NEW YORK STATE | Commission of Correction

Final Report of the New York State Commission of Correction:

In the Matter of the Death of

Miguel Pena (16A0625), an incarcerated individual of the Five Points Correctional Facility

March 29, 2022

To: Honorable Anthony Annucci
Acting Commissioner
NYS Department of Corrections
And Community Supervision
The Harriman State Campus
1220 Washington Avenue
Albany, New York 12226

Allen Riley
Chairman

Thomas J. Loughren
Commissioner

Yolanda Canty
Commissioner

GREETINGS:

WHEREAS, the Medical Review Board has reported to the NYS Commission of Correction pursuant to Correction Law, section 47(1)(d), regarding the death of Miguel Pena who died on October 29, 2018, while an incarcerated individual in the custody of the NYS Department of Corrections and Community Supervision at the Five Points Correctional Facility, the Commission has determined that the following final report be issued.

FINDINGS:

1. Miguel Pena was a 66-year-old, White, Hispanic male who died on 10/29/2018 from a suicidal hanging while in the custody of the Department of Corrections and Community Supervision (DOCCS) at Five Points Correctional Facility (CF).

2. Pena was born in San Jose, Dominican Republic. Pena came to the United States from the Dominican Republic by plane on 9/29/1973 when he was 20. Pena completed the 4th grade in the Dominican Republic. Pena was unemployed and did not have any gang affiliations. Pena was survived by his parents, 5 brothers, 3 sisters and 1 child.

3. [redacted] In the instant offense on 6/23/2011 in Manhattan, New York, Police had been investigating the disappearance of a female. Police banged on Pena's bedroom door, to which Pena did not open. Once police had entered the room, they observed the body of the deceased woman wrapped in plastic and covered by a bedsheet on the floor of Pena's bedroom. Pena's motive in the crime was listed as poor anger management. Pena was convicted of murder and was serving his first New York State prison incarceration at the time of his death. Pena was originally received by DOCCS on 1/22/2016 at Downstate CF (Reception) and was transferred to Sing Sing CF on 3/11/16. Pena was transferred from Sing Sing CF and to Five Points CF on 4/25/2016.

4. [redacted]

5. [redacted]

6. [redacted]

[redacted]

7. On 3/11/16, Pena was admitted to Sing Sing CF. [redacted]

8. [redacted]

9. [redacted].

10. [redacted]

11. [redacted].

12. [redacted]

13. [redacted]

[redacted]

14. [redacted]

15. [redacted]

16. On 10/29/18 at 5:15 p.m., per the NYS DOCCS Office of Special Investigation, written review of video surveillance of Building 8, Gallery A, Block 1, 18 Bottom Cell (8-A1-18B), CO M.B. was seen making a security round on 8-A1-18B in which nothing seemed unusual. At 5:28 p.m., Pena was seen entering his rec pen from his cell (8-A1-18B) and had walked behind a blanket that had been tied to the rec pen bars.

17. At 5:44 p.m., Pena's cellmate Incarcerated Individual (I.I.) [redacted] returned from the mess hall and found Pena hanging in the rec pen. I.I. [redacted] yelled for help. Correctional Officers (COs) M.P. and A.D. responded. The COs had I.I. [redacted] step out of the cell and when they entered, they found Pena hanging on the right side of the rec pen in the corner suspended by a 37-inch black shoelace. One end of the shoelace was tied to the rec pen bar gate and the other was tied to Pena's neck forming a garrote. COs M.P. and A.D. held Pena's body up to relieve tension on the ligature and yelled for a cut-down tool. COs J.H., C.Y., and M.K responded. CO M.K. brought the cut-down tool and handed it to CO C.Y. then left to retrieve a stretcher. CO C.Y. cut the shoelace from the bars with a pair of medical scissors. Pena was placed on the floor and CO M.P. cut the shoelace from Pena's neck. CO M.P. then got the Block 8 AED and placed it on the stretcher and area Sgt. J.E. was notified. However, OSI noted that the responding officers, COs M.P., A.D., J.H., and C.Y., failed to immediately start CPR and apply the AED to Pena while in the cell and waiting for medical staff to arrive.

