NEW YORK STATE | Commission of Correction

Final Report of the New York State Commission of Correction:

In the Matter of the Death of

Brandon Rodriguez, an incarcerated individual of the Otis B Bantum Center

June 28, 2023

To: Commissioner Louis Molina
NYC Department of Correction
75-20 Astoria Blvd., Suite 100
East Elmhurst, NY 11370

Allen Riley
Chairman

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 Brandon Rodriguez who died on August 10, 2021, as result of circumstances which occurred while an incarcerated individual in the custody of the New York City Department of Correction, the Commission has determined that the following final report be issued.

FINDINGS:

1. Brandon Rodriguez was a 25-year-old male who died on 8/10/21 due to a suicide hanging while in the custody of the New York City Department of Corrections (NYC DOC) at the Otis Bantum Correctional Center (OBCC). The Medical Review Board opines that chronic and repeated staffing issues and the failure of the administration of the NYC DOC to assure adequate supervision and safety of the incarcerated individuals in their custody resulted in the opportunity for Rodriguez to successfully take his own life and constitutes a violation of Correction Law §500-c(4) that requires the Department to keep incarcerated individuals safe. During the approximately 5 days that Rodriguez was in the custody of NYC DOC, he was never properly classified and was not placed in a proper authorized housing area in accordance with NYS Minimum Standards. The Board opines that had Rodriguez been properly admitted, classified, housed, and supervised in accordance with minimum standard requirements, his death could have been prevented.

2. [redacted] In the instant offense, on 8/4/21, Rodriguez was arrested and charged with Strangulation 2nd Degree. Rodriguez was to return to court on 8/9/21 and his bail was $15,000.

3. [redacted].

4. Per the NYC DOC Arraignment and Classification Risk Screening form completed for Rodriguez, a commitment from the court was received on 8/5/21 at 3:56 p.m. and at 4:08 p.m., NYC DOC assumed physical custody. A suicide screening was completed at that time by Correction Officer (CO) A.W. and Rodriguez answered no to all questions. The plan was for Rodriguez to be transported to OBCC.

5. Per the NYC DOC Investigation Division Callout Report and Checklist, Rodriguez arrived at OBCC on 8/5/21 at 11:00 p.m. and was processed at 11:30 p.m. The report noted that Rodriguez was seen in the clinic on 8/6/21 at 1:30 a.m. This information was also documented in the new admission logbook. On 8/6/21 at 3:36 a.m., Rodriguez was transferred to OBCC Reception per the Inmate Movement Activity form.

6. [redacted].

7. On 8/8/21 at 9:45 a.m., per the NYC DOC inmate injury report, Rodriguez was involved

in a fight with another incarcerated individual in the intake housing area.

8. [redacted]. There was no documentation of this event in the clinic injury report logbook. Per the main clinic logbook, EMS was activated for Rodriguez at 1:40 p.m.

9. Per the NYC DOC Investigation Division Callout Report and Checklist, on 8/8/21, Rodriguez returned from the hospital and was brought to the clinic at approximately 11:00 p.m. Per the inmate movement activity form, Rodriguez returned to OBCC on 8/9/21 at 6:42 a.m.

10. [redacted].

11. [redacted].

12. [redacted]

[redacted]

