delay in obtaining a psychiatric evaluation of Bradley, a patient with a known psychiatric history who had a stat referral from the admission physician. Additionally, the Board opines that Bradley was improperly discharged from Bellevue Hospital. The Board finds that CHS providers failed to recognize Bradley's chronic suicidality and that he needed in-patient psychiatric hospitalization for stabilization.

16. On 11/9/21, Bradley was not produced by DOC staff

17. On 11/10/21, Bradley was not produced by DOC staff as there was no escort.

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27. On 11/20/21, Bradley was not produced by DOC staff

28. On 11/21/21, Bradley was not produced by DOC staff

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30. On 11/23/21, The Medical Review Board opines that the clinical review and removal of Bradley's Schizoaffective Disorder diagnosis was in error as substance abuse history does not eliminate the pathway and symptomatology of Schizoaffective disorder. On 11/23/21, There was no suicide watch logbook or Enhanced Supervision Officer (ESO) assigned. There was no documentation provided to indicate any notification or action was taken to protect Bradley from self-harm with no ESO assigned. The lack of an officer assigned to Bradley's suicide watch is a violation of 9 NYCRR §7003.3(h) which states:

(h) The chief administrative officer and/or the facility physician shall determine whether a prisoner requires additional supervision based on the prisoner's condition, illness or injury, and the chief administrative officer shall order such supervision if warranted. Additional supervision may include:

(1) more frequent supervisory visits;
(2) active supervision when only general supervision is required; or
(3) constant supervision.

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33. On 11/26/21, Bradley was not produced by DOC staff

34. On 11/27/21, DOC would not allow staff to enter the house area due to security issues. The DOC staff stated that a peer was not allowing anyone to enter the unit.

35. On 11/28/21, . There was no ESO assigned. There was no documentation provided to indicate any notification or action was taken to protect Bradley from self-harm with no ESO assigned in violation of 9 NYCRR §7003.3(h).

36. On 11/29/21, [redacted] There was no ESO officer assigned. There was no documentation provided to indicate any notification or action was taken to protect Bradley from self-harm with no ESO assigned in violation of 9 NYCRR §7003.3(h). There was no documentation regarding Bradley's reported attempt to hang up. [redacted].

37. On 11/30/21, [redacted] There was no ESO officer assigned. There was no documentation provided to indicate any notification or action was taken to protect Bradley from self-harm with no ESO assigned in violation of 9 NYCRR §7003.3(h). Bradley was not produced by DOC staff [redacted]. Per DOC there was no escort available.

38. On 12/1/21, [redacted] there was no ESO assigned and there was no documentation provided to indicate any notification or action was taken to protect Bradley from self-harm with no ESO assigned in violation of 9 NYCRR §7003.3(h). [redacted] The Medical Review Board has found that there was a failure by medical to assess Bradley after the reported overdose as there was no documentation provided that indicated any evaluation occurred. Additionally, the Board finds that there was no proper psychiatric evaluation completed of Bradley's reported suicide attempt nor any consideration of in-patient hospitalization in response to it.

39. On 12/2/21, [redacted];

. There was no ESO assigned. There was no documentation provided to indicate any notification or action was taken to protect Bradley from self-harm with no ESO assigned in violation of 9 NYCRR §7003.3(h).

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43. On 12/4/21, There was no ESO assigned. There was no documentation provided to indicate any notification or action was taken to protect Bradley from self-harm with no ESO assigned in violation of 9 NYCRR §7003.3(h).

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45. On 12/6/21,

there was no ESO assigned and there was no documentation provided to indicate any notification or action was taken to protect Bradley from self-harm with no ESO assigned in violation of 9 NYCRR §7003.3(h).

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48. On 12/14/21, there was no ESO assigned and there was no documentation provided to indicate any notification or action was taken to protect Bradley from self-harm with no ESO assigned in violation of 9 NYCRR §7003.3(h).

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51. On 12/17/21, r." There was no ESO assigned. There was no documentation provided to indicate any notification

or action was taken to protect Bradley from self-harm with no ESO assigned in violation of 9 NYCRR §7003.3(h).

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54. On 12/20/21, The floor officer was assigned to the ESO post. There was no documentation provided to indicate any notification or action was taken to protect Bradley from self-harm with no ESO assigned in violation of 9 NYCRR §7003.3(h).

