NEW YORK STATE | Commission of Correction

Final Report of the New York State Commission of Correction:

In the Matter of the Death of

David McPeck
an incarcerated individual of the
Anna M. Kross Center

December 21, 2021

To: Commissioner Vincent Schiraldi
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 David McPeck who died on August 27, 2018, 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. David McPeck Jr. was a 43-year-old Caucasian male who died on 8/27/18 of a suicide due to asphyxia from an airway obstruction by foreign material while in the custody of the New York City Department of Correction (NYC DOC) while at the Anna M. Kross Center (AMKC). The Medical Review Board finds that NYC DOC failed to provide adequate security and supervision and failed to discover McPeck's suicide attempt in a timely manner. The Medical Review Board found numerous violations of minimum standards regarding security and supervision in the matter, for which if adequate compliance had occurred, McPeck may have been discovered in a timely manner and his death prevented. Additionally, the Medical Review Board found there were systemic deficiencies in McPeck's healthcare prior to his terminal event including failures to provide medication and necessary follow-ups.

2. McPeck was arrested by the New York City Police Department (NYPD) on 8/21/18 for reckless endangerment. [redacted]

3. On 8/23/18, McPeck [redacted] and transported to Manhattan Central Booking for arraignment. McPeck was charged with Assault in the Third Degree and had an Active Warrant from Wayne County, New Jersey for Aggravated Assault and Assault on a Health Care Worker. McPeck was ordered to be remanded until McPeck was extradited to New Jersey. The securing order contained "Medical Attention" in the area for remarks.

4. According to the Arraignment and Classification Risk Screening Form, McPeck was placed in NYC DOC custody at 8:51 p.m. on 8/23/18. McPeck informed the admitting officer about having a catheter and stated that his physical condition was "alright". McPeck reported being homeless and gave the name of a friend as a person to contact in case of an emergency. McPeck reported being disabled but did not request a reasonable accommodation. A Suicide Prevention Screening Guidelines form was completed with McPeck. McPeck scored a zero on the form and no referrals were made by the screening officer. During the screening process, McPeck did not request any special housing, indicate any gang affiliation or report any history that would require special security while in the jail.

5. McPeck was transferred to the Manhattan Detention Center at 9:28 p.m. from Central Booking. McPeck remained in the receiving area until transferred to AMKC on 8/25/18. According the to the Preliminary Investigative Report completed by the New York City Department of Health Affairs, while McPeck was awaiting a housing assignment at

Manhattan Detention Center, McPeck requested protective custody. McPeck reported being targeted by the “Bloods” gang. McPeck’s request was reviewed and approved. At 12:10 p.m., McPeck was placed in AMKC Quad 4-Lower in a protective custody cell. The Quad 4 A post log noted McPeck’s arrival. McPeck was moved to Quad 2-Lower, cell #23 at 10:30 p.m., which is located on the same housing unit but in a different wing.

6. [redacted] The Medical Review Board finds that this was a violation of 9 NYCRR §7010.2(j) which states that adequate health services and medical records shall be maintained including a record of medication prescribed by the physician and dispensed to a prisoner by a staff person. [redacted]

7. [redacted]

[redacted] The Medical Review Board finds that there was a neglect by health staff to provide care due to failing to recognize the removal of a previously noted indwelling catheter and to provide follow up to ascertain who and how the catheter was removed.

8. There was no documentation specific to McPeck in the Quad Lower unit logbook for 8/26/18 and there were no encounters documented with health staff. As per the unit logbook of the C Post, the total count at the beginning of the 3:00 p.m. to 11:00 p.m. shift was 27, which included McPeck.

9. Per a review of video, McPeck was last seen at 4:20 p.m. receiving a meal tray. McPeck took the meal tray to the cell. At 4:45 p.m., McPeck handed the floor officer the dinner tray through the door. The floor officer can be seen making supervisory tours frequently until approximately 7:00 p.m. when an individual was admitted to the unit in cell #22. It was documented in the C Post logbook that the count was now 28. At 7:06 p.m., CO M.A. makes a supervisory tour and appears to speak to McPeck. CO M.A. was observed on recorded video making supervisory tours approximately every 15 minutes until 8:12 p.m. when the officer stopped and spoke to McPeck through the cell door.