13. On 8/9/21 at 3:35 p.m., Rodriguez was being escorted back to intake and had a use of force after he became disruptive and resisted cuffing. Rodriguez refused escort officers directions and was twisting and showing aggression toward the correction staff and dropping to the floor. The Emergency Response Unit (ESU) was in the corridor after another response and assumed the transfer of Rodriguez. Rodriguez continued to be non-compliant with officers' instructions and was restrained on a gurney and taken to the segregation intake area. Rodriguez continued to resist and eventually he complied with the officers' instructions when he was advised that chemical agents would be utilized. At 3:51 p.m., Rodriguez was placed in shower pen #1 per the video review. During an interview with Commission Staff, Captain C.L. stated that Rodriguez was placed in the shower pen as there were no clean cells available and sanitation was being performed on his arrival. Rodriguez was told that once a cell was cleaned, he could be moved. Rodriquez was secured and was to be taken to medical when security assured that Rodriguez was safe to be evaluated. At that time, Segregation (Seg) Intake was an overflow area for the main intake and was used as needed. Per Assistant Deputy Warden (ADW) S.T., Rodriguez became more compliant and was to be taken to medical for an examination from the use of force. Rodriguez refused to be seen when offered. Captain K.C. was sent to speak to Rodriguez to encourage the medical examination. Rodriguez then agreed to be seen and a mechanical restraint was applied to one wrist. Rodriguez then refused to be seen and refused to have the mechanical restraint removed. Rodriguez refused to come out of the shower pen. During an interview with Commission staff, Captain K.C. stated that the tour commander was notified of the situation and was assembling an extraction team. Captain K.C. left the area pending the extraction team and then was instructed to return to the main intake area due to an incident in that area. During an interview with Commission staff, ADW S.T. stated that at that time, due to a staffing shortage, there was no extraction team available to remove Rodriguez and multiple staff members were brought to Rodriguez to utilize interpersonal communication skills (IPC) to get Rodriguez to agree to his medical evaluation. Rodriguez continued to refuse and could not be taken out of the shower pen.

14. Rodriguez remained in the Shower Pen #1 from 3:51 p.m. on 8/9/21 until being found unresponsive at 12:35 a.m. on 8/10/21, over eight hours later. There was no documentation in the Seg intake A post or B post logs of Rodriguez being placed on the unit or of any staff checking his status in the shower pen . There was no record of Rodriguez's placement on the Inmate Movement History Log. Per the callout report due to a series of documented incidents, Rodriguez was not assigned a housing area, however attempts were made to assign him a housing area. During Rodriguez's

incarceration on 8/8/21, the facility reported that there were 41 incarcerated individuals who were in non-standard housing for over 12 hours, including Rodriguez, due to individuals awaiting medical attention. The Medical Review Board has found that there were substantial violations of minimum standards in this matter including 9 NYCRR §7003.4(a) Supervision of Prisoners Outside Facility Housing Areas, 9 NYCRR §7013.8(a)(b) Classification: Assignment to facility housing area and 9 NYCRR §7040.5(a-d) Maximum Facility Capacity: Multiple occupancy housing units.

Additionally, the Board finds that Rodriguez was not properly placed in a housing area, had expressed serious safety concerns of being in the intake pen area, had assault incidents while in the intake area and then was locked in a shower pen area for over eight hours which constitutes a violation of Correction Law §500-c(4) that requires the Department to keep incarcerated individuals safe. The Board opines that had Rodriguez been properly admitted, classified, housed, and supervised in accordance with minimum standard requirements, his death could have been prevented.

15. On 8/9/21 at 11:20 p.m., CO D.D. conducted a supervisory tour and completed a count with 20 live breathing bodies noted. At 11:30 p.m., CO D.D. completed a supervisory tour.

16. On 8/10/21 at 12:35 a.m., CO D.D., who was on his third consecutive shift, noted that Rodriguez was found in Segregation Intake Pen #1 unresponsive with a white cloth tied around his neck. The cloth was tied to the cell door. CO D.D. noted that he had to slowly open the door to remove the cloth and lower Rodriguez to the floor. Rodriguez called a medical emergency and started CPR. CPR was continued until medical staff arrived at 12:42 a.m. [redacted]. [redacted]. EMS was activated. At 12:49 a.m., Urgi care was called and Dr. [redacted]. arrived at 12:56 a.m. [redacted] At 1:10 a.m., EMS arrived.

17. During the Commission's investigation, a review of the Seg intake B logbook revealed discrepancies in the count including:

On 8/5/21 at 4:00 p.m., per the logbook, the total count was 8

On 8/5/21 at 4:30 p.m., per the logbook, the total was count 9 without any indication of new incarcerated individuals (II) being placed on the unit.

On 7/6/21(sic) at 10 a.m., per the logbook, the total count was 12 without any indication of new II being placed on the unit.

On 8/6/21 at 3:01 p.m., per the logbook, the total count was 9 without documentation of an II being released from the unit.

