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**DOI REPORT FINDS SIGNIFICANT BREAKDOWNS BY CORIZON HEALTH INC.
FAILURES IN EMPLOYEE SCREENING AND MENTAL HEALTH TREATMENT OF INMATES IN CITY JAILS**

*Recent arrests of Corizon employees by DOI highlight problems with background checks
Mental health staff with prior criminal convictions including Second Degree Murder
Oversight by the City Departments of Correction and Health also found lacking*

Today, Department of Investigation ("DOI") Commissioner Mark G. Peters issued a critical review of Corizon Health Inc. ("Corizon"), a private company contracted by the City to provide medical and mental health services in Rikers Island jails. The Report highlighted acute failures in Corizon's hiring processes and treatment of mentally ill inmates. The investigation also revealed the City's Department of Correction ("DOC") and Department of Health and Mental Hygiene ("DOHMH"), both responsible for supervising Corizon, failed to properly oversee the company's hiring and supervision of clinical staff. DOI's Report follows this release and can also be found at: <http://www.nyc.gov/html/doi/html/doireports/public.shtml>

DOI Commissioner Mark G. Peters said, "DOI's investigation found that Corizon did not provide adequate screening or supervision of its employees, and the City did not properly oversee this taxpayer-funded vendor, ignoring multiple red flags. DOI's arrests of Corizon employees on contraband smuggling charges is an example of one of the disturbing results of these careless practices. Going forward, stringent reforms must be established and DOC has already begun to implement critical changes."

DOI began its investigation after arresting a Corizon nurse in September 2014 and charging him with taking bribes to smuggle in tobacco and alcohol. Over the last six months, DOI investigators reviewed thousands of pages of documents and conducted surveillance of and site visits to 28 of 30 housing areas reserved for inmates needing mental health treatment. DOI found Corizon failed to provide adequate care to inmates, including improperly removing inmates from court-ordered suicide watch, failing to supervise inmates with serious mental illnesses, and poorly supervising inmates while they took medications, including psychiatric prescriptions. DOI's Report found that two of these inmates died. One of those instances is now under criminal review by DOI and the Bronx District Attorney's Office.

This Report is the latest outcome of DOI's ongoing investigation of criminal activity and violence at Rikers Island. Since the beginning of this investigation, DOI has arrested more than one dozen correction officers and supervisors, and other workers at the City's jails, on an array of criminal charges, including contraband smuggling and assault; and more than three dozen inmates for a variety of illegal conduct in the jails. DOI's investigation has highlighted deficient hiring practices of correction officers; poor controls and oversight of use of force by correction

more

officers; and a lack of controls and screening for contraband. Those reports can also be found at <http://www.nyc.gov/html/doi/html/doireports/public.shtml>

As part of its investigation into Corizon, DOI reviewed 185 Corizon Mental Health Clinician (“MHC”) and Mental Health Treatment Aide (“MHTA”) personnel files and found Corizon failed to engage in rudimentary screening processes and supervision of staff, missing serious red flags in employees’ backgrounds and resulting in the hiring of unqualified and unfit candidates. Specifically in its review, DOI found:

- **Corizon failed to conduct adequate background checks on employees resulting in employment of eight mental health staff with prior criminal convictions including Second Degree Murder and drug possession.**
- **Corizon knowingly hired candidates that did not fully disclose prior misdemeanor and felony convictions, including one candidate who disclosed 13 prior convictions for crimes including petit larceny, criminal possession of a controlled substance and attempted burglary.**
- **In 89 of the 185 files reviewed, there was no evidence that Corizon conducted a candidate background investigation of any kind.**
- **In 58 of the 137 MHC files reviewed, there was no evidence that Corizon verified candidates’ professional licenses prior to employment or monitored the licensing of employees after they began work.**
- **Only 8 of 134 employees who have worked at Corizon for over one year had performance reviews in their files covering each year of their service.**

DOI investigators found Corizon did not ask candidates whether they had ever been disciplined at work or terminated from a previous job, factors that could indicate whether a potential candidate has difficulty with authority or exhibits poor judgement.

The review also exposed a lack of oversight and accountability by DOC and DOHMH. The review further exposed that the three entities who share responsibility for the administration of this care do not effectively communicate, which has prevented solutions. In the most concerning example, DOC stated it had no ability to conduct background checks of staff hired by Corizon. In fact, DOC did have both the authority and responsibility to conduct fingerprint checks of employees. However, during the course of the investigation, DOI found a DOC Deputy Commissioner allowed a total of 658 fingerprint cards from employees hired between 2011 and 2014 to pile up on a shelf outside his office – never having been sent for screening.

Even after DOI notified DOC of this breach in October 2014, fingerprinting was slowly and improperly handled. In May 2015, DOC had just begun properly submitting the 1,100 Corizon employee fingerprints for screening.

In addition, DOI found that while DOHMH has oversight of Corizon’s performance, by admission of its own officials, it exercised virtually no oversight of Corizon’s hiring of clinical staff, instead leaving Corizon’s hiring unsupervised. As a result, yearly staff evaluations of mental health personnel appeared irregular at best.

In light of these findings, DOI has significant concerns about Corizon continuing as the health care provider for the City’s jails and recommends a series of reforms regarding the provision of health and mental health services at DOC facilities, including among others:

- **Strict professional and character standards must be established when assessing applicants and follow-up background investigations must be conducted into disclosures that call an applicant’s judgement and character into question. DOI recommends the provider use a standard list of disqualifying criteria.**

- **Make clinical staff screenings uniform, thorough and tailored to the unique corruption vulnerabilities at DOC. The health care provider must also document its personnel decisions clearly.**
- **DOHMH, DOC and the health care provider should form a joint hiring committee with officials from each agency to discuss and review hiring decisions. Hiring decisions must be documented.**
- **DOC must immediately fingerprint all health care employees and submit those fingerprints for analysis as part of background investigations.**
- **Any future health care provider must require candidates to disclose all prior convictions and arrests with detailed descriptions regarding the circumstances and whether they have been previously disciplined or terminated from a job.**
- **Conduct routine compliant checks of medical licenses to confirm that employees are properly licensed and are in good standing with the New York State Education Department.**

Commissioner Mark G. Peters thanked DOC Commissioner Joseph Ponte and DOHMH Commissioner, Dr. Mary Bassett, and their staffs, for their assistance and cooperation in this investigation, including from DOHMH, General Counsel Tom Merrill and Agency Counsel Patrick Alberts; and from DOC, Captain Nathaniel Bialek and Deputy Commissioner Michael Blake.

This investigation was conducted by DOI's Office of the Inspector General for DOC, specifically Assistant Inspector General Kate Zdrojeski and First Deputy Inspector General Chin Ho Cheng. In addition, assistance on this investigation was provided by the following DOI staff: Counsel to the DOC Inspector General Adam Libove, Investigator Rich Askin, Correction Officer Investigator Larry Bond, Investigator Margaret Riviera, Investigator Mike Garcia, Correction Officer Investigator Jerome Corrica, and Inspector General Clint Daggen. The investigation was supervised by Senior Inspector General Jennifer Sculco, Associate Commissioner Paul Cronin, and Deputy Commissioner and Chief of Investigations Michael Carroll.

Criminal complaints and indictments are accusations. Defendants are presumed innocent until proven guilty.

DOI is one of the oldest law-enforcement agencies in the country and New York City's corruption watchdog. Investigations may involve any agency, officer, elected official or employee of the City, as well as those who do business with or receive benefits from the City. DOI's strategy attacks corruption comprehensively through systemic investigations that lead to high-impact arrests, preventive internal controls and operational reforms that improve the way the City runs.

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New York City Department of Investigation

**Investigation Finds Significant Breakdowns by Corizon Health Inc., the
City-Contracted Health Care Provider in the City's Jails, and a Lack of
Oversight by the City Correction and Health Departments**

**MARK G. PETERS
COMMISSIONER**

June 2015

Executive Summary

In September 2014, the Department of Investigation (DOI) arrested a nurse working at Rikers Island, after he took bribes to smuggle tobacco and alcohol into a facility. The nurse, like virtually all health care providers at Rikers Island, was not employed by the Department of Correction (DOC), but by Corizon Health Inc. (Corizon), a private company that provides medical and mental health services to Rikers Island and many other correctional institutions across the country. In early May 2015, DOI arrested a second Corizon staffer, again for smuggling contraband into Rikers Island. One week later, DOI arrested a third Corizon employee for smuggling a straight edge razor into a Rikers Island facility. Upon arresting this third employee, DOI learned that he had multiple prior felony convictions and served 13 years for kidnapping.

Beyond these and other criminal acts detailed below, DOI surveillance and document review over the past six months revealed that a number of Corizon employees have failed to properly provide the medical and mental health services for which the City contracted. For example, DOI observed staff dispensing medication, including psychiatric medication, without engaging in basic precautions to make sure that inmates actually swallowed the pills they were prescribed.¹ Further, on several occasions, Corizon staff improperly removed inmates from suicide watch or otherwise failed to supervise inmates with serious mental illnesses. Two of those inmates died while unsupervised. One of those instances is now under criminal review by the Bronx County District Attorney and DOI.

These failures should not be seen in isolation. Rather, they have occurred in the context of the failure to engage in proper screening and supervision of staff. Given the huge number of factors that contribute to the delivery of medical and mental health care for inmates, it is difficult, if not impossible, to conclusively demonstrate a direct causal link between poor hiring and quality of care. Nonetheless, DOI reviewed 137 Corizon Mental Health Clinician (MHC) and 48 Mental Health Treatment Aide (MHTA) personnel files and found that:

- Corizon failed to do adequate background checks on employees, resulting in employment of eight mental health staff with prior criminal convictions including Second Degree Murder and drug possession. Even where Corizon did have evidence of criminal activity—including possession of a controlled substance, burglary, and forgery—Corizon nonetheless hired these individuals.
- In 89 of the total 185 files reviewed, there was no evidence that Corizon conducted a candidate background investigation of any kind.