10. At 8:30 p.m., in the A post logbook, it was documented that the new count was 53 reflecting two admissions to the housing unit, one on the two side and one on the four side.

11. At 8:35 p.m., per video review, CO M.A. can be seen attempting to remove a set of keys from the lock of cell #21. Incarcerated individuals also can be seen attempting to remove the keys without success. The Medical Review Board finds that this was a serious violation of 9 NYCRR §7003.9(b) which states that all keys used in a local correctional facility shall be maintained in a safe and secure area. Additionally, critical failures of locking mechanisms where keys can no longer be secured should be subject to an immediate response from facility maintenance.

12. At 9:09 p.m., an incarcerated individual was observed passing out fruit. The individual knocks, looks into McPeck's cell, appears to get no response and then moves on.

13. At 9:10 p.m., in the A post logbook, it was documented that Capt. C.C. made a tour of the area and all appeared secure.

14. At 9:11 p.m., a fight between two individuals took place in the day room. Chemical agents were used to stop the fight. Documentation in the C post log indicated that at 9:15 p.m., "An incident occurred where there was an inmate on inmate fight. OC was utilized." The A post log indicated that at 9:15 p.m., "Level A Q2L inmate on inmate fight with incarcerated individuals [redacted] and [redacted] At 9:20 p.m., it was documented in the A Post log that two incarcerated individuals were off the unit to the clinic. A new count was documented of 53 total, 51 in the unit and 2 out. The two incarcerated individuals sent to the clinic were never documented as being returned to the unit or being off the count.

15. Tours by the correction officers were conducted timely for the rest of the shift. It was noted that several incarcerated individuals remained outside of their cells following the

institutional lock in time at 10:00 p.m. No one was seen entering or leaving McPeck's cell. CO M.A. documented "general supervision tours" from 9:30 p.m. to the end of the shift even though there were several incarcerated individuals out of their cells.

16. On 8/26/18 at 11:31 p.m., CO A.B. began the 11:00 p.m. to 7:00 p.m. shift on the C Post. The total count for the area was recorded as 29 incarcerated individuals. Prior to midnight, CO A.B. had completed the security check and two general supervisory tours with "nothing to report" documented in the unit logbook. At 11:30 p.m., in the A Post log, a count of 53 with two out to the clinic with nothing unusual to report was noted. Per video review, it was noted that there was still a set of keys hanging from the lock of cell #21 in gross violation of 9 NYCRR §7003.9(b).

17. On 8/27/18 at 12:10 a.m., CO M.I. documented taking over the A Post as a late entry. A total count of 29 for the two side, 24 for the four side and a total count of 53 with no out count was noted in the logbook. CO M.I. documented that all post keys were accounted for despite a set remaining in the lock of cell #21. Shortly after 12:00 a.m., two officers can be seen attempting to remove the keys without success. Per video review, between 12:00 a.m. and 12:20 a.m., several incarcerated individuals were walking about the hallway going in and out of different cells and different areas of the living unit. CO A.B. was unavailable to be interviewed by Commission staff during the investigation.

18. At 12:40 a.m., CO A.B. took a dinner break and was relieved by CO A.W. CO A.W. performed a general supervisory round at 1:00 a.m. with nothing to report. Per video review, CO A.W. could be seen making a supervisory tour with a flashlight and looking into cells. CO A.W. also can be seen conversing with incarcerated individuals who were not locked in. CO A.W. stated during an interview with Commission staff that the officer could not recall any details specific to this date or McPeck. When asked why it was documented that general supervision was conducted with incarcerated individuals still out of their cells, CO A.W. stated that the incarcerated individuals probably went in by the time the officer documented. When asked if it was usual to receive unit keys during a meal break, CO A.W. stated yes. CO A.W. went on to say that on the night shift, Officer A.W. does not always receive unit keys. CO A.B. returned to the unit at 1:20 a.m.

19. From 1:30 a.m. to 5:00 a.m., CO A.B. documented conducting general supervisory rounds every 30 minutes at the top and bottom of the hour with nothing to report despite incarcerated individuals were observed out of their cells. The Medical Review Board finds that there was a pattern of performance of general supervisory tours when incarcerated individuals were not confined to their cells which is a violation of 9 NYCRR §7003.3(a) which states:
Active supervision shall be maintained in all facility housing areas, including multiple occupancy housing units, when any prisoners are confined in such areas but not secured in their individual housing units.
Per a video review, supervisory rounds were made at 1:43 a.m., 1:53 a.m., 2:30 a.m. 3:12 a.m., 4:01 a.m. and 4:37 a.m. The officer performing the supervisory rounds did not look into the cells during these supervisory tours. The Medical Review Board finds that corrections staff failed to document true and accurate times when supervisory tours were actually conducted.