On 8/6/21 at 8:00 p.m., per the logbook, an II was rehoused with no change in the count noted.

On 8/6/21 at 11:00 p.m., the Seg intake count was left blank.

On 8/7/21 at 12:00 a.m., per the logbook, the total count was 12 without documentation of any new II's being housed on the unit.

On 8/7/21 at 5:00 a.m., per the logbook, 3 new II's were admitted, however there was no change in count.

On 8/7/21 at 7:00 a.m., the officer was documented as being off post, but no count was documented as being completed.

On 8/7/21 at 3:46 p.m., per the logbook, the total count was 16, however there was no documentation of any new IIs being housed on the unit.

On 8/8/21 at 2:45 p.m., the officer documented "NTC" 20-disruptive. There was no documentation of new II being housed on the unit.

On 8/8/21 at 3:30 p.m., the officer documented the count was 16, however there was no documentation of any IIs being released from the unit.

On 8/9/21 at 7:30 a.m., per the logbook, the total count was 15 but 17 IIs remained in Seg intake. There was no documentation of any IIs being removed from the unit.

On 8/9/21 at 10:00 a.m., the officer documented that one II was moved to intake.

On 8/9/21 at 11:55 a.m., the officer documented that six IIs were rehoused and all six were returned, however the total count remained at 15.

On 8/9/21 at 1:00 p.m., the officer documented that one II left, however the total count remained at 15.

On 8/9/21 at 3:31 p.m., per the logbook, the total count was documented as being 15.

On 8/9/21 at 11:20 p.m., the officer documented that he was on post for his third consecutive tour. The officer noted that the total count was 20. There was no documentation of new IIs being housed on the unit.

The noted discrepancies are in violation of 9 NYCRR §7003.5(a) *Prisoner Population counts* which states*:*

> *(a) Prisoner population counts shall:*
> *(1) be conducted at the completion and commencement of each regularly scheduled shift;*
> *(2) be conducted by the facility staff member completing such regularly scheduled shift;*
> *(3) be conducted by the facility staff member beginning the next regularly scheduled shift; and*
> *(4) include an accounting of all prisoners housed in or otherwise assigned to the facility area in which such count is conducted.*

This is also a violation of 9 NYCRR §7003.5(b) which states:
The results of each prisoner population count conducted pursuant to paragraphs (a)(2) and (3) of this section shall be recorded in writing. Such written records shall include the:

(1) date and time of the count;
(2) facility area in which the count was conducted;
(3) number of prisoners accounted for; and
(4) name of facility staff member conducting the count.

ACTIONS REQUIRED:

TO THE COMMISSIONER OF THE NEW YORK CITY DEPARTMENT OF CORRECTIONS:

1. The Commissioner shall conduct an investigation into the actions of the DOC officers assigned to supervise the housing unit and who failed to follow the requirements of 9 NYCRR §7003.4(a) and properly supervise Rodriguez while in the shower pen. Administrative action should be taken if the officers are found to be in violation of department directives.

2. The Commissioner shall conduct an investigation into the failure of the Department to follow the requirements of 9 NYCRR §7013.8(a)(b) Classification: Assignment to facility housing area.

3. The Commissioner shall conduct an investigation into the failure of DOC staff to follow the requirements of 9 NYCRR §7040.5(a-d) Maximum Facility Capacity: Multiple occupancy housing unit.

4. The Commissioner shall conduct an investigation into the failure of DOC staff to follow 9 NYCRR § 7003.5 Prisoner Population Counts.

The Commissioner shall provide the Board a written response of all findings along with an action plan to comply with the cited minimum standard violations.

WITNESS, HONORABLE ALLEN RILEY, Chairman, 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 28th day of June, 2023.

Allen Riley
Chairman
Commission of Correction

AR:DC:jdb
2021-M-0103
June 2023

cc: Paul Shechtman, Deputy Commissioner of Legal Matters/General Counsel

Ronald Brereton, Deputy Commissioner of Security Operations
James Saunders, Deputy Commissioner of Health Affairs
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NYC Board of Correction