¹ DOI is not qualified to offer medical opinions and, for that reason, does not opine on medical issues in this Report. Rather, DOI's investigation focused on whether basic safety steps were being taken, and agreed upon rules were being followed, by the Corizon staff who provide inmate care. By way of example, DOI did not consider whether DOHMH and Corizon prescribe appropriate medications; rather, DOI's findings in this regard were confined to the fact that Corizon and DOHMH failed to take precautions to make sure inmates actually took whatever medications were prescribed.

- In 58 of the 137 MHC files reviewed, there was no evidence that Corizon verified the candidates' professional licenses prior to employment. Further, Corizon failed to monitor the licensing of employees after they began work.
- Corizon's failures continued even after employment. Only 8 of 134 employees who have worked at Corizon for over one year had performance reviews in their files covering each year of their service at Corizon.²

The Department of Health and Mental Hygiene (DOHMH), along with DOC, have responsibility for supervising Corizon, to ensure, among other things, that hired employees have been properly vetted. They failed to do so.

In perhaps the most concerning example of this failed supervision, at the outset of this investigation, certain DOC staff informed DOI that DOC had no ability to conduct background checks of the staff that Corizon sent to Rikers Island. In fact, however, DOC did have both the authority and the obligation to conduct fingerprint checks of such employees. As a result, Corizon sent fingerprint cards to DOC on a regular basis; but, rather than forwarding the cards to the State to run checks, a DOC Deputy Commissioner allowed the cards to pile up on a shelf outside his office. The cards were discovered, unprocessed, by DOI in the course of its investigation.

Indeed, DOC only began processing fingerprints for Corizon employees in May 2015, six months after DOI informed DOC—including Commissioner Ponte—of this basic failure.³

DOHMH similarly failed to adequately supervise Corizon.⁴ For example, DOHMH did not review staff files to see if Corizon was properly supervising and reviewing employee performance. As noted above, such evaluations rarely took place. Additionally, DOHMH never followed up to make sure the fingerprints submitted to DOC by Corizon were actually processed.

² DOI spoke with several Corizon officials during the course of this investigation, including calls or meetings on October 28, 2014; February 18, 2015; May 11, 2015; and June 4, 2015.

³ Since DOI's review of the screening process for Corizon employees, DOC has already made some improvements to its processes and has agreed to the recommendations in this Report. Notably, DOC has run name-based criminal background checks on all Corizon staff to prioritize fingerprinting efforts, and begun conducting electronic fingerprinting of Corizon staff and submitting fingerprints to DCJS. DOC is informing Corizon of the results of each employee's criminal history. Moreover, going forward, DOC will perform phone checks and visitation history checks for prospective employees, and perform periodic checks after the employees begin working in DOC facilities. DOC also will work with DOHMH and the healthcare provider to establish 1) clear criteria and thresholds for denying access to the facilities for provider staff; 2) training requirements for provider staff working in DOC facilities; and 3) rolling refresher training and performance/collaboration checks.

⁴ DOI spoke with numerous DOHMH officials during the course of this investigation, specifically, in meetings (on June 25, 2014, June 30, 2014, and October 28, 2014), via conference call (on July 18, 2014 and December 5, 2014), and through countless emails and informal phone communication. DOI also received extensive written feedback from DOHMH on an earlier draft of this Report, and has addressed that feedback, below, as appropriate.

As with DOI's earlier reports on contraband smuggling and Correction Officer (CO) screening, the various illegal activities discussed above, most notably the September 2014 arrest, demonstrated the need for a more comprehensive investigation of Corizon's activities. This Report sets out the findings of that investigation.

During the course of its investigation, DOI spoke with senior staff from Corizon, DOC and DOHMH regarding the failures documented herein. At various points, each entity blamed the other two for the failings identified by DOI, and each entity claimed that the responsibility for preventing those failings belonged to the other two. This lack of communication has, itself, been a significant impediment to solving the problems uncovered in this investigation.

Corizon's contract with the City is set to either expire or be renewed by the end of this year. In light of DOI's findings, we have significant concerns about permitting Corizon to continue, on a long term basis, to provide health care services at Rikers Island.

Further, given the ineffective communication between Corizon, DOHMH and DOC, DOI has concerns about the current model where three entities share responsibility for the health care of inmates in the City's jails. (In this regard, we note that of the 58 prison systems presently served by Corizon, only three involve a contractual intermediary third-party Health Department.) If the City determines that DOHMH should continue to be involved in prison healthcare – a policy decision beyond DOI's purview – then explicit written lines of authority and responsibility must be adopted.

I. The Duties of Corizon MHCs and MHTAs Give Them Unfettered Access to Inmate Housing Areas and Allow Them to Develop Intimate Relationships with Their Inmate-Patients. This Level of Inmate Access Should Subject MHCs and MHTAs to Greater Pre-Employment Scrutiny.

Corizon mental health staff, particularly the MHCs and MHTAs discussed in this report, spend most of their time interacting with inmates in need of mental health treatment either during therapy sessions or through casual interaction. The daily frequency, duration, and quality of inmate contact encountered by MHCs and MHTAs working in specialized housing areas like the Clinical Alternative to Punitive Segregation (CAPS) Program for Accelerating Clinical Effectiveness (PACE) units, for example, far surpasses that of many of their CO counterparts.⁵ In view of their significant daily inmate contact, MHCs and MHTAs are at least as vulnerable to corruption and inmate manipulation as COs. Yet MHCs and MHTAs are subject to a much less extensive pre-employment screening process than COs. The duties of these staff—and the concomitant corruption risks they face—are described below.

A. Mental Health Clinicians

According to Corizon’s MHC job posting, MHCs are generally responsible for “providing assessment and counseling services to inmates.” Additional responsibilities include crisis intervention, determining and coordinating disposition of patients for appropriate level of mental health care, developing and leading group treatment, participating in case conferences and treatment planning for inmates, and collaborating with DOC to ensure access to patients, proper housing and treatment disposition, among other things. MHCs must have a Master’s degree in Social Work, Psychology or a related field, and a New York State license or limited permit to practice in Social Work, Mental Health Counseling, or Psychology.

MHCs spend the majority of their time interacting with inmate-patients in individual and group treatment sessions in various housing areas across different facilities and are not supervised or overseen by uniformed DOC staff.⁶ Individual sessions typically can be as short as three minutes or as long as 30 minutes. During these sessions, which may occur in the facility clinic, a housing area office space, or outside an inmate’s cell, the inmate-patients discuss a range of personal topics. Following each session, MHCs must document in the inmate-patient’s medical record the information discussed and the counsel provided. MHCs can counsel as many as 12-15 inmates a day.

Inmates receiving ongoing mental health care may be seen by MHCs daily, weekly, monthly or on a referral basis, depending on an inmate’s specific needs. Some DOC housing areas, such as the Restricted Housing Units (RHUs) and the Clinical Alternative to Punitive Segregation (CAPS), have MHCs assigned to those units full time. Those MHCs, therefore,

⁵ The CAPS units are clinically-driven housing areas reserved for inmates who are infracted by DOC and are designated as seriously mentally ill by mental health services. CAPS units include enhanced programming and therapy, as well as additional mental health staff. The PACE units extend the CAPS model of enhanced therapeutic programming to mentally ill inmates who are not infracted by DOC.

⁶ DOC staff are not medical or health care professionals and do not oversee or supervise any Corizon staff. Rather, DOC staff work with Corizon staff to ensure that security and movement procedures are followed.

interact with the same inmates every day. In those housing areas, the one-on-one sessions generally occur in a secluded part of a common area, away from other inmates or DOC staff, or within a windowed office space separated by a door that is closed during the sessions, away from uniformed DOC staff.⁷

B. Mental Health Treatment Aides

MHTAs, who work exclusively within specialized inmate housing areas such as CAPS, spend the vast majority of their days interacting with the roughly 15 inmates assigned to their particular housing areas. According to Corizon's listed job function, MHTAs, who often have less stringent educational and professional requirements and need no professional license,⁸ "perform crisis and/or de-escalation interventions, therapeutic observations, conduct groups, conduct patient supervision and other behavioral health related duties."

MHTAs, like MHCs, are tasked primarily with engaging and socializing with their inmate-patients. Specifically, MHTAs regularly check on a listed group of inmates to determine whether any have concerns that require immediate attention. MHTAs also participate in daily meetings with their assigned group of inmate-patients and have one-on-one meetings with inmates in their assigned housing area or facilitate various inmate group activities such as art therapy or role playing sessions. Afterwards, MHTAs normally hold a group meeting with the inmates before concluding their duties for the day. MHTAs can interact with an inmate in their assigned housing area approximately every 15 minutes.

In sum, MHCs and MHTAs have regular, largely unrestricted, and often lengthy individual and group inmate contact. Prior DOI investigations into allegations of bribery, contraband smuggling, and inappropriate inmate-staff relationships demonstrate that MHCs and MHTAs possess ample opportunities to engage in misconduct with their inmate-patients. As such, MHCs and MHTAs—along with other clinical staff who have regular and extensive inmate contact—should be subject to an extensive pre-employment background investigation in order to eliminate candidates whose profiles signal potential security risks. However, as discussed below, the employee personnel files reviewed by DOI suggest that Corizon has done little to ensure that quality candidates fill its MHC and MHTA positions. DOC and DOHMH, furthermore, have done little to assist Corizon in the screening of its MHC and MHTA applicants. Worse, each of these entities assign responsibility to do this screening to the other two and, due to the inability of each to communicate with the other two, effective screening has not been done. As a result, the entities have left themselves vulnerable to the potential security risks and liability presented by unfit clinical employees.

