APNewsBreak: NYC inmate 'baked to death' in cell

March 19, 2014

By JAKE PEARSON
Associated Press

NEW YORK (AP)

Jerome Murdough was just looking for a warm place to sleep on a chilly night last month when he curled up in an enclosed stairwell on the roof of a Harlem public housing project where he was arrested for trespassing.

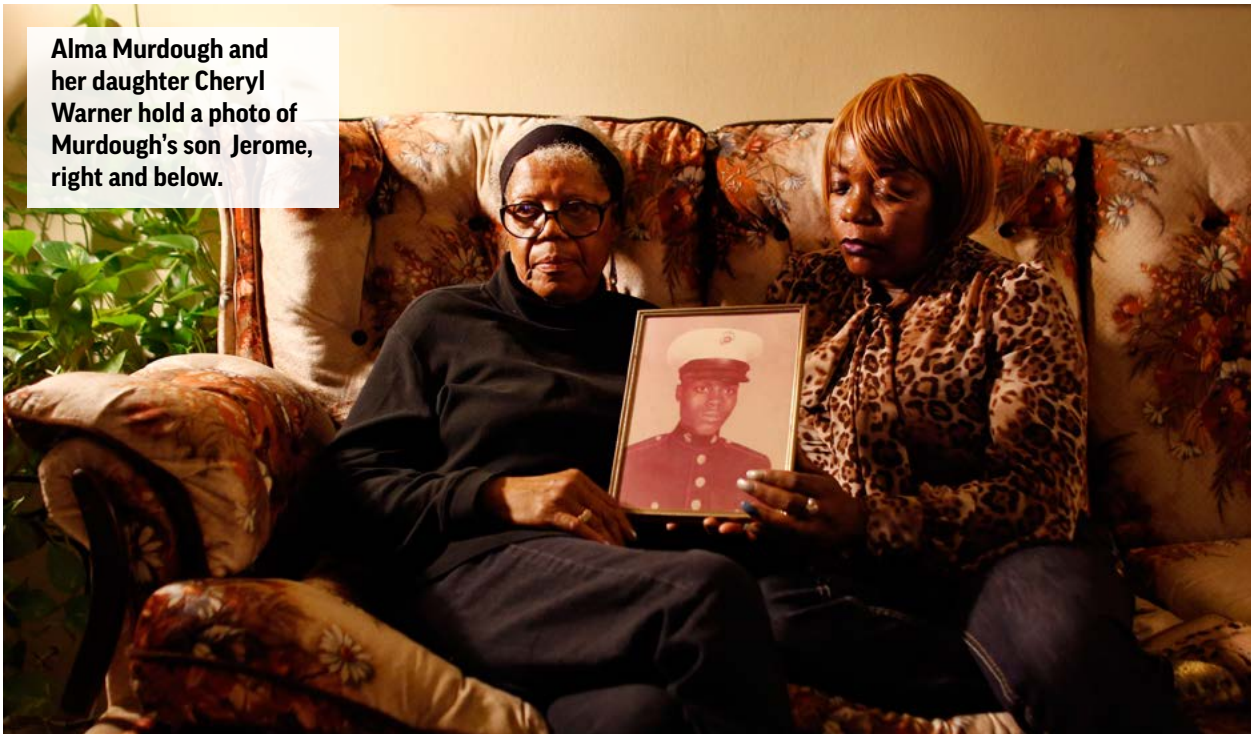
A week later, the mentally ill homeless man was found dead in a Rikers Island jail cell that four city officials say had overheated to at least 100 degrees, apparently because of malfunctioning equipment.

The officials told The Associated Press that the 56-year-old former Marine was on anti-psychotic and anti-seizure medication, which may have made him more vulnerable to heat. He also apparently did not open a small vent in his cell, as other inmates did, to let in cool air.

"He basically baked to death," said one of the officials, who all spoke on condition of anonymity because they were not permitted to discuss specifics of the case.

The medical examiner's office said an autopsy was inconclusive and that more tests were needed to determine Murdough's exact cause of death. But the officials, all with detailed knowledge of the case, say initial indications from the autopsy and investigation point to extreme dehydration or heat stroke.

