**Testimony to the New York City Council Committee on Criminal Justice**

**NYC Health + Hospitals/Correctional Health Services**

**September 27, 2024**

Good morning Chair Nurse and members of the Committee on Criminal Justice. I am Bipin Subedi, Chief Medical Officer for NYC Health + Hospitals/Correctional Health Services, also known as "CHS." I am here with my colleague, Jeanette Merrill, CHS' Sr. Assistant Vice President of Communications and External Affairs. We appreciate the opportunity to participate in today's hearing on the proposed legislation. My testimony will focus on providing information on the impact that three of these bills would have on our service provision and operations, including concerns we have about how some of these proposals could adversely affect patient care and staff safety.

**Intro 423 - in relation to procedures following the death of an individual in custody of the department of correction and a report on compassionate release**

CHS strongly opposes several aspects of Intro 423, which would require the NYC Board of Correction (BOC) to issue a public report on its investigations into the deaths of individuals in the custody of the NYC Department of Correction (DOC) and to include the names of CHS employees whom the Board determined were "involved in the circumstances that contributed to" the deaths. The bill would also require CHS and DOC to "conduct a joint investigation of each death of an individual in custody of the department, including the review of all medical records" and to submit a joint report of the findings to BOC. It would also establish a "jail death review board," with CHS participation, in order "to identify systemic issues that contributed to such deaths." Finally, the bill would require a public report on "individuals who have been released from custody due to a medical condition."

We have serious concerns about the bill's requirement that BOC publish the names of CHS employees "involved in the circumstances that contributed to" a death. Publicly naming health care staff following an adverse clinical event contradicts the approach recommended by national professional organizations, such as the American Medical Association and the American Nurses Association. These groups caution against an unnecessarily punitive approach precisely because it promotes a culture that deters disclosure and frank, introspective, and exhaustive discussions of the events surrounding adverse clinical events. They also recognize that there is a range of accepted clinical practice within which clinical judgment is exercised, and that the context in which health care is delivered should be considered in reviews.

Reviews are best conducted by individuals who have the clinical expertise and nuanced understanding of CHS workflows and the actual clinical and environmental circumstances at the time care was rendered. Retrospective reviews, especially if conducted by non-clinicians unfamiliar with this unique context, can result in second-guessing after the fact. Given this, publicly naming CHS staff may not only risk mistakenly attributing an adverse event to a clinician, but it could also serve to minimize and distract from the complexity of care delivery in the jail environment, including the impact of jail operations on individual health. This would adversely affect CHS morale, retention, and recruitment and would interfere with our ability to investigate, identify, and remediate root causes in order to prevent recurrences.

CHS was established as a new division of NYC Health + Hospitals, in part, to bring greater transparency and accountability to the provision of health care in New York City jails after decades of contracted health care providers, most recently Corizon, a for-profit correctional health care company. As a new division of our municipal health care system, CHS adopted and expanded a clinical review process for each death,

structured around well-established and universally accepted quality assurance principles and protocols in healthcare. This multistep, rigorous approach, which begins immediately after every patient death, includes video and record review, discussions with relevant staff members, and a focused case review with CHS clinical leadership. The review process identifies areas for improvement and, wherever appropriate, corrective action plans to improve care quality, even when not directly related to the cause of death. This process precedes the additional supplemental death reviews conducted by the NYC Health + Hospitals Board, the NYC Board of Correction, and the State Commission of Correction (SCOC).

When applicable, CHS' Human Resources and clinical leadership ensure staff involved in an adverse clinical event receive counseling, training, and education and, when warranted, discipline. This occurs in consultation with CHS' health care unions – the New York State Nurses Association, DC37, 1199, and Doctors Council – to ensure our doctors, nurses, and other health care staff receive appropriate professional development, as well as legal protections. Our staff are also accountable to applicable State licensing boards.

In accordance with applicable laws, CHS does provide BOC – and other authorized agencies and oversight boards, including SCOC – the medical records of a person who dies in DOC custody and works with BOC as they review the case and write their public report. CHS also provides, with patient consent, complete and select patient medical records to defense attorneys on request. CHS has established a productive working relationship with BOC in conducting thorough reviews of the draft reports. This includes sharing information, providing feedback, correcting errors, and, ultimately, responding to the recommendations.