⁷ DOI understands the importance of protecting patient confidentiality in the context of mental health treatment sessions and, therefore, does not suggest that one-on-one sessions are improper or negative. Nonetheless, such sessions do create security risks and could provide an opportunity for inmates to manipulate any mental health staff with poor judgment or moral character, thus heightening the need for proper screening of such staff.

⁸ Corizon does require its MHTAs, however, to have a bachelor's degree or associate's degree in criminal justice, social services, or a health-related area and between one and two years of clinical experience with the mentally ill or developmentally delayed.

II. Overview of Corizon’s Hiring Process for MHCs and MHTAs

MHC, MHTA, and other related health care vacancies are initially posted on Corizon’s Intranet and then externally on job websites such as Career Builder. Prospective applicants must submit their resume and complete an employment application, of which DOI has seen at least three variations.⁹ Generally, the application begins by asking the candidate to provide a variety of personal information such as name, address, social security number, and personal telephone numbers. The “personal data” section concludes by asking for the name of the position sought (e.g., MHC, MHTA, etc.), the date the candidate is available to start, and the salary expected. Applicants are not required to disclose the names, addresses, dates of birth or other personal information of their family members.

The next section of the application queries an applicant’s professional and technical licenses, requesting a list of any licenses or certificates received (if applicable for the position sought), license registration information, license number, state of registration, and license expiration date. Applicants were further asked to note whether any license had ever been suspended, revoked, or limited in any way. In one application variation, candidates were required to disclose whether any licenses were currently under investigation. Candidates were further asked to list other qualifications or special skills and languages spoken other than English.

Next, an educational history section asks candidates to list the schools, beginning with high school or the equivalent, attended, including the location of any school, degree obtained and/or major studied, and the date of graduation if achieved.

Candidates are next required to supply their prior employment history. In addition to prior workplace/company names, titles, and dates employed, candidates must provide the prior company’s address and telephone number, his or her duties and responsibilities, supervisor’s name, starting and ending salary, and reason for leaving. The candidate is also asked to indicate whether Corizon may contact the company. A number of applicants whose personnel files DOI investigators reviewed included resumes in lieu of completing the prior employment section of the application.

After candidates are asked to provide three professional references, they are required to disclose prior criminal convictions. DOI investigators observed three different ways in which candidates were asked to disclose their criminal history. One application variant asks the candidate to state, by checking “Yes” or “No,” whether he or she has been convicted of a felony in the last seven years. Another version of the application asks the candidate to state whether he or she has ever been convicted of a felony. In a third version of the application, the candidate is required to state, by checking “Yes” or “No,” whether he or she has been convicted of a crime by any court, including military court; this third variant further asks candidates to indicate whether they have relatives, business associates, or friends incarcerated in a correctional institution, on parole, or in the custody of any DOC or county detention facility. All applications include a blank space below the criminal history question and ask the applicant to explain the details of an affirmative response.

⁹ DOI’s review of the 185 MHC and MHTA files revealed that over the last approximately 14 years, at different points, Corizon used three different employment applications, which were largely similar except for changes to the question regarding the applicant’s prior criminal conviction history, discussed in greater detail below.

After reviewing the resumes and completed applications, a Corizon Hiring Manager contacts a select number for an initial panel interview, which consists of staff responsible for supervising the prospective employee. Each interview is documented using an Interview Sheet, a single-sided form on which the interviewer notes: 1) the position the candidate is applying for; 2) the candidate's name and date of interview; 3) whether the candidate has previously worked for Corizon; 4) how the candidate learned of Corizon; and 5) whether the interviewer is interested in offering the candidate a position. The interviewer completes the form by signing his or her name. The interviewer is not required to complete any written evaluation documents that form the bases of his or her opinion to hire a candidate. In fact, the one-page Interview Sheet does not even contain a section for the interviewer to write interview notes.

Candidates who are successful in the first interview are then asked to come back for a second interview, which can include meeting their prospective colleagues and a visit to the DOC facility where the candidate will be assigned. Thereafter, the Medical or Mental Health Department head, along with a Corizon human resources official, extends an employment offer to the selected candidate pending a background investigation and medical clearance.

After candidates receive a conditional offer from Corizon, they are fingerprinted at Corizon's offices. The fingerprints are then forwarded to DOC for processing as part of a criminal background check.¹⁰ Corizon officials must also verify, when applicable, the candidate's professional licenses. Although a license is not a prerequisite for employment as an MHTA, Corizon requires all MHCs to have a license in social work, mental health counseling, or psychology.

In October 2014, Corizon began using a background check agency, HireRight, to verify three areas of a prospective employee's background, which include 1) verification of professional licenses; 2) an education report, verifying degrees, certificates and diplomas earned; and 3) a criminal history report, which includes a search for felony and misdemeanor convictions occurring only within the applicant's county of current residence.¹¹ None of the MHC or MHTA files DOI investigators reviewed contained any sort of checklist detailing the records or verifications that must be included in a personnel file.¹²

¹⁰ As discussed in Section IV(A) below at page 19, DOC has not been processing these fingerprints since, at least 2011.

¹¹ In theory, hired candidates undergo a full criminal background check by submitting their fingerprints to DOC for processing. The fingerprinting process will be discussed in depth in section IV below.

¹² Only beginning in April 2015 did Corizon hiring officials begin using a "New Hire Checklist" to ensure that all requisite documents are included in a new employee's personnel file. The New Hire Checklist includes 22 items, such as tax forms, a medical clearance form, copies of diplomas and degrees, and a variety of other HR documents. Among the forms listed on the New Hire checklist are several that are intended to verify parts of an employee's background: a fingerprint authorization form and fingerprint report, a background check authorization form, and a professional license check. According to Corizon hiring officials, prior to April 2015, it was simply assumed that all the documents specifically mentioned on the New Hire checklist were being included in the employee personnel file.

III. DOI's Review of 185 Corizon personnel files of its MHCs and MHTAs Revealed a Flawed Employment Process That Resulted in the Hiring of Unfit Candidates.

DOI's review of 185 MHC and MHTA personnel files reveals that Corizon has 1) consistently failed to require candidates to disclose sufficient personal history information that would be indicative of their judgment and character, and routinely failed to conduct adequate background investigations of its candidates; 2) knowingly hired candidates who have disclosed past misdeeds indicative of poor integrity and character, or related corruption risks; 3) does not consistently verify candidate references or even the necessary professional licenses of its mental health applicants; and 4) failed to document its hiring process.

A. Corizon Failed to Adequately Screen Candidates, Resulting in the Hiring of Employees with Judgment and Character Concerns.

The 185 personnel files DOI investigators reviewed showed that MHC and MHTA applicants were only required to disclose limited personal information indicative of judgment and character. First, Corizon's employment application contained three variations of a question requesting candidates to disclose prior criminal convictions; one variation of the application, apparently seldom used, also requested candidates to disclose whether they presently had any inmate contacts in any correctional facility. The other application forms did not, despite the obvious risks posed by such contacts. The three variations were as follows:

- In 125 personnel files, candidates were only asked: "Have you been convicted of a felony in the last 7 years?"
- In six personnel files, candidates were asked, "Have you ever been convicted of a felony?"
- Only 44 of the applications asked candidates, "Have you ever been convicted by a court of law, or a military court martial, of a crime?"¹³

The limited scope of these questions poses a serious problem in adequately screening the background of these candidates. Merely asking candidates if they had been previously convicted of a felony or previously convicted of a felony within the last seven years limits an employer's inquiry into a candidate's integrity and character as it assumes that only felony convictions (or felony convictions within the last seven years¹⁴) are of any value in judging a candidate's fitness. It also fails to cover a candidate's prior misdemeanor convictions, which might encompass crimes of moral turpitude, such as petit larceny, forgery, or falsification of records, and indicate a candidate's propensity for dishonesty or disregard for the law.

These screening questions also fail to address felony or misdemeanor arrests whose underlying facts might demonstrate that a candidate exercises poor judgment or has criminal associations. Additionally, nowhere in the files DOI investigators reviewed were candidates asked whether they had ever been disciplined at work or terminated or asked to resign from a

¹³ The remaining 10 files were missing an application altogether, making it impossible to determine which prior conviction question was asked of the applicant.

¹⁴ It is unclear why a seven-year cutoff is of any greater value than, say, five years or ten years.

previous job, the underlying facts of which might indicate that the candidate has difficulty with authority, poor judgment or poor work habits.

DOI investigators further discovered that approximately 89 of the MHC and MHTA personnel files DOI investigators reviewed contain no evidence that either Corizon or DOC ever conducted a candidate background investigation of any kind. Specifically, these files not only failed to contain an investigative report, they did not even have documented confirmation that such a report was ever generated. Only nine personnel files DOI reviewed—all belonging to staff hired in or after October 2014—contained a HireRight report confirmation demonstrating that the candidate had been subject to some form of background investigation.

The HireRight investigation, however, is inadequate for screening candidates assigned to work in a correctional setting, as it only verifies a candidate's educational history and professional license and prior criminal convictions occurring within his or her county of residence. This HireRight investigation falls short of gathering information on prior statewide or federal convictions. Significantly, also, this limited background investigation fails to conduct a candidate credit history check. In fact, not one of the files DOI investigators reviewed contained a credit history report, which would assist hiring officials in discovering, for example, whether the severity of a candidate's debt might make him or her susceptible to accepting inmate bribes.¹⁵

Additionally, approximately 42 of the files contained no evidence that the Corizon employees had been fingerprinted for a criminal background investigation. As this report discusses in further detail below, DOI's findings indicate that neither Corizon nor DOC has subjected a single Corizon employee to a fingerprint-based criminal background check since at least 2011.¹⁶ Instead, the system has functionally relied on its candidates to truthfully self-report prior criminal convictions with the limited queries discussed above.