20. A review of the housing area video recording showed that incarcerated individuals were seen moving about the living unit and hallway through the night. Incarcerated individuals

can be seen opening their doors by themselves and going into the cells of other incarcerated individuals. No individuals can be seen going into or out of McPeck's cell. Officers can be seen speaking with individuals in their cells through open doors. Officers can also be seen opening doors for individuals to exit or enter their cells throughout the shift. At 1:40 a.m., the A Post log shows that the count changed to 28 in the housing unit and 1 out to the clinic. The Medical Review Board finds that the observation of unsecured cells was a violation of 9 NYCRR §7003.1 which states that each local correctional facility shall develop and employ policies designed to ensure that proper facility safety, security and supervision is maintained and a violation of Correction Law §500-c which requires the chief administrative officer safely keep each person lawfully committed to their custody.

21. At 5:00 a.m., the food wagon arrived on the housing unit with the breakfast meal. At 5:38 a.m., Capt. Y.B. conducted an unannounced tour of the unit and documented that all appeared secure. The Medical Review Board finds that there was a pattern of inadequate security checks made by DOC staff evidenced by the documentation of "all secure" in the presence of a set of facility keys not maintained in safe and secure area and incarcerated individuals outside of their cells during periods of facility lock in.

22. Active supervision rounds were documented by CO A.B. at 6:00 a.m. and 6:30 a.m. with nothing to report indicated. Per a video review, at 5:55 a.m., CO A.B. can be seen walking up and down the tier checking to see that doors are locked. At 5:56 a.m., it can be seen that Capt. Y.B. conducted a tour with a flashlight and looked into cells. At 6:20 a.m., the A Post logbook indicated that an incarcerated individual left for court making the new count 28 on the housing unit and 1 off the housing unit for a new total count of 52. Per a video review, at 6:28 a.m., CO A.B. can be seen walking up and down the tier, however the officer did not look into the cells. At 7:01 a.m., CO A.B. can be seen walking the tier and checking to see if the doors were locked. The Institutional lock-in was documented in the logbook at 7:00 a.m. and a general supervisory tour was conducted at 7:30 a.m. Also, at 7:30 a.m., CO M.I. documented that there was a total count of 47.

23. At 7:37 a.m., CO T.F. assumed the C Post for the unit. During the security check of equipment, it was noted that the C post keys were missing. At 7:40 a.m., CO T.F. documented that CO T.F. completed a unit security check and discovered the C post keys were jammed in cell #21 door. Per a video review, CO T.F. made a supervisory tour, looked into the cells, and checked locks at 7:30 a.m. The Medical Review Board finds that the failure of NYC DOC officers to properly document the missing keys that were jammed in a door lock in the area logbook for the next oncoming shift to be aware of was in violation of 9 NYCRR §7003.6(b) which states:
Requirements of facility staff members prior to assuming responsibilities in an assigned facility area. Each facility staff member shall, prior to assuming responsibilities in an assigned facility area, perform the following:
(b) obtain all necessary keys for the assigned area in accordance with the provisions of section 7003.9 of this Part;

24. At 8:00 a.m., CO T.F. documented conducting an active supervision tour with nothing to report. Additionally, Capt Y.B. documented an unannounced tour indicating that all appears secure. Per a review of the housing area video, Capt Y.B. and CO T.F. made a supervisory tour together. They can be seen looking into the cells. The captain stops at McPeck's door at 8:09 a.m. An officer opens the cell door at 8:13 a.m. and the captain

goes to the front of the living unit. Officers M.I. and S.D. go in and out of McPeck's cell at 8:17 a.m. At 8:18 a.m., all the officers and the captain start to go to the front of the living unit then turn around and return to McPeck's cell and Officer M.I. enters. At 8:20 a.m., the captain closed McPeck's door and all of the officers walk to the front of the living unit.

