NEW YORK STATE | Commission of Correction

Final Report of the New York State Commission of Correction:

In the Matter of the Death of

Wilson Diaz-Guzman, an incarcerated individual of the Otis Bantum Correctional 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 Wilson Diaz-Guzman who died on January 22, 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. Wilson Diaz-Guzman was a 30-year-old male who died on 1/22/2021 due to a suicidal 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 has found that there was a failure by Correctional Health Services (CHS) to recognize and treat Diaz-Guzman's acute suicidal ideation. The Medical Review Board opines that had Diaz-Guzman received proper psychiatric referrals and treatment, his death may have been prevented. The Board has also found that there were a failures of NYC DOC staff to comport with Minimum Standard requirements for supervision and deprivation of essential services and a failure to refer Diaz-Guzman to mental health services despite displaying signs of severe agitation.

2. [redacted].

3. Diaz-Guzman was charged with Predatory Sexual Assault Against a Child on 1/16/21. Diaz-Guzman was to return to court on 1/22/21 and was detained on $150,000 bond or $50,000 cash bail.

4. Diaz-Guzman was received in NYC DOC at the Eric M. Taylor Center (EMTC) on 1/17/21. Diaz-Guzman had no known previous incarcerations. At 12:30 a.m., a suicide screening was completed, and Diaz-Guzman responded "no" to all questions. At 12:22 a.m., per the arraignment and classification risk screening form, there was no indication of any medical needs. The intake sheet noted that Diaz-Guzman spoke English. Diaz-Guzman was housed on 7 lower which is medical cohort housing.

5. [redacted].

6. [redacted] The Medical Review Board opines that there was a failure by the CHS clinical staff to refer Diaz-Guzman, a stat patient from medical who expressed suicidal ideation, to psychiatry for assessment and possible treatment prior to clearing him to be housed in general population.

7. [redacted].

8. [redacted] The Medical Review Board opines that concurrent referrals from medical to mental health indicating both suicidal ideation and self-harm were indicative of suicidal risk which were not adequately identified nor addressed by the CHS mental health providers. The concurrent referrals should have prompted mental health to request an increase in Diaz-Guzman's supervision, a measure which could have prevented his death.

9. On 1/21/21 at 2:13 p.m., per NYC DOC documentation, the EMTC tour commander prompted a request for rehousing due to security concerns and Diaz-Guzman was transferred to OBCC and housed in 3S cell 17. There was no available additional documentation regarding this request.

10. [redacted].

11. [redacted].

12. [redacted].

13. On 1/22/21, a review of the Gentech video review revealed:

At 3:20 p.m., CO S.S. conducted a supervisory tour and looked into all cells.
At 3:53 p.m., CO K.B. conducted a supervisory tour and looked into all cells.

At 4:04 p.m., 4:27 p.m., and 4:52 p.m., CO S.S. performed phone hook ups for cells 19, 20, and 21.

At 4:00 p.m., 4:30 p.m., 5:00 p.m., and 5:30 p.m. per the 3-control logbook and 3 south logbook, active supervision tours were completed and verified per review of the housing area video.

At 5:40 p.m., an unidentified CO interacted with Diaz-Guzman in cell 17.

At 5:43 p.m., CO R. was on the unit affording unknown services.

At 5:45 p.m., Captain R.N. and CO S.S. conducted a supervisory tour and looked into all cells. Captain R.N. was seen knocking on cell 17 and standing there for short period. Captain R.N. then continued his tour. Captain R.N. returned to cell 17 and knocked again before walking away.

At 5:46 p.m., Captain R.N. and CO S.S. had cell 17 opened and removed a mattress. CO S.S. gestured for Diaz-Guzman to step out of the cell but Guzman did not. Captain R.N. spoke to Diaz-Guzman and the cell door was closed.
During an interview with Commission staff, CO S.S. reported that Diaz-Guzman was blocking the view of his cell with the mattress and therefore it was removed. Captain R.N. also stated that Diaz-Guzman had smeared a substance on the cell door window. CO S.S. stated that he was unaware of the plan to deal with Diaz-Guzman's behaviors. Per Captain R.N. and CO S.S., Diaz-Guzman did not speak English. There was no

indication in the housing or control logbook of this incident or the mattress removal. This is a violation of 9 NYCRR §7003.3(j)(6)(i), (ii), (iii), and (iv) which states:

"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;"

Additionally, there was no documentation as to why Diaz-Guzman's mattress was removed or if the removal had been reviewed and approved by a commanding officer. This was in violation of 9 NYCRR §7075.5(b) which states:

"*Unless otherwise specified by the provisions of this Title, the provision of an essential service to an inmate shall not be denied, restricted or limited unless the chief administrative officer determines that providing such essential service would cause a threat to the safety, security, or good order of the facility, or the safety, security, or health of the inmate, staff or other inmates. Any such determination shall be made by the chief administrative officer in writing, and shall state the specific facts and reasons underlying the determination*".

