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State Board Calls Rikers Suicide a Glaring Case of Poor Care

By PAUL von ZIELBAUER

It was 2:50 p.m. on July 18, 2004, when David Pennington, a 27-year-old small-time thief in jail on a third-degree burglary charge, was sent from a clinic back to his cell at Rikers Island's largest jail. During the previous three days, jail doctors had received ample evidence showing that Mr. Pennington should not be left alone.

Two days earlier, according to investigators, he had told a social worker at Rikers about two attempts to kill himself, about his psychiatric hospitalizations, about his father, who had killed himself in prison. Near the end, Mr. Pennington, increasingly agitated, had even told a jail doctor that he was hearing voices and was thinking again of killing himself.

Still, Mr. Pennington was sent back from a Rikers mental health clinic to what is called the jail's general population - Cell 26 in Quad 14 - without any special instructions to correction officers or medical staff to keep a close eye on him. In fact, state investigators later discovered, Mr. Pennington was returned to his cell after a jail psychiatrist, despite being alerted by another doctor, chose not to examine him.

Six and a half hours later, jail officers heard a commotion outside Cell 26. Inmates were gathered around the locked cell door, yelling for help. The officers rushed over to find Mr. Pennington slumped against the door, hanging from a bedsheet tied to the door's small window. He was brain dead, and three days later, at Elmhurst Hospital Center in Queens, his family had him removed from life support.

For the correction and medical workers at Rikers Island, Mr. Pennington was another entry in the disturbing catalog of suicides inside city jails in recent years.

In the view of state investigators, Mr. Pennington was another casualty of the sometimes deadly mistakes made by the Tennessee company hired to provide health care at Rikers, and to thereby tackle the problem of the growing number of mentally ill inmates who populate the jail, a sprawling complex in the East River.

Over the past four years, in a series of increasingly urgent reports, the New York State Commission of Correction has excoriated the company, Prison Health Services, for mistakes in the care of 23 inmates who died in city and upstate jails. The commission, which is appointed by the governor to oversee jail

and prison standards, has repeatedly condemned Prison Health for flouting state medical standards, hiring poorly qualified doctors and nurses and failing to properly treat several of its sickest patients, who eventually committed suicide - the leading cause of death in American jails.

In its report on Mr. Pennington, made available to the public last week, the commission issued some of its harshest criticism of the company, calling its care of Mr. Pennington "flagrantly inadequate," and again asserting that the company was practicing in the state in violation of the law because executives in Tennessee, and not doctors at Rikers Island, were ultimately in charge of dispensing care.

In a letter accompanying the report, the commission also criticized the city's Department of Health and Mental Hygiene, which monitors Prison Health's work at Rikers, for excusing the company's errors and for what it said is the company's continuing improper operations in the state.

State law requires that a company dispensing medical services for a profit must be owned and controlled by doctors, to keep business interests from affecting medical decisions. Prison Health Services, a publicly held profit-making company that the city pays \$100 million a year, says it subcontracts its medical services at Rikers to a small corporation run by a doctor who is also its regional medical director. The state commission, in its letter to the city's health department, said that the arrangement "begs credulity" and "only raises further questions" about the legality of the company's operation here.

City health officials have said that Prison Health does a satisfactory job and performs its work legally. In a letter to the commission in January, James L. Capozziello, the health department's deputy commissioner in charge of monitoring jail health care, disputed the commission's conclusion that Mr. Pennington received poor or improper care.

A department spokesman declined to comment last week on the commission's findings in Mr. Pennington's death or the letter that accompanied the report. Prison Health, through a spokeswoman, also declined to comment on Mr. Pennington's treatment but said the company's work in New York complied with state laws.

But officials with the city's Board of Correction, a watchdog agency that monitors the safety of the city's jails and sets minimum health standards, said that the lack of care Prison Health gave Mr. Pennington before his death was particularly troubling given his mental-health history, his report that his father had killed himself in prison and his own increasingly suicidal behavior.

In an interview on Friday, Cathy Potler, the board's deputy executive director, said, "The question is, what happened between the time he was noted to be hallucinating and suicidal and the time he was found unresponsive in his cell?"

Indeed, by the time the jail psychiatrist sent him back to his cell for the last time, the state commission said, Mr. Pennington had done "everything he could to attract psychiatric attention to himself."

Three times in three days before he was found hanging, correction officers had noticed Mr. Pennington acting bizarrely and had sent him to the jail's mental health clinic to be treated. After the first referral, on July 16, Mr. Pennington told a mental health worker about his past psychiatric hospitalizations and disclosed his two previous attempts to kill himself - with pills in 1998 and by slashing his wrists in 1997, the state commission's report said. He was returned to his cell without treatment, the report said.

The next day, officers again escorted Mr. Pennington to the mental health unit, after news of a relative's death had sent him into an even deeper anxiety, the state report said. After evaluating him, a jail social worker found him stable enough to return to his cell without special observation. The social worker also scheduled Mr. Pennington to see a psychiatrist on July 19.

On July 18, about 9:30 a.m., jail officers sent him to the mental health unit for the third time. A social worker ordered an immediate evaluation by a psychiatrist, the state report said. But the Prison Health psychiatrist, after speaking briefly with Mr. Pennington, did not complete an evaluation.

"He is not suicidal or homicidal," the psychiatrist wrote, according to the state report. The psychiatrist, who had received his state medical license a year earlier, also said that Mr. Pennington had walked out of their meeting after the psychiatrist refused to give him an anti-anxiety medication he had asked for.

Back in his cell, four hours later, jail workers called in a doctor after Mr. Pennington appeared to be having seizures. He told the physician he was hearing voices and wanted to kill himself, the commission's report said. The physician immediately escorted him back to the psychiatrist who had seen him that morning. The psychiatrist agreed to evaluate Mr. Pennington and have him moved to a mental health unit for closer observation, the state report said.

But Mr. Pennington was not treated or moved to a more secure cell. The only action the psychiatrist took, state investigators found, was to send Mr. Pennington back to his usual cell, where he killed himself.

"This deliberate refusal to provide treatment to patient with active suicidal ideation who was directly referred by another physician constitutes professional medical misconduct on the part of the psychiatrist and flagrantly inadequate mental health care by PHS, Inc.," the state report said.

The city's health department, in its response to the state commission, defended the work of the social worker and the psychiatrist and said the state investigators had overstated how clearly suicidal Mr. Pennington was. It also said the psychiatrist did not remember being told Mr. Pennington was suicidal or looking at a medical chart.

Prison Health Services fired the psychiatrist three months later, for reasons that a company spokeswoman said were unrelated to Mr. Pennington's death.