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57. On 12/23/21, . There was no ESO assigned. There was no documentation provided to indicate any notification or action was taken to protect Bradley from self-harm with no ESO assigned in violation of 9 NYCRR §7003.3(h).

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59. On 12/25/21, There was no ESO assigned. There was no

documentation provided to indicate any notification or action was taken to protect Bradley from self-harm with no ESO assigned in violation of 9 NYCRR §7003.3(h).

60. On 12/26/21, " There was no ESO assigned. There was no documentation provided to indicate any notification or action was taken to protect Bradley from self-harm with no ESO assigned in violation of 9 NYCRR §7003.3(h).

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62. On 12/28/21 at 3:06 p.m., LMSW . attempts to enter the Mod 9 housing area were unsuccessful. LMSW . noted that there was either no officer in the control room or they were not answering. LMSW documented that a supervisor was informed but there was no further information available regarding what occurred.

63. On 12/29/21, . Later that evening, LMSW . was unable to assess due to an altercation in the housing area. LMSW . was advised by DOC staff that a fight had just occurred.

64. On 12/30/21, LMSW . but due to lack of staffing was unable to enter the unit. There was no ESO assigned. . There was no ESO assigned. There was no documentation provided to indicate any notification or action was taken to protect Bradley from self-harm with no ESO assigned in violation of 9 NYCRR §7003.3(h). . There was no documentation provided to the Commission to indicate that DOC staff were notified of substance use.

65. On 12/31/21, There was no ESO assigned. There was no documentation provided to indicate any notification or action was taken to protect Bradley from self-harm with no ESO assigned in violation of 9 NYCRR §7003.3(h).

66. On 12/6/21, 12/10/21, 12/12/21, and 12/14/21, Bradley was not produced by DOC staff . On 12/2/21, 12/4/21, 12/15/21, 12/16/21,

12/18/21, and 12/23/21, Bradley was not produced by DOC staff On 12/20/21, Bradley was not produced by DOC staff Per DOC staff Bradley had refused. The Medical Review Board finds that the repeated pattern of failing to produce individuals for scheduled appointments is an unacceptable practice and is tantamount to denying incarcerated individuals access to health care.

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68. On 1/2/22, . There was no ESO assigned. There was no documentation provided to indicate any notification or action was taken to protect Bradley from self-harm with no ESO assigned.

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74. On 1/20/22, Bradley was transferred for two days to Westchester County Correctional for another court case, . Bradley had returned to NYC DOC for his present charge.

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76. On 1/3/22, two times on 1/4/22, and 1/5/22, Bradley was not produced by DOC staff On 1/31/22, Bradley was not produced by DOC staff

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81. . The Medical Review Board opines that Bradley's established history and lack of current hallucination symptoms was indicative that he needed an antipsychotic therapy regimen and that his prescribed medication was being effective, thus a clinical error by PA - . to discontinue the medication and a failure to assure there was adequate mid-level provider supervision by the attending psychiatrist.

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85. On 2/18/22, 2/19/22, 2/20/22, and 2/23/22, Bradley was not produced by DOC staff

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89. . The Medical Review Board again finds another error in clinical judgment by PA . by now prescribing a different antipsychotic therapy to Bradley nearly 28 days after discontinuing Risperdal to which Bradley had effective therapeutic response.

90. On 3/8/22, There was no documentation provided to the Commission staff that DOC staff was notified of the substance use.

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94. The Medical Review Board finds that this was a substantial error by CHS clinical staff. Bradley had long term depression symptoms with at times minimal response to prescribed therapies. There was little evidence to suggest that Bradley would function safely in custody without a therapeutic support housing assignment and program.

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97. On 3/28/22, There was no ESO assigned. There was no documentation provided to indicate any notification or action was taken to protect Bradley from self-harm with no ESO assigned.

98. [redacted]

99. On 3/1/22, 3/4/22, 3/8/22, 3/9/22, 3/12/22, 3/19/22, twice on 3/23/22, and 3/29/22, Bradley was not produced by DOC staff [redacted].

