NEW YORK STATE | Commission of Correction

Final Report of the New York State Commission of Correction:

In the Matter of the Death of

Christopher Cruz, an incarcerated individual of the Anna M. Kross Center

June 28, 2022

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

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 Christopher Cruz who died on October 9, 2020, 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. Christopher Cruz was a 27-year-old male who died on 10/9/20 due to unknown causes while in the custody of the New York City Department of Corrections (NYC DOC) at the Anna M Kross Center (AMKC). Although viral DNA was identified at Cruz's autopsy, a specific antigen could not be identified and toxicology studies had no positive findings. The Medical Review Board has found that NYC DOC staff failed to comport with the requirements of 9 NYCRR §7003.3 due to failing to document Cruz's flooding of his cell and behavior in the 12 hours prior to his terminal event.

2. [redacted].

3. [redacted] On 12/27/19, Cruz was incarcerated as a court direct admission from the Bronx Criminal Court for charges of Kidnapping 2nd Degree and Arson 5th Degree with a bail amount of $10,000. Cruz had an extraordinarily difficult adjustment to incarceration and was infracted nineteen times and found guilty seventeen times. He was in at least 26 documented use of force incidents with NYC DOC staff during his near 10 months of incarceration. The violations varied from assault on staff and other incarcerated individuals, fighting and physically resisting staff.

4. [redacted]

5. [redacted]

6. [redacted]

[redacted]

7. [redacted].

8. [redacted]

9. [redacted].

10. [redacted]

11. [redacted]

[redacted]

12. [redacted].

13. [redacted].

14. [redacted]

15. [redacted]

16. [redacted]

17. [redacted]

18. On 2/11/20, Cruz was involved in an altercation with another incarcerated individual (II) without injury [redacted].

19. [redacted].

20. [redacted]

21. [redacted]

22. [redacted].

23. [redacted].

24. [redacted]

25. [redacted].

26. [redacted]

27. [redacted]

.

28. [redacted]

29. [redacted]

30. [redacted]

31. [redacted]

[redacted]

32. [redacted]

33. [redacted].

34. [redacted]

35. [redacted]

36. [redacted]

37. [redacted]

[redacted].

38. [redacted]

39. [redacted]

40. [redacted].

41. [redacted]

42. [redacted]

[redacted]

43. [redacted]

44. [redacted].

45. [redacted]

46. [redacted]

47. [redacted]

48. [redacted]

49. [redacted]

50. [redacted] During an interview with Commission staff, CO M.B. reported that he transported Cruz [redacted]. Prior to the transfer, Cruz reportedly ripped the entire holding pen apart and was very erratic and irrational.

51. [redacted],

[redacted]

52. [redacted]

53. [redacted].

54. [redacted]

55. [redacted]

56. [redacted]

57. [redacted].

58. [redacted]

[redacted].

59. [redacted].

60. [redacted].

61. [redacted]

62. [redacted]

63. [redacted]

64. [redacted]

65. [redacted]

[redacted]

66. [redacted]

67. [redacted]

68. [redacted]

69. [redacted]

70. [redacted]

71. [redacted]

72. [redacted]

73. [redacted]

74. [redacted]

75. [redacted]

76. [redacted]

77. [redacted].

78. [redacted]

79. [redacted]

80. [redacted]

81. [redacted].

82. [redacted]

83. [redacted]

84. [redacted]

85. [redacted]

86. [redacted]

[redacted].

87. [redacted]

88. [redacted].

89. [redacted].

90. [redacted]

91. [redacted]

[redacted]

92. [redacted]

93. [redacted]

94. [redacted]

95. [redacted]

96. [redacted]

97. [redacted]

98. [redacted]

99. [redacted]

100. [redacted].

101. [redacted]

102. [redacted]

103. [redacted]

104. [redacted]

105. [redacted]

106. [redacted]

107. [redacted]

108. [redacted]

109. [redacted]

110. [redacted].

111. [redacted].

112. On 8/11/20 at 2:20 p.m., Cruz was involved in an altercation with another II and then DOC staff. [redacted]

113. [redacted].

114. [redacted].

115. [redacted]

116. [redacted]

117. [redacted]

118. [redacted]

119. [redacted]

120. [redacted]

121. [redacted].

122. [redacted]

[redacted].

123. [redacted]

124. [redacted]

125. [redacted].

126. [redacted]

[redacted].

127. [redacted].