As a result of these lax screening protocols, eight of the 185 MHCs and MHTAs whose files DOI reviewed had been convicted of a crime prior to their application for employment with Corizon. Most notably, one MHC had been convicted of Murder in the Second Degree in connection with an attempted robbery that resulted in the stabbing death of the victim. Because this MHC's murder conviction occurred over seven years prior to his application for employment with Corizon, he was not required to disclose the conviction in his application, which only asked if he had been convicted of a felony in the previous seven years. Another MHC, also asked if he had been convicted of a felony in the previous seven years, had been convicted five times of crimes ranging from misdemeanor petit larceny and drug possession to felony possession of a forged instrument and stolen property. Because the felony convictions occurred over seven years prior to his application for employment, he did not disclose them.

¹⁵ As discussed in Section IV(C) below, Corizon did not have access to the databases DOC uses for security screening and was relying on DOC to perform background investigations. However, DOI uncovered little evidence showing that Corizon, DOHMH or DOC communicated with each other about criminal background checks for new employees, or the results thereof, further demonstrating the inability of the three entities to work cooperatively—even regarding an issue, security, that they all agree is important.

¹⁶ A DOC official informed DOI via email that the agency is “somewhat at a loss for a full and complete explanation” as to what happened to the fingerprints sent by Corizon between 2008 and 2011. The DOC official further stated that he believes “only the first batch of prints were ever processed—meaning, the first set to come in following the signing of the MOU [in 2008].”

Another MHC was convicted three times of operating a motor vehicle while intoxicated and twice convicted of driving with a suspended license, all misdemeanor offenses, prior to his application for employment with Corizon. Again, because this MHC was only asked if he had been convicted of a felony within the last seven years, he was not required to disclose these convictions, the repetitiveness of which strongly suggest that the MHC consistently disregarded the law and the well-being of other drivers whom he placed at risk with his behavior.

B. Corizon Knowingly Hired Applicants with Evidence of Poor Judgment and Character.

Even when candidates did fully disclose prior misdemeanor and felony convictions, however, Corizon officials still hired those individuals. For instance, one MHTA disclosed 13 prior convictions, including multiple convictions for petit larceny, criminal possession of a controlled substance and attempted burglary, as well as conviction for possession of a forged instrument.¹⁷ Another MHTA reported a prior misdemeanor conviction for attempted assault, while a third candidate reported a misdemeanor conviction for criminal possession of a forged instrument. Corizon officials nevertheless hired these individuals without even requiring them to give any documented explanation regarding the circumstances surrounding their arrest and conviction. The personnel files of the MHCs and MHTAs with these convictions were devoid of any evidence that Corizon officials investigated these convictions.

Corizon also hired candidates even when they made other troubling disclosures that were probative of poor judgment and integrity. One MHC, for instance, revealed that he had had his New York State law license suspended for 30 months for, as the MHC noted in his application, “failure to maintain records for one client.” DOI’s review of the MHC’s file revealed no evidence that Corizon officials further investigated this alarming disclosure which, according to DOI’s investigation, appears to have been severely understated by the MHC.

Even a cursory investigation conducted on the New York State Office of Court Administration would have revealed that an appellate court suspended the MHC’s license after he failed to generate or maintain the necessary records for multiple clients in his client trust account (known commonly as an Interest On Lawyer’s Account or “IOLA” account) for approximately three years, in violation of various attorney ethics codes. The appellate court presiding over the matter further found that the MHC had “misappropriated” over \$1,000 in client funds “for a use other than that which they were intended,” which would constitute grand larceny,¹⁸ and “engaged in conduct prejudicial to the administration of justice by failing to timely or completely cooperate” with the investigation into these allegations.

DOI’s investigation into this MHC further reveals that the Suffolk County District Attorney’s Office arrested and charged him with Grand Larceny in the Second Degree in April 2014 in connection with an alleged mortgage fraud scheme perpetrated against a partially blind

¹⁷ Subsequently, DOI investigators discovered documents in this MHTA’s personnel file indicating that the MHTA had been formally disciplined twice for sleeping on duty and once for lateness.

¹⁸ The putative grand larceny occurred in or before 2008. At the time of DOI’s investigation, the statute of limitations on this crime had already expired, making prosecution of the crime impossible.

60 year-old client over a four-year period. These allegations raise concerns of this MHC similarly manipulating a vulnerable inmate-patient under his care.¹⁹

C. Corizon Failed to Consistently Verify Candidates' References, Prior Employment History, and Professional Licenses.

DOI's review of the personnel files also revealed that Corizon officials failed to consistently verify candidate references, employment history, and, when required by the position, professional licensing information. Of the 185 files DOI investigators reviewed, approximately 107 contained no documented evidence that Corizon hiring officials ever performed any kind of employment verification or reference check.

In fact, in one MHC file, the candidate listed only the names of the references without listing their contact information. While the MHC noted that she would provide a complete list of references at a later date, the file contains no evidence that she ever provided such a list or that Corizon officials ever contacted her references. Approximately 23 personnel files did not even contain any mention of the candidate's references.

The failure to require or even verify basic candidate information such as references, prior employment, and professional licensure is, at best, emblematic of Corizon's sloppiness in screening its candidates. At worst, it demonstrates Corizon's indifference toward the quality of the employees it hires to work within DOC's jails, and, as discussed below, the quality of care these employees deliver to DOC inmates.

Corizon similarly failed to document confirmation of professional licenses.²⁰ Of the 137 MHC files DOI investigators reviewed, approximately 58 did not contain any evidence that Corizon officials verified the candidates' professional licenses. According to Corizon officials, although the professional licenses of medical professionals are checked daily, until recently there was no existing process whereby the professional licenses of MHCs, as well as other mental health professionals whose duties require licensure with the New York State Education Department (NYSED),²¹ were checked for good standing with the same kind of vigilance. Corizon's failure to regularly verify the professional licenses of its mental health staff has potentially severe legal consequences as the unlicensed practice of a profession is a felony under

¹⁹ Indeed, this same MHC was recently reprimanded for failing to properly address an inmate suicide referral. Specifically, the Corrective Action Memorandum found in the MHC's personnel file notes that the MHC "closed out" the inmate suicide referral as "[a]ddressed" and noted that the patient "was rescheduled." The memorandum notes, to the contrary, that the patient was in fact "never... "seen," nor was he re-scheduled." Additionally, the Memorandum notes that the MHC failed to notify other mental health administrators of the patient-inmate's status.

²⁰ Corizon informed DOI that, as of May 2015, licenses for all mental health staff are electronically checked on a daily basis. While it would be unreasonable to expect that the daily licensing checks are noted in each employee's personnel file, Corizon should undoubtedly have some record in the employee's file demonstrating that his or her license was verified (for example, at the time of hire).

²¹ NYSED regulates the licensure of various medical and non-medical professions in New York State, including architecture, interior design, medicine, physical therapy, pharmacy, and dentistry.

the New York State Education Law. Moreover, in a potential malpractice claim made by an inmate, the unlicensed practice of a profession may constitute prima facie evidence of negligence, which leaves DOHMH and DOC exposed to possible liability.

According to NYSED grievance papers found in one MHC's file reviewed by DOI investigators, NYSED had suspended the MHC's social work licenses for three months because he had intentionally failed to disclose any of his prior five criminal convictions, which ranged from misdemeanor drug and larceny convictions to felony convictions for possession of stolen property and a weapon, in each of his two social work license applications.²² Corizon ultimately suspended the MHC for failing to notify Corizon that his social work licenses had been suspended and that he "knowingly worked and treated patients without his [social work] license to practice" over the course of five days.²³

D. Corizon Failed to Document its Evaluations of MHC and MHTA Applicants, Resulting in the Hiring of Some Unqualified Clinical Staff.

Corizon hiring officials also failed to document their evaluations of MHC and MHTA applicants, calling into question the criteria used to evaluate these applicants and the bases for which these individuals were hired. DOI's review of the MHC and MHTA personnel files revealed that Corizon's evaluation of these candidates is mostly undocumented or poorly documented.²⁴

As described in Section II above, Corizon interviewers document the first interview using only a one-page Interview Sheet, which does not direct or allow space for the interviewer to leave substantive information about the candidate. In fact, the Interview Sheet provides no guidance at all as to what information the interviewers should seek to obtain from the candidate. The only remark the document asks interviewers to make is a check next to a "Yes" or "No" as to whether the interviewer would be "interested in offering a position to the... applicant." Of the 185 files DOI investigators reviewed, only 12 contained an Interview Sheet with interview notes, which were handwritten in the margins. In another 12 of the Interview Sheets included in the personnel files, the interviewer did not check "Yes" or "No" in response to whether he or she would be interested in hiring the candidate; on one of those Interview Sheets, the interviewer wrote, "Maybe." All 12 were subsequently hired without any documented explanation.

²² The false filings occurred in 1999 and 2005. At the time of DOI's investigation, the statute of limitations on these putative crimes had already expired, precluding prosecution of the offenses.

²³ According to his own filings, the MHC disputed that he treated patients without a license as the suspension of his license had yet to take effect during that span. During most of his suspension period, the MHC was apparently on FMLA leave.

²⁴ Approximately eight of the personnel files reviewed did not even contain a job application, and six did not contain a job application or resume. The absence of such critical hiring records indicates Corizon's poor record keeping, a complete failure to substantively evaluate a prospective employee, or both. Corizon officials, in response to DOI's findings, claimed that some of the missing records may have been kept in other areas. However, DOI investigators were told by Corizon human resources staff, during the investigation process, that all such information was centrally located in the employee personnel files.

