Final Report of the New York State Commission of Correction:

In the Matter of the Death of

David Ortiz (11A0168), an incarcerated individual of the Greene Correctional Facility

January 25, 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

80 South Swan Street, 12th Floor, Albany, New York 12210 | 518-485-2346 – phone | 518-485-2467 – fax | www.scoc.ny.gov

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 Ortiz who died on November 7, 2019, while an incarcerated individual in the custody of the NYS Department of Corrections and Community Supervision at the Greene Correctional Facility, the Commission has determined that the following final report be issued.

FINDINGS:

1. David Ortiz was a 48-year-old male who died due to a suicidal hanging on 11/7/19 while in the custody of the New York State Department of Corrections and Community Supervision (NYS DOCCS) at the Greene Correctional Facility (CF).

2. . In the instant offense, in March 2008, Ortiz was found in possession of cocaine. Ortiz was convicted of Attempted Criminal Possession Controlled Substance 3rd Degree and Assault 2nd Degree and was sentenced to 12 years.

3. .

4. On 1/13/11, Ortiz was received in NYS DOCCS. In February 2011, Ortiz was transferred to Franklin CF. In December 2011, Ortiz was transferred to Clinton CF. In 2013, Ortiz was transferred back to Franklin CF. In 2014, Ortiz was transferred to Upstate Special Housing Unit (SHU), then to Bare Hill CF, and then to Midstate CF. In 2015, Ortiz was transferred to Mohawk CF. In 2016, Ortiz was transferred to Cayuga SHU 200, then to Orleans CF, then to Collins SHU 200 and then to Marcy CF. In August 2017, Ortiz was transferred to Greene SHU 200. Ortiz was later transferred to Greene CF general population.

5. In February 2018, Ortiz was transferred to Greene SHU 200 following an infraction for Violent Conduct, Bribery, Harassment, Threats, and Facility Correspondence.

6.

7. .

8. . On 8/6/18, Ortiz returned to Greene CF. ( )

9. .

10. .

11. .

12.

12. .

13. .

14.

15.

16.

17. .

18. .

19.

20. However, the Medical Review Board raises concern that since Ortiz had a documented suicide attempt on 7/29/18, whether a referral to OMH for Ortiz would have been appropriate per Department Directive . Directive 4101 (II)(C)(5) Suicide Prevention. (Note: as the reported suicide attempt on 7/29/18 was noted only in hospital records, the Commission accepts that it is questionable if DOCCS ever received this notification.)

21. On 11/7/19 at 2:30 a.m., Ortiz was seen walking to the shower by Correction Officer (CO) D.P. At 2:49 a.m., another incarcerated individual told CO D.P. that he needed to check on an individual in the E1 bathroom. CO D.P. responded and found that Ortiz was hanging in the bathroom from the curtain rod between the toilet area and the shower. CO D.P. called a medical response and with assistance from another incarcerated individual that had entered the shower area, CO P.U. was able to use nail clippers to cut Ortiz down. CPR was initiated immediately and medical and security staff arrived. . EMS was activated at 3:02 a.m. . At 3:12 a.m., EMS arrived and assumed care. .

22. A letter was turned into DOCCS from an addressee that was dated 11/1/19. Ortiz stated in the letter that he could not do this anymore and he refused to spend another birthday in prison.

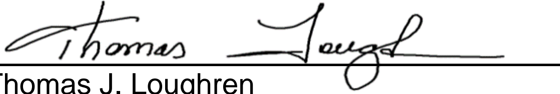
ACTIONS REQUIRED:

TO THE COMMISSIONER OF NYS DEPARTMENT OF CORRECTIONS AND COMMUNITY SUPERVISION:

That the Commissioner conduct a review of Ortiz's suicide to ascertain whether a referral to OMH would have been appropriate after his parole hearing, per Directive 4101 (II)(C)(5), and whether policy should be enhanced to include referring individuals who have had recent suicide attempts.

In a response to the Commission's preliminary report dated 10/26/22, NYS DOCCS provided the following:
"*In the case of Incarcerated Individual Ortiz, DOCCS Directive 4101, "Inmate Suicide Prevention", specifically section (II)(C)(5), would not be applicable as Incarcerated Individual Ortiz made no physical appearance before the Parole Board as it was a non-discretionary case. Rather, Incarcerated Individual Ortiz's parole paperwork was reviewed by the Parole Board who then set release conditions. Per documentation, the assigned Offender Rehabilitation Coordinator met with Incarcerated Individual Ortiz on 11/6/19 to discuss potential release addresses to be reviewed by Community Supervision due to the SOH 220 condition being imposed. Documentation from 11/6/19 does not indicate that Incarcerated Individual Ortiz was in mental health distress or in need of a mental health referral (Form 3150 "Mental Health Referral") at the time*".

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 25th day of January, 2023.



Thomas J. Loughren
Commissioner & Chair
Medical Review Board

TJL:DC:jdb
2019-M-0119
January 2023

cc: Dr. Carol Moores, Chief Medical Officer
Bryan Hilton, Assistant Commissioner for Mental Health
Superintendent Christopher Collins, Greene 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