Advocates for mentally ill inmates in New York say the death represents the failure of the city's justice system on almost every level: by arresting Murdough instead of finding him help, by



Alma Murdough and her daughter Cheryl Warner hold a photo of Murdough's son Jerome, right and below.

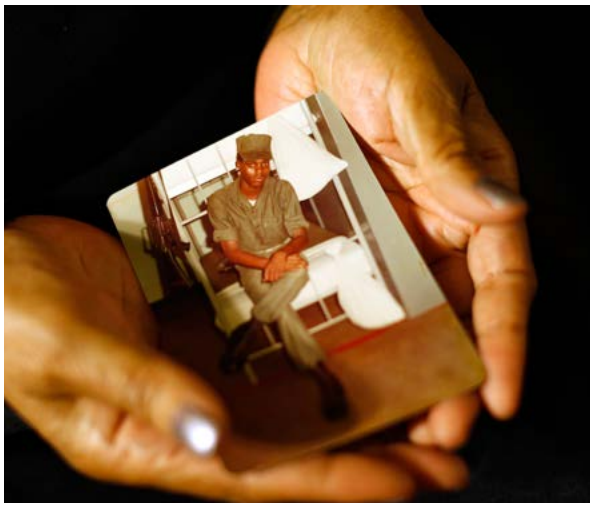
Jason DeCrow • AP (2)

setting bail at a prohibitive $2,500 and by not supervising him closely in what is supposed to be a special observation unit for inmates with mental illnesses.

In a statement issued Wednesday, Department of Correction Acting Commissioner Mark Cranston called Murdough's death "unfortunate" and reiterated that an internal investigation will look into the entire episode, "including issues of staff performance and the adequacy of procedures."

Cranston also acknowledged that the temperature in Murdough's cell was "unusually high" and said that action has been taken to fix mechanical problems to ensure safe temperatures, "particularly in areas housing vulnerable inmates."

The department said it had addressed two contributing factors an outside consultant identified as causing the excess



heat. It also said temperature checks immediately after the death revealed that several cells nearby were over 80 degrees.

Murdough's 75-year-old mother, Alma Murdough, said she did not learn of her son's death until the AP contacted her last week, nearly a month after he died. His public defender was told of the death three days after the inmate was found, the DOC said.

"He was a very lovely, caring guy," said Murdough, adding that her son had bipolar disorder and schizophrenia and that she had not seen him in about three years.

"He had beer problems. Drinking beer. That was his downfall. Other than that, he was a very nice guy. He'd give you the shirt off his back."

Family members say Murdough grew up in Queens and joined the Marine Corps right out of high school, doing at least one stint in Okinawa, Japan.

When he returned from the service, his family said, both his mental illness and thirst for alcohol became more pronounced, and he would often disappear for months at a time, finding warmth in hospitals, shelters and the streets.

"When he wanted to venture off, we let him, we allowed him to come and go," recalled his sister, Cheryl Warner. "He always came back."

Murdough's criminal record included 11 misdemeanor convictions for trespassing, drinking in public and minor drug charges, said Ivan Vogel, a public defender who represented him at his arraignment on the trespassing charge.

According to the city officials, Murdough was locked alone into his 6-by-10 cinderblock cell at about 10:30 p.m. on Feb. 14, a week after his arrest. Because he was in the mental-observation unit, he was supposed to be checked every 15 minutes as part of suicide watch, they

Jerome Murdough was a mentally ill, homeless former Marine who was arrested for sleeping in the roof landing of a New York City public housing project.

Jason DeCrow • AP

said. But Murdough was not discovered until four hours later, at about 2:30 a.m. on Feb. 15. He was slumped over in his bed and already dead.

When Murdough was found and his cell opened, his internal body temperature and the temperature in the cell were at least 100 degrees. Those temperatures could have been higher before he was discovered because the cell had been closed for several hours, the officials said.

mental problems the department said. Advocates and others have long argued that correction officers are not sufficiently trained to deal with mentally ill inmates whose needs are complex.

Catherine Abate, a member of the New York City Board of Correction, an agency charged with overseeing the city's jails, suggested at a recent public meeting that Murdough should have been referred to psychiatric care, not to Rikers Island.