This shallow documentation sheds absolutely no light on how these employees were evaluated and deemed fit for their jobs. Some candidates appeared to lack the necessary education, training, or experience and were nonetheless hired. For example, one candidate, who applied to become an MHTA, had a resume that included an objective that stated, “To obtain a position of clerical assistant, data entry clerk, file clerk, medical records clerk, or mail room clerk.” Indeed, her prior work experience included positions as a data entry clerk, an administrative assistant and a customer service clerk at a drug store. She was interviewed 10 days after submitting her application for employment, but, according to the Interview Sheet in her file, was not recommended for hire. Then, approximately two months later, with apparently no material changes to her education, training, or experience, she returned for another MHTA interview and was recommended for hire. Neither Interview Sheet found in her personnel file documented the reasons for the candidate’s rejection or approval for hire.

A second MHTA candidate whose file DOI reviewed similarly had virtually no relevant experience. Although she had a Bachelor of Science in Criminal Justice, her prior work experience included only jobs as a customer service associate at several office supply stores and a toy store. She also listed a two-month internship at the Department of Juvenile Justice. Despite not satisfying even the minimum requirements expected of an MHTA as described by Corizon’s own job posting, this candidate was hired.

Finally, 78 of the 185 files reviewed did not even contain an Interview Sheet or any other record demonstrating that the candidate was in fact interviewed prior to being hired.

IV. DOC Failed to Screen Corizon Employees and DOHMH Failed to Adequately Supervise Corizon’s Hiring Process.

Despite provisions found in Corizon’s contract with DOHMH that call upon DOC to assist Corizon in the screening of its clinical applicants, DOI’s investigation reveals that DOC, by admission of its own hiring officials, has likely not conducted a single background investigation on a Corizon applicant since at least 2011.²⁵ DOC’s failure to perform any kind of background investigation includes 1) receiving the fingerprint cards of Corizon applicants and simply placing them atop a filing cabinet without forwarding them for a fingerprint-based criminal history analysis and 2) failing to use DOC-exclusive databases to determine whether prospective Corizon hires have any connection to DOC inmates that would subject them to undue influence and thereby present a possible DOC security risk.

Separately, as will be discussed in detail in Section IV(D) below, DOHMH failed to adequately supervise the care provided by Corizon despite multiple red flags that such care was deficient.

²⁵ The fact that the fingerprinting issue began in at least 2011, but was not identified until 2014, further demonstrates the inability of DOC, DOHMH and Corizon to effectively communicate with each other.

A. DOC Was Responsible for the Criminal Background Investigations of Corizon's 1,100 Clinical Employees Staffed at DOC's Facilities But Failed to Do So.

The issue of whether Corizon employees were being subject to fingerprint-based criminal history screening was first brought to DOI's attention in September 2014, when DOI investigators arrested Jeffrey Taylor, a Corizon licensed practical nurse, on allegations that he had received cash bribes from various inmates to smuggle alcohol and tobacco into his assigned jail. Following Taylor's arrest, DOC officials expressed concern that DOC had no ability to conduct criminal background investigations on Corizon employees working in DOC's facilities. According to DOC officials, Corizon was solely responsible for conducting all background screening of its employees.

By contrast, around the same time, Corizon and DOHMH officials familiar with Corizon's hiring and background investigation processes informed DOI that DOC is responsible for conducting criminal background investigations on all prospective Corizon employees assigned to DOC facilities. Corizon, according to its hiring officials, merely obtains fingerprints from its prospective employees, which are placed on eight-inch by eight-inch cards, and sends them to DOC for an extensive criminal history check.²⁶

DOHMH and Corizon never followed up with DOC about the results of the criminal background investigations, instead assuming that DOC was conducting them without issue. As a result of this lack of oversight and communication between all three entities, no criminal background checks were done.

DOI reviewed Corizon's contract with DOHMH and determined that DOC was, in fact, responsible for processing the fingerprints of new Corizon employees. Specifically, Corizon's contract with DOHMH states that Corizon must "collect and submit to DOC for background investigation, the fingerprints of all employees, subcontractors and employees of subcontractors." DOC, in turn, must "provide Corizon with the results of the DOC background investigation."²⁷ The contract further states that Corizon "shall ensure that all prospective and new employees and employees of its subcontractors are advised, in writing, that vital information will be shared with both DOC and DOI for the purposes of background investigations, including home and cell telephone numbers."

Given that relevant DOC staff seemed unaware of this obligation, in October 2014, DOI requested that Corizon provide proof of mailing for the employee fingerprint cards sent to DOC for the year to date. Corizon subsequently provided DOI with 16 FedEx receipts for parcels containing fingerprint cards, which it sent to DOC between January 1, 2014 and October 31,

²⁶ A fingerprint-based criminal history investigation, conducted by the New York State Division of Criminal Justice Services (DCJS), allows for a listing of any and all aliases, addresses, or dates of birth reported during prior arrests. It also includes all prior city, state, or federal criminal convictions, the type and degree of prior convictions, sentences imposed, terms of imprisonment and post-release supervision, and the existence of any orders of protection.

²⁷ While the term "background investigation" is not defined in the DOHMH-Corizon contract, representatives from DOHMH, Corizon, and DOC have separately informed DOI investigators that they each believe the term "background investigation" to mean fingerprint-based criminal background investigations.

2014.²⁸ The receipts showed that Corizon addressed the FedEx parcels to then-DOC Deputy Commissioner of Human Resources, Labor and Training Alan Vengersky. According to Corizon officials, the fingerprint cards were sent to Vengersky because he was the designated liaison between Corizon and DOC for background checks. Corizon continued to send fingerprint cards to Vengersky even after June 2014, when Vengersky had retired. Corizon continued to direct the fingerprint cards to Vengersky's attention until October 2014, and only stopped when DOI informed DOHMH and Corizon that Vengersky had retired, further demonstrating these entities' inability to effectively communicate.

When DOI investigators spoke to Vengersky's administrative assistant at Vengersky's DOC office, she insisted that DOC was not responsible for conducting background checks on Corizon employees. Vengersky's administrative assistant further informed DOI investigators that Corizon had never directed any requests for background checks to Vengersky. When DOI investigators explained that the requests came in FedEx envelopes containing fingerprint cards for prospective Corizon employees, Vengersky's administrative assistant said, "Oh, you mean those?" and pointed to a stack, nearly one-foot high, of FedEx envelopes atop a filing cabinet located outside Vengersky's office:



Those envelopes contained 658 fingerprint cards for employees whom Corizon had hired between 2011 and 2014.²⁹ When asked to explain how the fingerprint cards came to be stacked

²⁸ Notably, Corizon informed DOI that it had 141 new hires between January 1, 2014 and October 31, 2014. Nonetheless, only 125 fingerprint cards (one fingerprint card per employee) were included in the stack of cards DOI took.

²⁹ DOI investigators subsequently took the FedEx envelopes containing the fingerprint cards and reviewed their contents. DOI cross-referenced the fingerprints cards with a list of Corizon employees hired since January 1, 2014, in order to sample the contents and confirm that Corizon did in fact send fingerprint cards to DOC for all of its new employees. DOI found that of Corizon's 141 new hires since January 1, 2014, 25--or 17%--did not have a fingerprint card in the stack taken from DOC. The missing fingerprint

atop a filing cabinet, Vengersky's administrative assistant said that Vengersky instructed her and other staff to put them there after opening the envelopes and reviewing the contents. She informed DOI that DOC did not conduct background checks on Corizon employees and, since neither Vengersky nor his staff knew what to do with the fingerprint cards, they simply left them stacked on the filing cabinet. The administrative assistant further stated that neither Vengersky nor any of his staff ever contacted Corizon to inquire why it was sending these fingerprint cards. Additionally, neither Vengersky nor any of his staff returned the fingerprint cards to Corizon. Vengersky's assistant said that this practice of opening the envelopes and stacking them had begun in approximately 2011.³⁰ She did not know what retention procedure existed for the fingerprint cards prior to 2011.³¹

Further conversations with Corizon and DOHMH officials revealed that in 2007, Corizon, "out of concern,"³² informed DOHMH that although Corizon had been collecting fingerprints for new employees since it first contracted with DOHMH in 2001, it had not sent them for processing. According to Corizon officials, the company had "no clear direction"³³ as to where the fingerprints should be sent. Apparently, this lack of "clear direction" created an accumulation of unprocessed fingerprints for 937 employees. In order to clear this backlog, DOHMH and DOC signed a Memorandum of Understanding (MOU) pursuant to which DOHMH paid DOC a lump sum of \$70,275 to cover the cost of processing the prints with DCJS for the then-current employees.

To prevent future backlogs and to ensure that future Corizon employees would be subject to a fingerprint-based criminal history check, the MOU stated that Corizon³⁴ would obtain fingerprints from its staff members and forward those fingerprints, along with a \$75.00 money order from each staff member, to DOC for the purpose of conducting a background investigation. The MOU further called for DOC to notify Corizon "in writing of the results of such

cards indicate that either Corizon never sent DOC those 25 employees' fingerprint cards or that Vengersky and his staff misplaced or inadvertently destroyed the cards.

³⁰ Vengersky, who was also the subject of criticism in DOI's January 2015 report on DOC's flawed application process for newly hired COs, informed DOI investigators that, to the best of his knowledge, DOC did not conduct criminal background checks on Corizon employees. He further stated that he did not remember receiving fingerprint cards for Corizon employees, nor did he recall instructing his administrative assistant to stack the cards on a filing cabinet.

³¹ We include the statements of Vengersky's assistant solely to document certain historical past practices. Clearly, the assistant is not in a position to speak for DOC on policy issues, and her statements are not included for that reason. Under current efforts to fingerprint all Corizon employees, DOC is proceeding with electronic fingerprint captures, and is not retaining fingerprints of prospective or existing Corizon staff. Rather, DOC is directly sending such fingerprints electronically to DCJS.

³² Email to DOI from Vice President of Operations, Corizon Health Rikers.

³³ Email to DOI from Vice President of Operations, Corizon Health Rikers.