128. [redacted]

129. [redacted]

130. [redacted]

131. On 9/19/20 at 2:45 p.m., Cruz was involved in a use of force with DOC staff [redacted]

132. [redacted].

133. [redacted]

[redacted].

134. [redacted].

135. [redacted]

136. [redacted]

137. [redacted]

138. [redacted]

139. [redacted]

[redacted]

140. On 10/8/20 [redacted] At 6:06 p.m., Cruz was transferred to a new cell due to Cruz flooding his cell. Cruz was observed jumping from his bed onto the floor. When Cruz was asked how he was doing, Cruz did not answer and just laughed. During an interview with Commission staff, CO C.C. reported that Cruz had been removed from the cell, showered, and given clean clothes when his cell was changed under direction of Captain J. Institutional lock-in was documented as occurring at 9:00 p.m. with nothing unusual reported during the night shift.

141. [redacted].

142. A review of Gentech video footage of the housing area on 10/9/20 was completed by DOC staff and revealed:

At 6:06 a.m. a Captain is seen touring the MOD 1- lower housing area along with the B-officer. The Captain flashed a light in each cell as he passed.

At approximately 6:10 a.m., the Captain is seen leaving the area and an unidentified incarcerated individual was sitting in the dayroom wearing a white shirt and a white beany. The B-officer walked to the dayroom area and changed the channel on the TV, stood there for approximately two minutes and walked away.

At approximately 6:45 a.m., the B-officer returned to the dayroom area and was looking into a cell behind the TV area momentarily before walking back over to the B-post. He placed something on the desk and continued walking around the housing area.

At approximately 6:47 a.m. the B-officer sat at the desk making a logbook entry. At approximately 6:52 a.m., the B-officer left the housing area.

At 7:00 a.m., another officer entered the housing area, and was seen touring the housing area and then left.

At 7:35 a.m., the officers returned to the housing area and the second officer was observed taking notes.

At 7:38 a.m., the B-officer was observed alongside the second officer unlocking cell doors, making visual inspections, and taking notes. At 7:40 a.m., the second officer left the area.

At 8:02 a.m., a female staff member was seen walking through the housing area.

At 8:05 a.m., an officer was seen looking into a cell while another officer was performing supervisory rounds and looked into each cell. There were four officers in the housing area, two sitting at the13-post and two walking around the housing area. The worker II began conducting sanitation in the housing area and was seen retrieving the broom and supplies.

At 8:10 a.m., two officers were standing in front of the cell behind the TV area for a minute then they walked away.

At 8:29 a.m., there were three officers sitting at the B-post desk writing reports.

At 8:44 a.m., an officer was seen conducting supervisory rounds of the housing area and looked inside each cell before returning the B-post desk.

At 8:53 a.m., a female captain arrived and walked over to Cruz's cell with two officers and looked inside. The captain completed a supervisory tour of the unit and looked in each cell. At 8:58 a.m., the captain left the area.

At 9:14 a.m., an officer was observed standing looking into the cell near the dayroom area before the video is ghosted per the DOC report.

143. A review of the video by SCOC staff for AMKC Mod 1 on 10/9/20 revealed the following:

At 9:19 a.m., three officers were seen sitting at the desk. One II who was identified as an Suicide Prevention Aid (SPA) was sitting on a table watching TV in the area of cell 2, Cruz's cell.

At 9:21 a.m., two officers were seen at the door of Cruz's cell. One officer remained at the door looking in the cell. A third officer then walked to the cell and looked in. That officer then conducted a supervisory round on the unit looking in all cells.

At 9:30 a.m., two officers are at Cruz's cell door looking in.

At 9:31 a.m., the SPA was observed looking into the cell.

At 9:32 a.m., the cell door was opened and one of the officers was seen going to the control window.

At 9:34 a.m., medical responded.

A review of this recorded video footage by Commission staff revealed a gross violation of correctional security procedure. A medical staff member was observed running to the cell and removing their lab coat with photographic identification attached and throwing the lab coat in the direction of the II SPA who held the lab coat for the remainder of the time that he was out of his cell. When directed by DOC staff to return to his cell, the SPA is seen taking the staff member's lab coat into his cell with him.