100. On 3/30/22, [redacted] Upon arrival to the MOD bridge, an overwhelming odor of substances was observed. Due to lack of DOC officers on the unit and active substance use, [redacted] [redacted]. [redacted]

101. [redacted]

102. [redacted]

103. [redacted]

104. On 4/3/22, Bradley was not produced by DOC staff [redacted]

105. [redacted]

106. [redacted].

107. [redacted]

108. [redacted].

109. [redacted]

110. [redacted]

111. [redacted]

112. [redacted]

113. [redacted]

114. On 4/25/22, Bradley was at court in the Bronx Hall of Justice and the officer observed Bradley with a sweatshirt wrapped around his neck and attaching the sweatshirt to the gate. The Officer entered the pen and gave orders for Bradley to stop and he complied. [redacted]. There was no documentation supplied to the Commission to support that medical evaluated Bradley and there was no mental health referral in the records provided.

115. On 4/26/22, Bradley was not produced by DOC staff

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117. On 4/28/22, There was no documentation provided to the Commission to indicate that DOC staff was notified of the medications that Bradley reported possessing medications.

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123. On 5/8/22, 5/10/22, 5/17/22, and 5/25/22, Bradley was not produced by DOC staff . On 5/13/22 and 5/16/22, Bradley was not produced by DOC staff

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128. On 6/1/22, Bradley was not produced by DOC staff .

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135. On 6/7/22, [redacted]. The Medical Review Board opines that Bradley was improperly removed from suicide watch by CHS clinical staff having expressed suicidal ideation less than 24 hours earlier. Additionally, having a known prior incident at court, knowing that court appearance was an emotional trigger for Bradley to self-harm, and another appearance pending, suicide watch measures should have remained in place.

136. On 6/10/22, Bradley was not produced by DOC staff [redacted] Bradley was at court.

137. On 6/10/22. Bradley was transported to the Bronx Hall of Justice for his court appearance. Following his appearance Bradley was placed in pen #51 awaiting transport back to NYC DOC. Per the logbook active supervision tours were completed every 30 minutes with nothing unusual to report. The last supervisory tour was completed at 4:00 p.m. At 4:33 p.m., Captain C. was conducting a tour when he observed Bradley with a sweatshirt tied around his neck against the cell door. Captain C. called for assistance. CO C. responded and cut Bradley down. CO K.R., CO H.A., and CO S. responded and initiated Cardiopulmonary Resuscitation (CPR). CO H.A. applied the Automated External Defibrillator (AED). At 4:36 p.m., Emergency Medical Services (EMS) was activated and CPR was continued with rescue breaths administered. At 4:49 p.m., EMS arrived and assumed care of Bradley. [redacted]

138. On 6/15/22, Bradley was released from DOC custody. There was no Reportable Incident regarding Bradley's release from custody. This is a violation of violation of 9 NYCRR §7022.2(b) *which states:*
Each facility shall report incidents to the commission pursuant to the requirements outlined in the commission's Reportable Incident Guidelines for County Correctional Facilities.

139. On 6/18/22, following examination by two physicians, Bradley was determined to be brain dead and was pronounced dead.

140. On 6/13/22, RN C.T. documented that education was given to Bradley as he had refused his morning medications. After education and counselling, Bradley continued to refuse his medication. The Medical Review Board finds that this was false documentation as Bradley was hospitalized in a coma from 6/10/24 to 6/18/24.

<u>ACTIONS REQUIRED</u>**:**

<u>TO THE COMMISSIONER OF THE NEW YORK CITY DEPARTMENT OF CORRECTIONS:</u>

1. The Commissioner shall conduct an investigation into the staff that failed to properly complete the Classification of Bradley in comportment with 9 NYCRR §7013.7(a) and 9

NYCRR §7013.7(b)(11). Administrative action should be taken if staff are found to be in violation of department directives.

2. The Commissioner shall conduct an investigation into the failure of the Department to assign ESO staff to Bradley when he was placed on a constant supervision for suicidal ideations.

3. The Commissioner shall conduct an investigation into why Bradley was not produced to medical staff on 11/29/21 after reportedly attempting to hang himself and on 12/1/21 after reportedly swallowing multiple pills.

4. The Commissioner shall conduct an investigation into why staff were unable to enter a housing area on 12/28/21 and 12/30/21.