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Dr. Susi Vassallo, an associate professor at New York University School of Medicine and a national expert on heat-related deaths who monitors heat conditions at Rikers Island, said psychotropic medications can impair the body's ability to cool itself by sweating, making it retain more heat than it should.

Exposure to intense heat for a couple of hours by someone on such medications could be fatal, she said.

Last year, three Rikers inmates died from non-natural causes, according to Department of Correction statistics.

Of the 12,000 inmates who make up the nation's second-largest jail system, about 40 percent are mentally ill, and a third of them suffer from serious

Jennifer J. Parish, an attorney at the New York-based Urban Justice Center's Mental Health Project, said Murdough appeared to be a man in need of care.

"So Mr. Murdough violated the trespass law. So he suffered the consequences by going to jail," Parish said. "But the jail system committed more serious harm to him. And the question is, 'Will they ever be held responsible?'"

Wanda Mehala, another of Murdough's sisters, said the family wants an explanation.

"We want justice for what was done," she said. "He wasn't just some old homeless person on the street. He was loved. He had a life. He had a family. He had feelings."

AP Exclusive: Inmate died after 7 days in NYC cell

May 22, 2014

By JAKE PEARSON
Associated Press

New York State Department of Correctional Services • AP
Bradley Ballard in New York on December 15, 2010.

NEW YORK (AP)

After a mentally ill Bradley Ballard made a lewd gesture to a female guard at the Rikers Island jail, he was locked in his cell alone for seven increasingly agitated days in which he was denied some of his medication, clogged his toilet so that it overflowed, stripped off his clothes and tied a rubber band tightly around his genitals.

During that period, guards passed Ballard's cell in the mental observation unit dozens of times, peering through the window in the steel door but never venturing inside — until it was too late.

The 39-year-old Ballard was eventually found naked and unresponsive on the floor, covered in feces, his genitals swollen and badly infected. He was rushed to a hospital but died hours later.

"He didn't have to leave this world like that. They could have put him in a mental hospital, got him some treatment," Ballard's mother, Beverly Ann Griffin, said from her Houston, Texas, home. "He was a caring young man."

Ballard in Houston when he was 16.

Courtesy of Curtis Griffin • AP

Ballard's death last September, detailed in documents obtained by The Associated Press and in interviews with two city officials on condition of anonymity, came five months before another Rikers inmate in a similar mental health unit died in a cell that climbed to a suffocating 101 degrees because of malfunctioning heating equipment.

Experts say Ballard's death is only the latest example of how poorly equipped the city's jail system is to handle the mentally ill, who make up about 40 percent of the 12,000 inmates in the nation's most populous city. A third of those inmates suffer from serious mental illnesses such as schizophrenia and bipolar disorder.

In Ballard's case, his family said, he was diagnosed as schizophrenic more than a decade ago, and he also had diabetes.

Faced with rising criticism over conditions at Rikers, Mayor Bill de Blasio has vowed reforms. Correction Department spokesman Robin Campbell said in a statement Wednesday that Ballard's case is under investigation. He said mental health and jail officials have started shift-by-shift briefings on inmates like Ballard and are working on other measures "so that a similar tragedy will not happen again."

More tests are needed to determine exactly how Ballard died, the medical examiner's office says. But preliminary

findings show that he probably succumbed to sepsis, an infection that has spread through the body, according to the two officials.

Ballard grew up in Houston and moved to New York to pursue a better life after working as a cook at a fried chicken restaurant, his family said. He spent six years behind bars after being arrested in 2004 for assaulting a receptionist and another employee of a New York law firm.

In June, he was arrested in Houston on charges of public lewdness and assault for punching and exposing himself to a bus driver. He was sent back to jail in New York for not telling his parole officer that he'd left the city.

He was first placed in a Rikers facility for 17 days, then a Correction Department psychiatric hospital for 38 days. Then he was sent to a roughly 30-bed mental observation unit at Rikers.

In documents obtained by the AP via a public records request, Cathy Potler, executive director of the city Board of Correction, gave her account of Ballard's case, based on a review of records, security footage and interviews with inmates.

