NEW YORK STATE | Commission of Correction

Final Report of the New York State Commission of Correction:

In the Matter of the Death of

Travis Augustine (09A2824), an incarcerated individual of the Green Haven Correctional Facility

March 22, 2023

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 Travis Augustine who died on October 27, 2020, while an incarcerated individual in the custody of the NYS Department of Corrections and Community Supervision at the Green Haven Correctional Facility, the Commission has determined that the following preliminary report be issued.

FINDINGS:

1. Travis Augustine was a 35-year-old male who died on 10/27/20 due to a suicidal hanging while in the custody of the New York State Department of Corrections and Community Supervision (NYS DOCCS) at the Green Haven Correctional Facility (CF).

2. [redacted]. The instant offense represented a multi-count indictment. Augustine, between the dates of 7/2/08 and 7/5/08, caused the death of a 48-year-old female whom he was acquainted with by shooting her in the head and burying her in a shallow grave along with the female victim's dog which he shot five times in the head. Augustine buried the dog on top of the female victim in a 3-foot grave on a piece of property in the Town of Catskill. Augustine was convicted of Murder 2nd Degree and Criminal Possession Stolen Property 4th Degree and sentenced to 29 years to Life.

3. [redacted].

4. On 6/2/09, Augustine was received in the NYS DOCCS system at Downstate CF. In August 2009, Augustine was transferred to Attica CF. In March 2016, Augustine was transferred to Elmira CF. In January 2018, Augustine was transferred to Green Haven CF.

5. On 3/8/20, Augustine was found unresponsive in the recreation yard. [redacted]

6. On 7/21/20, a medical response was activated for an unresponsive incarcerated individual. [redacted]

[redacted].

7. [redacted].

8. An Office of Special Investigations (OSI) review of phone records indicated that Augustine's brother had died in September and as a result, Augustine had increased his requests to his family for money for "bills". An OSI review of his J Pay account revealed messages to his mother that he was depressed over the death of his brother despite not seeing him in 13 years. Augustine also informed his mother that despite family members sending money, he was still in debt and his payment was overdue and that he was running out of time.

9. On 10/27/20 at 6:20 a.m., CO A.S. was letting mess hall workers out of their calls and heard an incarcerated individual yelling for medical attention. CO A.S. responded to cell B 264 and found Augustine hanging from the cell bars by a shoelace tied around his neck with the other end secured to the front cell bars. CO A.S. called a medical response and used the cut down knife to release the shoelace from Augustine's neck. CPR was initiated and the AED was applied with no shock advised. Sgt. M.M. arrived and advised the officer to turn off the AED and stated that the cords were interfering with CPR. This was a violation of NYS DOCCS Directive 4059: Response to Health Care Emergencies. OSI identified this issue and Sgt M.M. was referred to the Bureau of Labor Relations for administrative action. Medical staff arrived on the first floor of the housing unit [redacted]. Em-Star EMS was activated at 6:39 a.m. however upon their arrival to the facility, there was a 30-minute delay for them to get to medical. At 7:14 a.m., EMS was in medical with Augustine. [redacted] The medical staff's failure to direct staff, apply the cervical collar, apply the AED and give Narcan was a violation of NYS DOCCS Directive 4059: Response to Health Care Emergencies. There was no nursing note related to the terminal event in the medical records or on the medical response record. This is a violation of NYS DOCCS Health Service Policy Manual 4.01 Inmate Health Records III.B.1.b. which indicate that health care encounters will be documented at the time of the occurrence.

10. The issue pertaining to the delayed EMS response at Green Haven CF was identified by OSI and has been addressed previously. Corrective action included a change in policy where the Watch Commander is to be notified that EMS has been contacted and an officer will be directed to the front gate in order to escort the EMS team . The OSI Investigation revealed that there was an outgoing message to Augustine's family in which he apologized for his actions.

ACTIONS REQUIRED:

TO THE DEPUTY COMMISSIONER OF THE NYS DEPARTMENT OF CORRECTIONS AND COMMUNITY SUPERVISION, DIVISION OF HEALTH SERVICES:

1. The Deputy Commissioner shall convene a quality assurance review regarding the emergency response care provided to Augustine specific to adherence to the Non-Patient Specific Standing Order for the Unresponsive and/or Respiratory Depression Possibly Caused by Opioid Overdose procedure as Narcan was not administered to Augustine in this instance.

2. The Deputy Commissioner shall convene a quality assurance review with Green Haven CF nursing staff regarding compliance with Health Service Policy Manual 4.01 Inmate Health Records III.B.1.b. which indicated that health care encounters will be documented at the time of the occurrence

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

In a response dated 3/8/23 to the Commission's preliminary report, the Deputy Commissioner for Health Services indicated that the requested reviews were completed with corrective action 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 22nd day of March, 2023.

Thomas J. Loughren
Commissioner & Chair
Medical Review Board

TJL:DC:jdb
2020-M-0113
March 2023

cc: Dr. Carol Moores, Chief Medical Officer
Bryan Hilton, Assistant Commissioner for Mental Health
Superintendent Mark Miller, Green Haven 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, Advocacy Letter Coordinator, CNYPC