At 5:51 p.m., ADW S. and Captain R.N. and an unidentified officer walked to cell 17 and looked inside. The officer retrieved the keys for the pipeline closet, opened it and did something inside closet before closing the door. The camera revealed that Diaz-Guzman was pacing in his cell. During an interview with Commission staff, Captain R.N. stated that the plan was to utilize the extraction team if Diaz-Guzman continued to be uncooperative and flood the cell. There was no documentation in the logbook to reflect that Diaz-Guzman was flooding the cell. This is a violation of 9 NYCRR §7003.3(j)(6)(i), (ii), (iii), and (iv).

At 5:52 p.m., CO S.S. was observed sweeping the water accumulated in front of cell 17.

At 5:57 p.m., Captain R.N. exited the housing area.

At 6:00 p.m., Fire Safety Unit (FSU) Officer S. and FSU CO J.S. entered the housing area and walked to cell 17. The officers looked inside the cell and took pictures. The officers exited the area at 6:05 p.m. Another officer approached cell 17 and engaged in conversation. During an interview with Commission staff, FSU J.S. stated that he tried to engage Diaz-Guzman in conversation and offer him assistance. Diaz-Guzman was just repeating get away from my cell. FSU J.S. attempted to speak to Diaz-Guzman in Spanish and Diaz-Guzman continued the same response.

The Medical Review Board finds that there was a pattern of escalating behavior with Diaz-Guzman that should have prompted an emergency referral to mental health.

14. At 6:18 p.m., CO S.S. and CO K.B. conducted a supervisory tour and looked into all cells. At cell 17, they engaged in brief conversation and walked away.

15. At 6:54 p.m., CO K.B. approached cell 17 and observed Diaz-Guzman with a sheet wrapped around his neck hanging from the sprinkler head. CO K.B. made a radio call and the cell door was opened. At 6:56 p.m., CO S.S. arrived at cell 17 and the officers entered the cell for approximately three minutes. CO S.S. then ran to the front of the housing area and used the housing area phone to activate a medical emergency. During an interview with Commission staff, CO S.S. reported that he held Diaz-Guzman up so CO K.B. could remove the cloth from around the neck and assist with CPR. CO S.S. could not recall the last time he completed CPR training. At 7:07 p.m., the medical staff, officers and Captain R.N. responded to cell 17. Diaz was placed on the floor in the hallway and CPR was continued. Urgi-care was called.
Per the EMS report and per the clinic logbook, at 7:11 p.m. EMS was activated and arrived at 7:19 p.m. At 7:19 p.m., Captain R.N. assisted with CPR.
[redacted]

16. [redacted].

17. Per a review of DOC phone recordings, a phone call on 1/22/21 from 10:17 a.m. until 10:32 a.m. between Diaz-Guzman and his mother was translated. Diaz-Guzman begged his mother to do anything to get him out of the facility. Diaz-Guzman stated that no one was bothering him, and that guards were good, but he could not stay inside another day. Diaz-Guzman's mother stated that she was trying but that $50,000 was a lot of money for poor people. Diaz-Guzman's mother stated tomorrow was another day. Guzman stated "do you think I am not going to make it tomorrow. And I wanna let you know that I love you if anything, if anything I love you and everybody." Diaz-Guzman's mother responded, "we are going to take you out of there and do not talk like that, we will talk in the afternoon and if anything, we will talk tomorrow."

ACTIONS REQUIRED**:**

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

1. The Commissioner shall conduct an investigation into the actions of DOC officers assigned to supervise Diaz-Guzman who failed to follow the requirements of 9 NYCRR §7075.5(b). 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 actions of the DOC officers assigned to supervise Diaz-Guzman to determine why an immediate mental health referral was not made following Diaz-Guzman's escalating behaviors.

3. The Commissioner shall conduct an investigation into the actions of DOC officers assigned to supervise Diaz-Guzman and failed to follow the requirements of 9 NYCRR §7003.3(j)(6)(i), (ii), (iii), and (iv). Administrative action should be taken if the officers are found to be in violation of department directives.

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 administration indicated that the cited officers have been referred to the Department of Investigation who have referred to matter to the Bronx District Attorney's office for investigation.

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

1. Correctional Health Services shall conduct a quality assurance review with the mental health care afforded to Diaz-Guzman. Focus should be on:
   -Why Diaz-Guzman was not referred to psychiatry promptly after being referred for suicidal ideation?
   -Why Diaz-Guzman was not placed on increased supervision after being referred to mental health a second time due to evidence of self-harm?

2. Correctional Health Services shall conduct a quality assurance review regarding why Diaz-Guzman was not timely for scheduled fingersticks for his diabetes.

In a response dated 5/16/22 to the Commission's preliminary report, Correctional Health Services indicated the requested reviews were completed with the following noted:

-[redacted].

The Medical Review Board remains opined that Diaz-Guzman should have been referred to psychiatry and placed on increased supervision.

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

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
2021-M-0011
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cc: Dana Wax, Chief of Staff
Melissa Guillaume, Deputy General Counsel
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