5. The Commissioner shall conduct an investigation into the failure of DOC staff to address illicit substance use on the housing units as noted on 12/30/21 and 3/30/22.

6. The Commissioner shall conduct an investigation into the failure of DOC staff to produce Bradley for 58 medical or mental health call outs during his incarceration. The Commissioner shall provide the Board with a comprehensive correction action plan to address this issue, an issue the Board has cited numerous times regarding in-custody mortalities, with a system of individual and staff accountability when medical appointments are missed.

7. The Commissioner shall conduct an investigation into why Bradley was not produced to medical staff on 4/25/22 following self-harm attempt at court and why a mental health referral was not made as indicated in the reportable incident.

8. The Commissioner shall conduct an investigation into why there were no Reportable Incident submitted for the release of Bradley in comportment with 9 NYCRR §7022.2(a).

A report of the findings and any corrective actions taken shall be provided to the Board upon completion.

In a response dated 2/18/25 to the Commission's preliminary report, NYC DOC indicated that the requested investigations were completed with corrective actions taken to include review and retraining of classification directive with staff, hiring initiatives and redeployment of correction staff, review proper submission of incident reports, and meeting with Correctional Health Services to improve production of individuals for appointments. The Commission will verify corrective actions taken a later scheduled evaluations.

<u>TO THE SENIOR VICE PRESIDENT OF CORRECTIONAL HEALTH SERVICES, NYC HEALTH AND HOSPITALS:</u>

1. Correctional Health Services shall conduct a quality assurance review to determine if Bradley was seen by medical as reported on 11/29/21 and if not seen why a referral was not made by mental health staff.

2. Correctional Health Services shall conduct a quality assurance review to determine on 12/1/21 following a referral by mental health staff for taking a large quantity of pills why

Bradley was not seen by medical, why a psychiatric assessment for suicide risk was not ordered, and why a referral for in-patient hospitalization was not made.

3. Correctional Health Services shall conduct a quality assurance review to determine if DOC staff was notified of concerns of substance use on 12/30/21 and 3/8/22.

4. Correctional Health Services shall conduct a quality assurance review regarding why Bradley's diagnosis was changed on 11/23/21.

5. Correctional Health Services shall conduct a quality assurance and practice review with the physician assistant who discontinued psychotropic medication despite a clear history of need and having a positive therapeutic response to then re-prescribe a different psychotropic medication nearly 28 days later.

6. Correctional Health Services shall conduct a quality assurance review to determine why Bradley was not referred to medical following a self-harm attempt at court on 3/25/22.

7. Correctional Health Services shall conduct a quality assurance review to determine if DOC staff were notified of Bradley's intent to take multiple pills on 4/28/22.

8. Correctional Health Services shall conduct a quality assurance review of Bradley's mental health care to determine if a higher level of supervision was appropriate when Bradely was at court given two prior attempts at self-harm while at court.

9. Correctional Health Services shall conduct an investigation into RN [redacted] documentation on 6/13/22 of Bradley receiving education regarding a medication refusal when he was no longer at the facility due to being hospitalized. Administrative action including a referral to the Office of Professional Discipline should be initiated if found to be in violation of agency policy(s).

A report of the findings and any corrective actions taken shall be provided to the Board upon completion.

In a response dated 1/31/25 to the Commission's preliminary report, Correctional Health Services indicated that the requested reviews and investigations were completed. CHS indicated that investigation revealed that a documentation error occurred by staff on 6/13/22 and staff were re-educated on proper documentation procedures. CHS indicated that observations of illicit substance use in the housing areas are escalated to DOC but federal regulations prohibit disclosure of substance abuse treatment without patient consent. The Medical Review Board disagrees with this interpretation and that indications of illegal activity and activity that poses a risk for an individual and others can be appropriately brought to DOC's attention. CHS conducted reviews of Bradley's diagnosis and psychiatric management but did not identify any corrective actions needed. The Medical Review Board remains opined that there were substantial errors in Bradley's psychiatric diagnoses and management by CHS providers that were not adequately addressed.

WITNESS, HONORABLE YOLANDA CANTY, 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 on this 26th day of March 2025.

Yolanda Canty
Commissioner
Commission of Correction

YC:DC:vc
2022-S-0005
March 26, 2025