She noted that even though Ballard was in a unit where inmates are ordinarily allowed in and out of their cells to mingle with others for 14 hours a day, he was locked up continuously for seven days and for most of that time wasn't given his medication. The type of medication was not disclosed.

Guards confined Ballard to his cell on Sept. 4 after he stared for hours at a female officer, rolled up his shirt to look like a penis and thrust it toward her, Potler said.

The next day, Potler wrote, Ballard intentionally flooded his combination sink-toilet, after which a mental health provider spoke with him for 15 seconds through the cell door. The next day, a plumber turned off the water to his cell.

Over the next few days, guards and deputy wardens looked in his cell dozens of times throughout the day, Potler wrote, and the inmate was at times seen at the door.

On Sept. 10, video of an inmate delivering a tray of food to Ballard's cell showed the inmate covering his nose with his shirt and three officers backing away, "presumably because of the foul odor coming from the cell," Potler wrote.

Ballard was checked on at least two dozen times that day and night, with an officer at one point seen kicking his cell door several times, according to Potler's account.

By the time medical staffers were called in and his cell was opened, Ballard was so weak he couldn't move. He was pronounced dead early on the morning of Sept. 11.

Under city rules, mental health staffers are required to make twice-daily rounds in the unit where Ballard was jailed, and the guards on duty are supposed to be steadily assigned there and receive annual

mental health training.

But mental health staffers visited Ballard's cell only once before he was discovered to be in distress, according to Potler. And of the 53 officers who worked in the unit in the days leading up to Ballard's death, only one was steady, and none had received the required annual refresher course on mental health, Potler wrote.

Following Ballard's death, Department of Health officials said a city investigation found workers missed multiple opportunities to treat him, transferred the unit chief to another facility and retrained staffers on how to do rounds and other procedures.

Benevolent Association, said Ballard's death was an example of "non-communication between medical staff and uniform staff." He said officers can notify members of the medical staff, "but it's clearly up to them and solely them to determine treatment."

Ballard's death, though tragic, was unsurprising to those familiar with how the mentally ill fare in jails, said Dr. Bandy Lee, a Yale psychiatrist who was a co-author of a report critical of jail officials' use of solitary confinement.

"Correctional institutions are such a poor substitute for mental hospitals, which is what they're basically functioning as in our society," she said. "The problem is the correction setting is not fit to deliver the proper care, and in fact many of the settings exacerbate their symptoms."

Jail officers have long complained that they aren't sufficiently trained to handle severely mentally ill inmates. <<

Jail officers have long complained that they aren't sufficiently trained to handle severely mentally ill inmates. At a recent public meeting, a union official said trainees get 21.5 hours of mental health training during their 16 weeks of academy instruction, plus the three-hour annual refresher.

In a statement, Norman Seabrook, president of the Correction Officers

Curtis Griffin, Ballard's stepfather, said a jail chaplain informed the family months ago of his son's death, but he wasn't told the specifics.

"They know," Griffin said, "that they were wrong in the way they handled the situation."

AP IMPACT: NYC jails neglected suicide precautions

June 27, 2014

By JAKE PEARSON
Associated Press

NEW YORK (AP)

In one case, a mentally ill New York City inmate hanged himself from a shower pipe on his third try in three days. During that stretch, orders to put him on 24-hour watch were apparently ignored, along with a screening form that said he was "thinking about killing himself."

Another inmate hanged himself with a bedsheet from an air vent in a solitary-confinement cell after repeatedly telling guards he was suicidal. The last time he said so, one of them replied, "If you have the balls, go ahead and do it."

In yet another case, an inmate hanged himself from a metal bed that he stood on end to create a scaffold, despite a year-old jailhouse directive to weld all beds to the floor. The directive was issued after another mentally ill man committed suicide in exactly the same way.

Investigative documents obtained by The Associated Press on the 11 suicides in New York City jails over the past five years show that in at least nine cases, safeguards designed to prevent inmates from harming themselves weren't followed.

"Is there a procedure? Yes. Did they follow it? Absolutely not," said a tearful John Giannotta, whose 41-year-old son Gregory used a jail jumpsuit to hang himself from an improperly exposed bathroom pipe last year even though he, too, was supposed to be on suicide watch. The psychiatrist's order wasn't entered into the computer system until hours after his death.