³⁴ Corizon was then known as "Prison Health Services."

investigations within five days of receipt of the same.”³⁵ The MOU was signed in March 2008, and DOHMH remitted payment to DOC to process the backlog of fingerprints in July 2008.

It is therefore unclear why, after DOC and DOHMH signed this MOU and processed a nearly seven-year backlog of fingerprints in July 2008, DOC subsequently stopped processing Corizon employee fingerprints. Despite multiple attempts to determine how Vengersky was designated as the DOC liaison for Corizon fingerprint processing and exactly when and how the process outlined in the MOU failed, DOI investigators failed to get a clear answer from DOC, DOHMH, or Corizon officials. Based on the fingerprint cards DOI found outside Vengersky’s former DOC office in October 2014, Corizon presumably sent at least some prints for new hires. Given that Vengersky’s administrative assistant remembered receiving—but not processing—the fingerprints since 2011, the most recent process failure dates back at least four years—to 2011—and possibly as far back as July 2008, after the initial 2001 to 2008 accumulation of unprocessed fingerprints was addressed.³⁶

Since the enactment of this MOU, which had no termination date, in 2008, Corizon has fingerprinted new employees and sent their fingerprints to DOC for processing. Corizon officials informed DOI investigators that DOC has never notified Corizon with the results of any background investigation on any prospective hire. Conversely, Corizon has never requested the results of any background investigation on its new employees or otherwise sought to obtain a new employee’s criminal history summary from DOC.³⁷

B. DOC Has Only in the Last Month Begun to Obtain and Process Corizon Employees’ Fingerprints, Despite the Fact that DOI Alerted DOC Officials in October 2014 That Fingerprinting Needed to Be Done Immediately.

On October 31, 2014, DOI alerted Commissioner Ponte and other DOC officials that DOC had not conducted fingerprint-based criminal background investigations on any of Corizon’s current employees as contractually required. DOC officials assured DOI that it would be an institutional “priority” to complete these investigations as soon as possible. However, only on February 18, 2015, nearly four months after DOI first notified DOC of this security oversight, did DOC officials begin fingerprinting Corizon employees using the traditional ink fingerprinting method. By March 5, 2015, DOC had only printed 127 of approximately 1,100 Corizon employees using the ink fingerprinting method.

However, DCJS stopped accepting inked fingerprint card submissions in January 2010. In fact, DCJS notified DOC in an interagency memorandum dated August 31, 2009 that in January 2010, it would begin accepting only electronic fingerprint submissions.

³⁵ DOHMH, DOC Intra City Agreement Section III(C), July 1, 2007.

³⁶ DOI’s investigation revealed that the newly hired Corizon employees did pay the required \$75, although their fingerprints were never processed. The employees paid the money to Corizon, which forwarded it onto DOHMH in the form of a credit. DOHMH officials informed DOI that they expected to be billed by DOC for the cost associated with processing the fingerprints, but they never were. DOHMH officials further stated that they did not follow up with DOC to find out why DOC had not requested payment.

³⁷ Corizon officials told DOI that they assumed DOC would notify them if there was a problem with an employee’s criminal background check.

Nevertheless, relevant DOC officials appeared unaware of this when they started using inked cards in 2015. (This fact also rendered pointless and moot Corizon's collection of the cards for the past four years.) While DOC has been aware of the fingerprinting oversight since October 2014, the agency only began properly submitting the 1,100 Corizon employee fingerprints for screening during the week of May 18, 2015.

With respect to the fingerprinting issue, DOC has acknowledged that certain officials did not properly perform their duty in ensuring that background checks for Corizon staff were properly conducted. The agency is performing its own review into the lapses in judgment and process to determine how it can prevent such errors, and ensure that the responsibilities are not isolated to a single individual, even at the Deputy Commissioner level.³⁸ Current DOC leadership is aware of its responsibilities in this area, and has now begun the process.

C. DOC Failed to Use Databases to Which It Has Exclusive Access to Conduct Additional Security Screening on Prospective Corizon Employees and So Did Not Learn of Multiple Suspicious Calls to Such Prospective Employees by Inmates.

DOC has also failed to use databases to which only it has access, to further screen Corizon applicants for inmate contacts that would make the applicants susceptible to inmate manipulation. Even though Corizon has sent DOC the personal telephone numbers of its applicants, DOI has learned that DOC does nothing to screen those telephone numbers through its databases for inappropriate inmate contact. Furthermore, DOC does not screen Corizon applicants for inmate contacts through its visitation databases, to which, again, only DOC has access. Such checks would have revealed that roughly 10% of applicants had suspicious contacts with inmates at around the time of hiring.

DOC exclusively maintains the Inmate Financial Commissary Management System (IFCOM), a telephone monitoring system that tracks and records inmate telephone calls.³⁹ At present, DOC does not subject Corizon candidates to IFCOM screening prior to employment despite the fact that Corizon and DOC officials both acknowledge that Corizon periodically provides its applicants' personal telephone numbers to DOC for background investigations.⁴⁰ Again, however, DOC and Corizon do not appear to have communicated about this process or the results. Had they done so, they would have realized that these phone checks were not being completed.

DOI investigators have now conducted IFCOM checks of the home and cellular telephone numbers listed by MHTAs in their respective employment applications. Of the 48

³⁸ In May 2015, DOC terminated the incumbent Deputy Commissioner of Strategic Planning and Programs, who was responsible for overseeing the criminal background check process for Corizon employees.

³⁹ Inmates are warned by posted signs and recordings before the call that the contents of their conversations are being recorded.

⁴⁰ As discussed in Section IV(A) on page 20, the contract states that Corizon "shall ensure that all prospective and new employees and employees of its subcontractors are advised, in writing, that vital information will be shared with both DOC and DOI for the purposes of background investigations, including home and cell telephone numbers."

MHTAs whose telephone numbers were screened through the IFCOM database, DOI investigators believe inmates contacted the personal telephones of approximately four MHTAs after they began working at Corizon and, therefore, while had access to DOC facilities.

One inmate contacted the home telephone of an MHTA three times approximately three months after the MHTA started working at a DOC facility, with each of those calls lasting between nearly five minutes and 15 minutes. An IFCOM database check on a second MHTA revealed that possibly two different inmates contacted the MHTA's cellular telephone a total of approximately 25 times, with seven of those calls lasting between approximately three minutes and 15 minutes. In another case, an inmate contacted, on six occasions, the home telephone of an MHTA assigned to the same facility in which the inmate was housed; each of those calls lasted between four minutes and 10 minutes. While DOI investigators have not been able to confirm the relationship between this inmate and MHTA, it is worth noting that the two share the same last name.

Additionally, of the 137 MHCs whose telephone numbers were screened through the IFCOM database, DOI investigators believe inmates contacted the personal telephones of approximately 12 MHCs after they began working at Corizon and, therefore, while had access to DOC facilities.

Further, Corizon candidates are also not subject to any DOC visitation checks, as are commonly done through DOC's Visitor Express database, to determine if they have recently visited an inmate. DOI investigators screened the 48 MHTAs' names through DOC's Visitor Express database and found that one MHTA had made two visits to Rikers Island. Additionally, DOI investigators found that one MHC made five visits to Rikers Island, to visit two different inmates. A second MHC made one visit to Rikers Island.

D. DOHMH Also Failed to Adequately Oversee Corizon's Employee Screening.

Although Corizon is responsible for hiring the clinical staff who work in DOC's facilities, DOHMH contractually has oversight of Corizon's performance in its administration of care. Under the DOHMH-Corizon contract, DOHMH annually evaluates Corizon's performance based on 40 performance indicators (PIs). Notably, sixteen of the 40 PIs address issues of timeliness, such as requiring inmates referred to mental health to be seen within 72 hours of the referral or inmates requesting a dental exam to be seen within 21 days of the initial request. Except for 10 senior positions listed in the Corizon-DOHMH contract, DOHMH, according to its own officials, exercises virtually no oversight over Corizon's hiring of mental health staff, instead leaving Corizon unsupervised.⁴¹

Further, DOHMH does not oversee or assist in Corizon's annual performance evaluations of clinical staff. DOHMH appears to assume that Corizon is evaluating its own staff to ensure

⁴¹ The current DOHMH-Corizon contract, under Section XI(A), allows for DOHMH to "reserve the right to approve the hiring of certain high-level medical and mental health directors," including "Program Director... Regional Medical Director... Deputy Medical Director... Director of Dentistry... Mental Health Director... Regional Director of Nursing, Site Health Service Administrators, Site Mental Health Unit Chiefs/Mental Health Managers, Site Medical Directors and Site Directors of Nursing."

quality of care once hired, but DOI's review of the MHTA and MHC personnel files showed that yearly staff evaluations appear irregular at best. Out of the 134 employees who have worked at Corizon for over one year, only 8 had performance reviews in their files covering each year of their service at Corizon.⁴² The Corizon performance review explicitly states that it must be completed within 30 days of the employee's yearly anniversary. Nonetheless, the vast majority of employees are missing at least one annual evaluation.⁴³

DOHMH failed to ever review these files or take proper steps to ensure appropriate supervision and reviews were completed.

DOHMH officials, in response to this Report, informed DOI that they were aware of Corizon's failure to consistently evaluate staff, and that the issue factored into a downgrade of Corizon's performance rating issued in the City's VENDEX system. Specifically, DOHMH officials pointed to language in their 2014 VENDEX evaluation of Corizon, which states, "Another area that remains subpar is implementing standardized performance evaluation for the staff."