25. The next entry documented in the logbook is untimed and lists the names of medical staff who respond to the unit after being called for McPeck. Finally, at 8:37 a.m. it was documented that McPeck was pronounced dead by Dr. A.T. The Medical Review Board has found that NYC DOC staff failed to properly document McPeck's discovery in the logbook in comportment with the requirements of 9 NYCRR §7003.3(j)(6)(i-iv) which states:
(j) All written records pertaining to facility housing supervision required pursuant to this section shall be recorded in ink in a bound ledger of consecutively numbered pages which shall be maintained in each housing area. Such records shall include, but not be 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; and

(iv) a description of the condition of any prisoners involved.

26. Commission staff were only able to interview CO T.F. during the course of the investigation as Capt. Y.B. has been on extended leave and Officers M.I, S.D., and A.B. have all resigned from their positions at NYC DOC. During the interview with Commission staff, CO T.F. recalled that there were two incarcerated individuals in the day room when the initial count was performed and that Capt. Y.B. was with them. CO T.F. stated that there was "a lot going on" on the unit. CO T.F. did not recall what McPeck looked like on the initial tour. CO T.F. stated that it was discovered that McPeck was not showing any signs of life when touring with Capt Y.B. CO T.F. did not recall who opened the cell door but did recall that McPeck was face down on the bed and that Capt C.B. called the emergency on the radio following CO M.I. determining there was no pulse.

27. As per written statements, all officers present documented that they attempted to get a response from McPeck by knocking on the door and touching him. Officers M.I. and S.D. both documented that they entered the cell and checked for signs of life by checking for a pulse. Officer M.I. documented that the cell was secured as a crime scene.

28. [redacted]

[redacted]

29. [redacted] Per a review of video, health staff left the housing unit at 8:28 a.m.

30. [redacted]. The Medical Review Board has found that there were advanced post-mortem changes documented on McPeck indicating that McPeck's death occurred hours before being found by NYC DOC Officers. This indicates that NYC DOC officers were not in comportment with the requirements of 9 NYCRR §7003.3(a) & (c) as proper supervisory visits for both active and general supervision were not properly performed.

ACTIONS REQUIRED:

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

1. The Commissioner shall conduct an investigation into the actions of all officers who failed to provide adequate supervision to McPeck and failed to comport with the requirements of 9 NYCRR §7003.3(a)&(c) as evidenced by untimely supervisory tours, the performance of general supervision when active supervision was indicated, and the failure to document true and accurate times of supervisory tours.

2. The Commissioner shall conduct an investigation into why facility keys were not maintained in a safe and secure environment for more than two tours without the documentation of any attempt to notify a supervisor or maintenance to secure the keys and repair the damaged lock. Additionally, the Commissioner shall review policy and procedure in accordance with 9 NYCRR §7003.1 Policy to assure all staff immediately address security concerns with keys.

3. The Commissioner shall conduct an investigation into why there was a pattern of inadequate security checks that were documented as "all secure" in the presence of a set of facility keys not maintained in secure location and incarcerated individuals outside of their cells during periods of facility lock in.

4. The Commissioner shall conduct an investigation into why there was a failure to adequately document the details of discovery of McPeck being unresponsive in accordance with the requirements of 9 NYCRR §7003.3(j)(6)(i-iv).

5. The Commissioner shall conduct in investigation into why the incarcerated individuals were able to enter and exit cell doors during periods of facility lock in when doors are secured. .

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

In a response to the Commission's preliminary report dated 12/7/21, the NYC DOC Commissioner indicated that the requested reviews and investigations were completed with corrective actions taken. The Commission has found the response acceptable and will noted for future verification and monitoring.

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

The Senior Vice President shall conduct an investigation into system care issues with McPeck regarding why there was no evidence in the health record of McPeck receiving the ordered doses of medication ([redacted]) and why medical staff failed to recognize and document the absence of a previously documented indwelling catheter and to ascertain who and how the catheter was removed.

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

In a response to the Commission's preliminary report dated 11/16/21, the Senior Vice President for Correctional Health Services indicated that the requested reviews and investigations were completed and will noted for future verification and monitoring by the Commission.

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 21st day of December, 2021.

Thomas J. Loughren
Commissioner & Chair
Medical Review Board

TJL:ET:jdb
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cc: Dana Wax, Acting Chief of Staff
Melissa Guillaume, Deputy General Counsel
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