John Giannotta, left, and his ex-wife Dorothy Keegan discuss the life of their son, Gregory Giannotta.

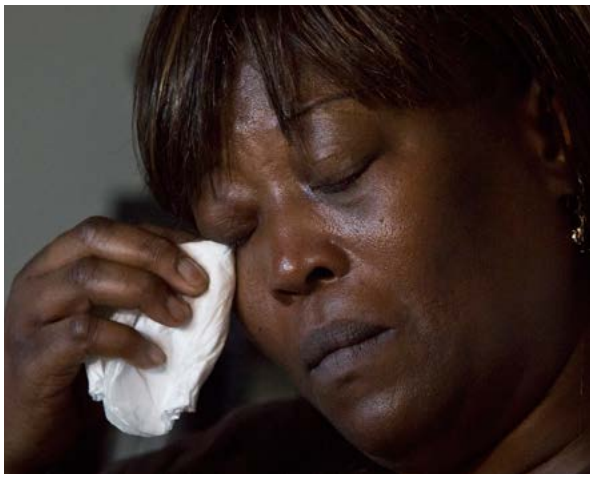
Mark Lennihan • AP

"What did he need? He needed his medication and follow-up care. He got nothing in jail."

Communication breakdowns between mental health staff and guards, sloppy paperwork, inadequate mental health treatment and improper distribution of medication were frequently cited by investigators as factors in the deaths, according to the city and state documents obtained by the AP via public records requests.

It is not clear from the documents whether any employees were disciplined over the suicides, and officials did not immediately respond to questions about that.

Nine of the suicides took place at Rikers Island, the city's huge jail complex near LaGuardia Airport.



Bebeto Matthews • AP

Desdemona Offley's son Quanell Offley made a suicide attempt on Nov. 30, 2013, while jailed on robbery charges. He died days later.

Suicide is the leading cause of death in jails nationally after illnesses such as heart disease and cancer, and New York City's rate — 17 suicides per 100,000 inmates — is well below the average for the nation's jails of 41 per 100,000.

But the documents suggesting that

most of the 11 suicides since 2009 could have been prevented raise new questions about the city's ability to deal with a burgeoning population of mentally ill inmates.

The mentally ill account for about 40 percent of the roughly 11,500 men and women in New York City's jails on any given day, up from 24 percent in 2007 — an increase attributed in part to the closing of large mental institutions over the past few decades in favor of community-based treatment.

Officials estimate a third of those inmates suffer from serious mental illnesses such as schizophrenia and bipolar disorder.

Previous AP disclosures about the deaths of two other mentally ill inmates — one who essentially baked to death in a 101-degree cell in February and another who sexually mutilated himself last fall — have prompted oversight hearings and promises of reform.

On Friday, Mayor Bill de Blasio called the suicides "very troubling" and "an indication of what has been wrong for a long time at Rikers and what has to change." He said that like many other jails and prisons across the country, New York City's have become "a substitute for a real mental health system, and that's unacceptable."

De Blasio, who took office in January, recently appointed a task force to come up with better ways of treating the mentally ill, and said $32.5 million secured in the budget for new housing for mentally ill inmates, more training for guards and more staff will "make a big difference."

Experts say such breakdowns are particularly egregious in New York City's jail system, the nation's second-largest behind Los Angeles County's, because it may be better equipped than any other to deal with the mentally ill, with 400 mental health staffers employed by the city or its contractor, Corizon Health Inc.

Daniel Selling, a psychologist who until two months ago headed mental health services in the jails, said that failures at Rikers can often be traced to conflicting missions: Mental health workers want suicidal inmates under constant watch, while jail guards often believe prisoners threaten suicide to gain more lenient treatment.