Additionally, CHS and DOC jointly hold a Joint Assessment and Review (JAR) following all in-custody deaths. CHS established the JAR process in 2016 to specifically examine the systems and environmental aspects unique to carceral settings within which clinical care is provided. This forum enables CHS and DOC leadership to share relevant findings and insights from each agency's independent review of a significant adverse event and to together identify systemic risk-reduction remedies that could reduce the likelihood of recurrence of such an event. This includes the sharing of limited clinical information when relevant to discussing operational factors that may have contributed to a death. The current JAR process was recently evaluated and supported by a court-appointment monitor related to the Nunez Settlement. We believe that the work of the JAR, coupled with that of the BOC's current death review and report, meets the intent of the proposed "jail death review board".

Regarding "compassionate release," CHS' Clinical Court Advocacy team provides defense counsel, with patient consent, clinical letters for our most medically complex patients. Attorneys may use these letters, which describe the individual's medical conditions and treatments, when advocating for their clients to the courts. When applicable, CHS will explicitly indicate when a patient has a serious medical condition that would benefit from clinical interventions that are not available in the jail setting.

As noted in a July 2023 Special Report by the Nunez Independent Monitor: "Release is not automatic, and an individual determination must be made by the Court. If the court determines release is appropriate, the Department is notified via a court order that the individual is being released on their own recognizance ("ROR"). However, the order does not specify a medical reason for the release." Therefore, neither CHS nor DOC could issue a "report on compassionate release" that identifies "individuals who have been released from custody due to a medical condition," as Intro 423 would require, as the Court may weigh several factors, including those that are not clinical, in deciding to release an individual from custody.

**Intro 412 - in relation to notifying emergency contacts and attorney of record when an individual in custody attempts suicide, is hospitalized, or is seriously injured**

CHS opposes Intro 412, which would require CHS to request authorization from every person in custody to notify the individual's attorney of record and emergency contacts, within one hour, should the individual attempt suicide, become hospitalized, or be seriously injured. The bill would also require CHS to ascertain the individual's attorney of record for this purpose, upon request from the incarcerated individual.

CHS recognizes the importance and value of communicating effectively with patients and, as permitted, external parties about the health care we provide. CHS' Patient Relations department manages concerns and inquiries from patients, family members, and attorneys relating to CHS' health services, and – with patient consent – can communicate directly with a patient's loved one about the individual's care. In addition, CHS' Clinical Court Advocacy team serves as a resource for defense bar and, with patient consent, facilitates communication among health care staff, attorneys, and patients. Regarding hospitalization, hospital staff are best situated to notify the family members of people in custody following a hospitalization, as hospital staff, not CHS staff, determine admission and serve as the treating physicians.

CHS understands that our patients' relationships with their attorneys, family members, and other loved ones are unique and dynamic, and we believe that any clinical communication about suicide attempts and serious injuries deserves an individualized and tailored approach. Accordingly, CHS clinicians will speak with a patient's loved ones about the complicated, often sensitive, factors and circumstances that may have led to or surround a significant medical event, but these conversations are, and remain, individualized, deliberate, in-depth discussions between the loved one and primary provider, not a universal "real-time" notification.

**Intro 1036 - in relation to requiring the department of correction to provide reports regarding people in custody who have been ordered to undergo a mental health examination**

CHS supports with modifications Intro 1036, which would require quarterly reports related to individuals in DOC custody who are ordered to undergo fitness to proceed evaluations, also known as 730 examinations, as well as information about these examinations, including the timeliness of the reports.

In order to create one unified system and to improve the quality and timeliness of evaluations, CHS consolidated and assumed management of the four Forensic Psychiatric Evaluation Court Clinics located in Manhattan, Bronx, Brooklyn and Queens. Under Criminal Procedure Law § 730, these clinics conduct court-ordered psychiatric evaluations of adult criminal defendants in order to assess competence to stand trial and support pre-sentencing investigations. CHS' forensic examiners, via their written reports, offer forensic psychiatric opinions regarding whether the defendant is an incapacitated person, meaning a defendant who, as a result of mental disease or defect, lacks capacity to understand the proceedings against him or to assist in his own defense. However, only a judge can legally determine if the individual is ultimately incompetent—that is, not fit to stand trial.

CHS currently collects and analyzes much of the information required by Intro 1036, and while we would propose minor amendments to some of the metrics outlined in the bill, we support making the information public through regular reporting.

We thank the Council for the opportunity to speak today about the important issues addressed in the legislation and are available to answer any questions you may have.