DOI finds DOHMH's response problematic for several reasons. First, statements in VENDEX are not relevant to the issue here, as they do not substantively address problems with an existing contract – they merely prevent others from using that contractor. If DOHMH believes that the way to deal with a failing contractor is by simply noting a concern in VENDEX, then agency staff do not understand the way in which city procurement is managed. Second, DOHMH informed DOI that the issue of inconsistent staff evaluation factored into the downgrade of Corizon's performance rating. In fact, Corizon's performance rating in VENDEX did not change from 2013 to 2014. In both years, DOHMH gave Corizon overall performance ratings of "Fair."⁴⁴ DOHMH did downgrade Corizon's performance rating from 2012 to 2013, from "Good" to "Fair," respectively. However, when testifying before City Council in March 2015, DOHMH Deputy Commissioner Dr. Homer Venters noted that, in 2014, Corizon "improved dramatically" in the areas that lead to the 2013 downgrade. Despite Venters's remarks, however, DOHMH gave Corizon a "Fair" overall performance rating on its 2014 VENDEX evaluation.

DOHMH officials further noted – also in response to DOI's findings of inadequate supervision -- that the agency holds numerous meetings (weekly, monthly and quarterly) with Corizon staff to address issues related to patient care. DOHMH provided minutes from those meetings, which, although silent on the issue of hiring Corizon staff, show that Corizon and DOHMH officials regularly discuss patient care, areas of concern, and problems with DOC staff,

⁴² Approximately 51 current MHTAs and MHCs have been employed for less than a year, and therefore have not received an annual performance evaluation.

⁴³ DOHMH and Corizon stated that, within the past two months, Corizon has put new HR procedures in place that DOHMH claims will remedy some of these issues. Further, Corizon officials, in response to this investigation's findings, informed DOI that employees' performance evaluations may not have been kept in their personnel files. This information, however, conflicts with what DOI investigators were told by Corizon human resources staff.

⁴⁴ Contractors are rated in VENDEX on a 1-5 scale: Unsatisfactory (1); Poor (2); Fair (3); Good (4); Excellent (5).

among other things. However, as the results of this investigation demonstrate, that supervision was not adequate with respect to hiring and supervision of staff.⁴⁵

Finally, DOHMH officials also informed DOI that, in response to Bradley Ballard's death in 2013, the agency and Corizon have taken numerous corrective actions to ensure that the failures that contributed to his death do not reoccur. Specifically, DOHMH has begun rolling out PACE units, which provide enhanced therapeutic programming for mentally ill inmates. One of the PACE units is designated for inmates who, like Ballard, are identified as decompensating.

V. Corizon's Failure to Screen and Supervise Staff, and DOHMH and DOC's Failure to Adequately Supervise Corizon, Cannot Be Disassociated from the Illegal Activity and Inmate Deaths and Injuries That Have Occurred.

Given the multitude of factors that contribute to delivering medical and mental health care in a correctional setting, it is virtually impossible to draw a direct correlation between hiring and inadequate care. However, the cumulative effect of Corizon, DOHMH, and DOC's combined failures to properly screen and supervise Corizon's employees has been significant. Of the 185 MHC and MHTA personnel files DOI reviewed, approximately 34 contained documented instances of employee discipline. While many of these employees were disciplined for excessive tardiness or abuse of sick leave, which signal concerns about their professionalism, some involved a disturbing neglect of inmate care. DOI surveillance of Corizon staff confirms these problems.

A. Recent DOI Investigations of Illegal and Improper Activity by Corizon Staff

DOI has conducted a number of investigations into the conduct of Corizon employees, some of which have already resulted in arrests. Further investigations are continuing. Several cases worth noting are discussed below.

Among other tasks, MHCs are required to complete daily rounds in Mental Observation housing areas, which requires them to look into inmate cells to ensure the inmates do not require immediate attention. In one instance, the MHC's failure to do so had widely publicized results. One of the cells that the MHC failed to inspect housed a diabetic, schizophrenic inmate who had tied a ligature around his genitals, smeared feces in his cell, and was in need of urgent medical attention. That inmate, Bradley Ballard, ultimately died, according to the coroner's report, from diabetic ketoacidosis with a contributing factor of genital ischemia.⁴⁶ The Bronx County District

⁴⁵ DOHMH officials still further noted—again in response to DOI's findings of inadequate supervision—that the agency does maintain a patient relations unit that investigates patient complaints regarding delivery of health care. However, it is unclear how inmates could be expected to know about systemic problems related to the hiring of Corizon staff, such as a lack fingerprinting and criminal background checks. Moreover, no properly regulated jail system should rely upon incarcerated mental health patients to self-report problems regarding their care.

⁴⁶ As noted in Section IV(D) above, DOHMH downgraded Corizon's VENDEX performance rating in 2013, following Ballard's death. However, DOHMH inexplicably glossed over Ballard's death when providing comments on Corizon's overall performance, noting only that one of the "discrete areas of sub-par performance during this reporting period included ... inconsistent care in several mental observation units."

Attorney's Office and DOI are currently investigating the circumstances surrounding Ballard's death.

DOI investigations, along with further file review, demonstrate multiple additional examples of Corizon staff failing to provide proper care or otherwise engaging in illegal conduct. The most significant examples are below:

In another instance, an MHC removed an inmate from a court-ordered suicide watch without consulting a psychiatrist, in violation of DOHMH policy. According to records contained in the MHC's personnel file, the inmate, a 17-year-old adolescent, had been referred for an "assessment of suicidal ideation." The MHC subsequently interviewed the inmate, determined that he was not a suicide risk, and attempted to move the inmate into a general population housing area without consulting a supervisor or psychiatrist. The MHC, despite learning that the inmate was on court-ordered suicide watch from COs assigned to the inmate's housing area, informed his clinical supervisor that the inmate did not need to be on suicide watch. The MHC then had the inmate removed from suicide watch. Later that day, DOC generated a new mental health referral for the inmate because he was "being depressed." Despite the referral, COs in the inmate's housing area sent the inmate back to his cell; no mental health employee conducted a follow-up assessment with the inmate, who was found the next morning hanging in his cell. He died 10 days later, as a result of his injuries.

During the course of DOI's file review, investigators noted other instances of malfeasance by MHCs that was unacceptable under any circumstance and could have exposed DOHMH and DOC to liability had they resulted in an inmate injury or death. In one instance, an MHC, whose personnel file does not contain an employment application let alone an interview sheet, interview notes, or reference verifications, allowed DOC to transfer an inmate-patient on suicide watch without continuing that watch. That same MHC had been suspended a total of approximately 14 days for excessive lateness and sick leave abuse.

Yet another MHC faced disciplinary action for copying and pasting inmate-patient notes, on four occasions, from reports she had previously written as well as from reports written by other MHCs.

DOI has also investigated multiple allegations of wrongdoing by Corizon clinicians. Several of these allegations have resulted in arrest or termination of the employees. As noted, in September 2014, for example, DOI investigators arrested a Corizon nurse, Jeffrey Taylor, on a 28-count felony bribe-receiving indictment filed by the Bronx District Attorney's Office on allegations that he smuggled tobacco and alcohol to inmates in his facility.

Also in September 2014, DOI substantiated allegations that an MHTA had smuggled tobacco and alcohol to seriously mentally ill inmates with disciplinary issues. DOC video surveillance corroborated the MHTA's misconduct, which ultimately led to his termination.

More recently, in early May 2015, DOI investigators arrested an MHC after he smuggled three packages of tobacco and synthetic marijuana secreted inside a lotion bottle. One week later, DOI arrested another Corizon employee for smuggling a straight edge razor into a facility on Rikers Island. Fingerprinting of this last employee at that time revealed a 13-year prison term for kidnapping.

B. DOI Investigators' Surveillance of Corizon Staff's Care for Inmates in Mental Health Housing Areas.

In order to determine how effectively inmates with mental health diagnoses are being treated by both DOC and Corizon staff, DOI investigators conducted a series of site visits to 28 of the 30 housing areas reserved for those M-designated inmates.⁴⁷ DOC has several different types of mental health housing areas, each reserved for inmates with different needs and disciplinary histories. As such, the anecdotal evidence DOI investigators received from DOC and Corizon staff varied, at times significantly, from housing area to housing area. Nonetheless, investigators made several observations related to medication compliance and mental health treatment sessions.

i. Medication Compliance – Site Visits

DOI investigators observed the distribution of medication in two different Mental Observation (MO) housing areas. Although the inmates housing in the MO units are M-designated, not all of the medication dispensed was for psychiatric purposes. This method of distribution is used for the majority of medication, from psychotropic drugs to lotions and vitamin supplements, dispensed to inmates.

The Corizon pharmacist, wheeling a large cart with compartments for various medications, was escorted to the housing area by a CO. The pharmacist wheeled the cart into the housing area's control room (*i.e.*, a central, enclosed room from which a CO can see the housing area and electronically control cell doors and the doors to the housing area). The inmates who were prescribed medication, and wanted to take it, lined up inside the housing area in front of a small window allowing for items to be passed from the control room to the housing area.

In the control room, the pharmacist said that as the inmates approached the window one by one, he verified their identities by asking them to present their inmate identification cards (rectangular paper cards that contain an inmate's photo, name, and inmate number). He then cross-referenced the inmate's name with his pharmacy medication distribution list (a list of the inmates and the medication each one receives), and passed the medication in the appropriate dosages to the inmate. The pharmacist said that if an inmate accepted his medication, he noted that on the medication distribution list. Likewise, the pharmacist noted if an inmate did not show up to the window to receive his medication or refused part of his prescribed medications.

The inmates who accepted their medications immediately walked five to 10 feet away from the pharmacy window, where a DOC escort officer waited with a jug of water or juice, cups, and a trash can. Most inmates poured themselves a small cup of liquid, appeared to swallow their medication, and threw the empty cup in the trash can.