"The challenge then is that they're

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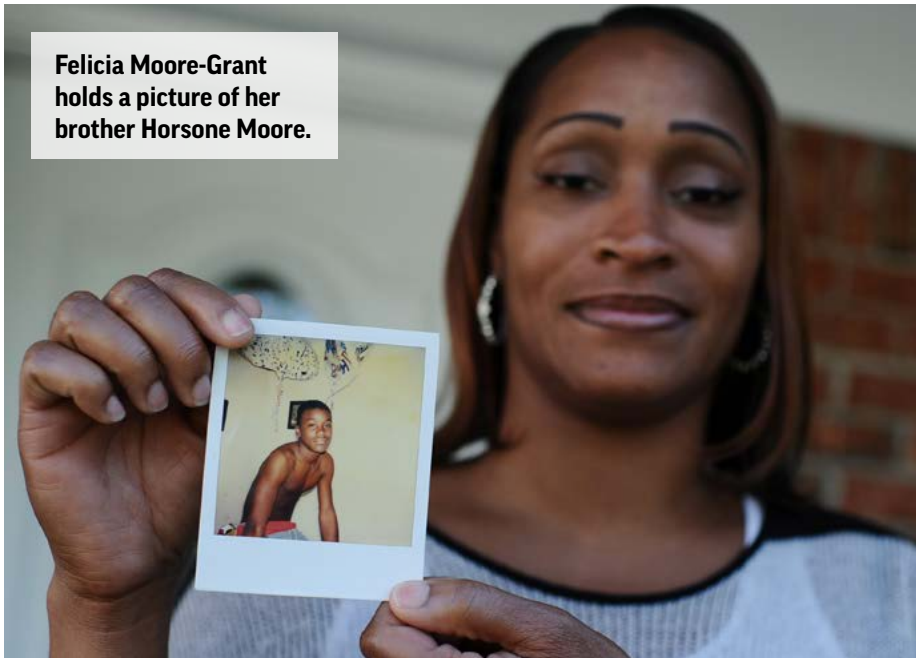

Felicia Moore-Grant holds a picture of her brother Horsone Moore.

Rainier Ehrhardt • AP

transferred into an authority whose mission is not aligned," Selling said. "And so people fall through the cracks."

The city Correction Department said in a statement that it "views every suicide in its custody as a tragedy that should have been prevented, and we are taking many steps ... to prevent these incidents going forward."

The city Health Department noted that suicide watches are conducted about 3,800 times a year in New York's jails, which hold defendants awaiting trial as well as those serving short sentences or awaiting transfer to prisons for longer stretches.

According to the documents, the safeguards broke down spectacularly in the case of Horsone Moore, 36, who had struggled with depression since his 20s,

Julie Jacobson • AP

Tracie Morales stands with a photo of her son, Jamal Polo, who committed suicide in May 2012 while jailed.

according to his family.

Moore had served time on assault and weapons charges and was taken to Rikers last October for missing appointments with his parole officer.

He committed suicide in a shower pen in the early hours of Oct. 14 after trying three times in quick succession. He was

pepper-sprayed by guards after his first attempt, never saw a psychiatrist, never received medication and wasn't watched constantly despite two such orders and a screening form that warned he was a suicide risk.

Video footage of the last 15 hours of his life, detailed in an email by a city official, shows an agitated, handcuffed Moore fashion his shirt into a noose. He is stopped by guards while attempting to string himself up, but the cuffs are removed and he is left alone. He then tears his underwear into strips and uses them to hang himself.

"There was so much time and opportunity, and nobody took any action whatsoever," said his sister, Felicia Moore-Grant, who lives in Varnville, South Carolina. "It hurts a lot because now all we have is memory and pictures. We can never talk to him again. We can never hear his voice."

After the May 2012 suicide of sexual misconduct suspect Jamal Polo, investigators found the 23-year-old wasn't properly evaluated to pick up "what clearly was a significant risk for suicide attempt."

Polo hanged himself from a metal bedframe he stood upright in his cell, prompting an order to secure all beds to the floor.

That work wasn't fully carried out until after the September 2013 death of 26-year-old Gilbert Pagan, who killed himself the same way.

Quanell Offley, 31, who had been sentenced for robbery, hanged himself with a bedsheet last fall. Investigators found that he had repeatedly threatened suicide and that his requests went unheeded by guards, including one who dared him to do it.

"People make mistakes and they go to jail, but that doesn't mean they have to be treated so cruelly," said his mother, Desdemona Offley. "I need this situation to be fixed."

Associated Press writer Jennifer Peltz and AP researcher Rhonda Shafner contributed from New York.