144. A review of Mod I Lower A post logbook revealed that on 10/9/20 from 12:00 a.m. until 5:00 a.m., general supervisory tours were completed every 30 minutes. At 5:30 a.m., the supervisory tours were noted to be active until the medical emergency occurred and

then they were conducted every 30 minutes. There was no indication in the logbook of any issues with Cruz or flooding of the cell. This in violation of 9 NYCRR §7003.3(j)(6)(i), (ii), (iii), and (iv) which states:

> All written records pertaining to facility housing supervision shall be recorded in ink in a bound ledger of consecutively numbered pages which shall be maintained in each housing areas. Such records shall include, but not limited to, the following information:
> (6)any significant events and activities occurring during supervision, including:
> (i)the date and time of such event or problem;
> (ii) the names of all prisoners and/or staff involved;
> (iii) facility staff response to such event or problem, including a summary of what occurred;
> (iv) a description of the condition of any prisoners involved;

145. A review of Mod 1 Lower B post logbook revealed that on 10/9/20 from 12:00 a.m. until 5:00 a.m., general supervisory tours were completed every 30 minutes. At 5:00 a.m., it was noted that Cruz refused breakfast. At 5:30 a.m., active supervisory tours began. At 6:30 a.m., active supervisory tours were completed. At 7:30 a.m., general supervisory tours were completed. At 8:30 a.m., 8:45 a.m., and 9:00 a.m., active supervisory tours were completed. At 9:15 a.m., Cruz was found unresponsive and a medical emergency was activated.

146. [redacted]

147. During an interview with Commission staff, CO J.T. stated that he performed supervisory tours and noted that Cruz was lying in bed breathing and appeared sleeping. When notified that Cruz was not breathing, CO J.T. assisted with CPR. CO J.T. was unable to recall the last CPR training he received.

148. During an interview with Commission staff, CO A.S. reported that the last time he received any CPR training was at the corrections academy. CO A.S. stated that Cruz's baseline was very erratic. CO A.S. reported that the night before, Cruz was up flooding the cell all night and it was not unusual for Cruz to be sleeping all morning . The requirements of 9 NYCRR §7010.2(f) state:

Facility personnel shall receive training and maintain certification in approved first aid and emergency life saving techniques including the use of emergency equipment.

As accepted certifications and trainings in CPR/First Aid are generally good for three years or less, the Medical Review Board finds that NYC DOC is not in comportment with the requirements of the Minimum Standard.

ACTIONS REQUIRED:

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

1. The Commissioner shall review the policies and procedures regarding the supervision of incarcerated individuals to ensure compliance with 9 NYCRR §7003.3. A copy of any revisions shall be forwarded to the Board to assure compliance with 9 NYCCRR §7003.3.

2. The Commissioner shall conduct a review of the CPR and First Aid training for DOC staff members and institute training plans to assure comportment with the requirements of 9 NYCRR §7010.2(f).

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

In a response dated 6/17/22 to the Commission's preliminary report, NYC DOC has indicated that the requested reviews were completed with the following:

-Policies and procedures for compliance with 9 NYCRR §7003.3 were reviewed. A security memorandum was issued to AMKC staff to reiterate making proper logbook entries. A facility referral was issued to the commanding officer at AMKC to the address the cited officers for non-compliance with the standard.

-A review of DOC members of service CPR certification was completed. 53% of members have current certifications and the Corrections Academy is working to increase the percentage of members certified. This will remain an open violation of 9 NYCRR §7010.2(f) with continued follow up by the Commission.

TO THE SENIOR VICE PRESIDENT OF CORRECTIONAL HEALTH SERVICES, NYC HEALTH AND HOSPITALS CORPORATION:

1. The Senior Vice President shall conduct an investigation into the failure of the medical staff to complete an electrocardiogram on Cruz that was ordered on 4/28/20.

2. The Senior Vice President shall conduct an investigation into the cited medical staff who violated security procedure by handing an incarcerated individual their lab coat and identification while responding to Cruz's medical emergency.

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

In a response dated 5/16/22 to the Commission's preliminary report, Correctional Health Services has indicated that the requested reviews were completed with corrective action taken.

TO THE OFFICE OF THE NYC COUNCIL SPEAKER:

As the appointing authority for the delivery of correctional health services pursuant to Correction Law section 501, the City Council shall review the above findings and conduct an inquiry into the fitness of the currently designated provider.

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 28th day of June, 2022.

Thomas J. Loughren
Commissioner & Chair
Medical Review Board

TJL:DC:jdb
2020-M-0109
June 2022

cc: Dana Wax, Acting Chief of Staff
Melissa Guillaume, Deputy General Counsel
Patricia Yang, DrPH, Senior Vice President
Correctional Health Services
Ross MacDonald, MD, Chief Medical Officer
Correctional Health Services
Ronald Greenberg, Director, Compliance and Inspections
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