18. At 5:50 p.m., COs A.D., J.H., and C.Y. were seen on video carrying Pena out of the cell and placing Pena on a stretcher. At 5:51 p.m., COs A.D., J.H., and C.Y. exited Building 8 while pushing Pena towards the infirmary.

19. At 5:53 p.m., COs A.D., J.H., and C.Y. were stopped in the hallway by medical staff LPN [redacted]. and Sgt. R.H. who asked if Pena had a pulse. CO J.H. checked for a pulse and when he did not find one, Sgt. R.H. ordered CO J.H. to start CPR. CO J.H. climbed onto the stretcher, straddled Pena, and began CPR. Sgt. R.H. noted the presence of the AED on the stretcher but had been unaware if it was attached or not. LPN [redacted]. was present at the time and no bag valve mask or AED had been applied nor had Narcan had been administered. CO J.H. continued CPR while COs A.D. and C.Y. pushed the stretcher to the infirmary. LPN [redacted] followed them behind holding the AED.

20. At 5:55 p.m., COs A.D., J.H., and C.Y. entered the infirmary and medical staff assumed care of Pena. [redacted]. Sgt. P.S. called 911.

21. [redacted]

22. [redacted].

23. [redacted].

24. After Pena's death, I.I. witnesses were interviewed and reported that Pena did not express any suicidal ideation or thoughts of self-harm.

25. On 3/22/19, investigative findings from the DOCCS Office of Special Investigation were submitted to the Bureau of Labor Relations who ruled that there would be no formal discipline for COs M.P., A.D., J.H., and C.Y. and that they would be re-trained in First Aid, CPR, and AED. On 4/7/19, COs M.P., A.D., J.H., and C.Y. were formally counseled by Sgt. J.E. for failure to provide proper First Aid, CPR, and AED for an unresponsive I.I. On 3/18/19, COs M.P., A.D., J.H., and C.Y. were re-trained in First Aid, CPR, and AED. A report of Training Form (RTF) was completed and signed by all officers involved. The Medical Review Board finds corrective action taken by DOCCS to formally counsel and retrain cited staff in First Aid, CPR and AED as acceptable, however makes note that the finding of inadequate and or delayed CPR response has been a finding cited by the Board in multiple previous matters laying concern regarding a need for system wide review and retraining.

ACTIONS REQUIRED:

TO THE ACTING COMMISSIONER OF THE DEPARTMENT OF CORRECTIONS AND COMMUNITY SUPERVISION:

That a system-wide review regarding emergency response and CPR training be conducted to identify areas where areas of improvement or additional training is needed.

A report of findings and corrective actions shall be forwarded to the Medical Review Board upon completion.

In a response to the Commission's preliminary report dated 2/9/22, DOCCS Deputy Commissioner of Health Services indicated that the requested reviews were completed with comprehensive corrective action(s) taken.

WITNESS, HONORABLE THOMAS J. LOUGHREN, Commissioner, NYS Commission of Correction, Alfred E. Smith State Office Building, 80 South Swan Street, 12th Floor, in the City of Albany, New York 12210 on this 29th day of March, 2022.

Thomas J. Loughren
Commissioner & Chair
Medical Review Board

TJL:JW:jdb
2018-M-0146
March 2022

cc: Dr. Carol Moores, Acting Deputy Commissioner, Chief Medical Officer
Bryan Hilton, Assistant Commissioner for Mental Health
Superintendent Amy LaManna, Five Points CF
Dr. Li-Wen Lee, Associate Commissioner
Division of Forensic Services, NYS Office of Mental Health
Danielle Dill, Executive Director, CNYPC
William Vertoske, Deputy Director of CBO, CNYPC
Meaghan Bernstein, Director of CBO Risk Management, CNYPC