As soon as one inmate stepped away from the window, the pharmacist turned his attention to the next inmate in line. For the length of the medication distributions observed by DOI, the DOC escort officer carried on conversations with other COs in the housing area. Neither the Corizon pharmacist, the DOC escort officer nor the COs assigned to the housing area

⁴⁷ DOHMH classifies inmates that have been admitted to Mental Health Services (MHS) as "M-designated." DOHMH informed DOI that if an inmate is not M-designated at intake, he will become M-designated after he receives mental health treatment three times.

actually watched the inmates put the medication into their mouths, or conducted any kind of mouth check to determine if the pills had been swallowed.

According to DOHMH policy # PH 16, medication designated for “immediate use,” such as psychotropic drugs and vitamin supplements, must be taken by the inmate when provided by the pharmacist, and a CO “will ask patients to speak after taking their medication and/or perform a mouth check for security reasons.”⁴⁸ The policy goes on to state that pharmacy staff are to “document this conversation in the pharmacy log book,” and that patients who do not comply should be reported to medical or mental health staff.

At no time did DOI investigators witness a CO ask an inmate to verbally or physically confirm that he took his medication. Nor did DOI investigators witness any verbal exchange between the Corizon pharmacist and any CO while medication was being distributed.

DOI investigators asked both the pharmacist and the DOC escort officer, who was in charge of distributing the water, if they monitored whether the inmates actually swallow their medications. The pharmacist stated that he marks on his list whether the inmates accepts or refuses his medication and that the CO watches to see whether the inmate takes it. The CO stated that the other COs assigned to the housing area note how many inmates line up at the pharmacy window to receive medication, and that the pharmacist tracks whether the inmate accepts his medication. In sum, the staff from Corizon and DOC each believe the responsibility has been delegated to the other. The result, during the shifts watched by DOI, was that no one actually checked to see if inmates with diagnosed mental health disorders had taken vital medication.

ii. Mental Health Treatment Sessions

In addition to observing the medication distribution process during site visits to mental health housing areas, DOI investigators also observed several mental health treatment sessions that took place in different MO housing units.

In general, DOI investigators were struck by the short length of time for both the mental health sessions and the medication appointments. In one housing area, DOI observed an MHC arrive in the housing area and begin calling inmates for one-on-one appointments. DOI investigators timed the length of one of the MHC’s sessions with an inmate. It lasted approximately three minutes.⁴⁹

DOI investigators approached the MHC and asked her for details on her role and the purpose of her sessions with the inmates. She stated that she was in the housing area conducting TPRs, or Treatment Plan Reviews, which she described as individual meetings with inmates used to evaluate their progress. On average, she said, she is assigned to see 12 inmates in a day.

⁴⁸ The policy notes that while the act of speaking “does not guarantee that the medication has been taken, it is a mechanism to deter hoarding of medication.”

⁴⁹ DOI offers no opinion on the therapeutic value of this or any other treatment session. Indeed, DOI discussed its observations with the Director of Correction-Based Operations for the NY State OMH. He stated that, in the state system, sessions with a therapist can be as short as five minutes, if the inmate wants nothing to do with mental health, or they can last as long as 35-40 minutes.

When asked if her sessions are generally as brief as those observed by DOI, the MHC said that the length of an appointment varies by inmate. She said that she was familiar with the two inmates she had already seen and neither usually like to talk for an extended period of time. She said that for other inmates the sessions could last 15 to 25 minutes. Subsequently, after becoming aware of DOI's observation, the MHC called over another inmate for a one-on-one session. The session lasted 22 minutes.

VI. Based on its Findings, DOI Recommends a Series of Reforms to the Provision of Health and Mental Health Services at DOC Facilities.

As noted above, DOI has significant concerns about Corizon continuing to serve as a health care provider in New York City's jails. Additionally, DOI has concerns that the lack of effective communication between Corizon, DOC and DOHMH, and the frequency with which these entities blame one another for the failings of all, present a significant roadblock to effective solutions going forward. Regardless, whatever entity is responsible for providing healthcare going forward must make changes to the staff screening and supervisory process. Further, DOC must also become involved in the provider's applicant screening as it is responsible for the safety and security of its own facilities. Therefore, DOI makes the following recommendations to DOC, DOHMH, and whatever direct provider is chosen, to improve the candidate screening process, and, if needed, to monitor new hires.

A. Any Future Health Care Provider Must Employ Stricter Professional and Character Standards When Assessing its Applicants and Conduct Follow-up Investigations Into Disclosures or Allegations That Call an Applicant's Judgment and Character Into Question.

As described in this report, Corizon hiring officials knowingly hired several MHCs and MHTAs with alarming character concerns. Given the sensitive and demanding nature of the work undertaken by medical and mental health professionals in DOC facilities and the corruption vulnerabilities they often face via frequent inmate contact, a health care provider must exercise stricter professional and character standards with which to assess its applicants. DOI recommends that such provider implement a list of disqualifying criteria with the Correction Officer Notice of Employment serving as a starting point:

“Proof of good character and satisfactory background will be absolute prerequisites to appointment. The following are among the factors which would ordinarily be cause for disqualification: (a) conviction of a felony; (b) conviction of any offense, the nature of which indicates lack of good moral character or disposition towards violence or disorder; (c) repeated convictions of an offense, where such convictions indicate a disrespect for the law; (d) discharge from employment, where such discharge indicates poor behavior or inability to adjust to discipline; (e) dishonorable discharge from the Armed Forces; (f) conviction for petit larceny and (g) conviction for domestic violence.”

B. Any Health Care Provider, DOHMH, and DOC Must Work Jointly to Make its Clinical Staff Screening Uniform, Thorough, and Tailored to the Unique Corruption Vulnerabilities at DOC. The Provider Must Document its Personnel Decisions.

DOI's investigation revealed that DOC and Corizon essentially act as two separate entities in the screening of Corizon's clinical staff candidates. For several years, Corizon mistakenly assumed DOC was conducting criminal background investigations while DOC mistakenly believed Corizon was doing so. DOHMH also assumed these checks were being done, without conducting any significant follow-up. Any direct provider and DOC must begin working collaboratively to screen Corizon's clinical staff applicants. While it is beyond DOI's purview and mission to discuss such policy decisions, the City must consider whether it is effective to have three entities involved, under the present structure, in inmate healthcare, rather than a provider that contracts directly with DOC. If the City determines to keep DOHMH's present role, then clear lines of authority and responsibility must be set forth in writing.

To improve the application process, DOI makes the following recommendations which DOC, after consultation with DOI, has agreed to:

1. DOI recommends that any future health care provider, DOHMH, and DOC form a joint hiring committee consisting of one official from each agency and hold regularly scheduled meetings to discuss and review the hiring of clinical staff. During these meetings, the direct provider, DOHMH, and DOC officials should share their findings regarding the proposed candidate and reach a joint decision as to whether the candidate should be hired before finalizing any offer of employment. Such process must be documented.
2. DOC must immediately fingerprint all health care employees and submit those fingerprints for analysis as part of a comprehensive criminal background investigation.
3. The direct provider's employment application must require candidates to disclose all prior convictions as well as arrests with a detailed description provided by the candidate regarding the circumstances involving each conviction or arrest. The application must also request candidates to disclose whether they have previously been disciplined at work or terminated or asked to resign from a job. If so, the candidate must describe in detail the circumstances surrounding such discipline, termination, or resignation.
4. The direct provider's hiring officials must contact candidate references and verify prior employment. The focus of such investigations is not merely to confirm whether a candidate was previously employed with the stated employer, but also to ascertain his or her work habits, attitude, competence, and professionalism displayed at prior jobs.
5. The direct provider and DOC must work in conjunction to conduct investigations into applicant disclosures of past misconduct, which should include an interview of the applicant seeking explanation for such disclosures and public records searches to obtain additional information into the misconduct.

6. The direct provider must use a standard detailed checklist that identifies all documents that it requires applicants to submit, including but not limited to copies of references, diplomas, professional licenses, and license verifications, and work cooperatively with DOC to ensure that all investigative steps necessary to complete a background investigation have been undertaken.
7. DOC should ensure that all prospective health care employees are subject to IFCOM and Visitor Express checks to determine whether inmate contacts exist. Specifically, not only should DOC investigators check IFCOM databases for applicant telephone contact with inmates, but investigators must also listen to the recorded telephone calls between the inmate and the applicant. The identification of an applicant's phone number in the inmate database is concerning, and only a review of the content of these calls will allow DOC to determine the extent of the relationship and whether it should disqualify the candidate.
8. DOC must work with the direct provider to ensure that the personal telephone numbers of clinical employees are regularly monitored in DOC's IFCOM database for inmate contact in order to discover those employees who might be having inappropriate inmate relationships and eliminate the potential security risk posed by such relationships.
9. Hiring decisions by interviewers and supervising officials must be documented. Interviews of candidates should be directed by a questionnaire that focuses on the applicant's competence, prior training and experience, and fitness and ability to work in a correctional setting. The interviewer(s) must document the candidate's answers to these questions.

C. Whatever Direct Health Care Provider is Chosen Must Monitor its Health Professionals for Licensing Compliance on a Daily Basis.

Based on the findings discussed above, DOI recommends that whatever provider is chosen begin routine licensing compliance checks of its medical as well as mental health staff to confirm that 1) that prospective employees are properly licensed and 2) any existing clinical staff requiring professional licensure maintain good standing with NYSED.

VII. Conclusion

Corizon has failed to either screen or properly supervise its employees. Further, Corizon staff have, on several occasions, provided inadequate care—sometimes seriously so—and have engaged in other illegal activity. For these reasons, we have significant concerns about Corizon's suitability as a contractor to provide healthcare services to the City's jails.

Further, both DOC and DOHMH have failed to properly supervise Corizon despite their clear obligation to do so. More troubling, a lack of effective communication between all three entities has resulted in a broken system, where necessary background screening for over 1,100 employees working in the City's jails was not done. Regardless of the healthcare provider that is selected to succeed Corizon, strict rules for DOC and DOHMH's roles must be set out to ensure proper supervision. DOI will continue to monitor these issues.