Commission of Correction

Final Report of the New York State Commission of Correction:

In the Matter of the Death of

Richard Blake, an incarcerated individual of the Otis Bantum Correctional Center

September 27, 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 Richard Blake who died on April 30, 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. Richard Blake was a 45-year-old male who died on 4/30/21 from Hypertensive and Atherosclerotic Cardiovascular Disease 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 NYC DOC officers to maintain active supervision in accordance with Minimum Standards.

2. . On 3/12/21, Blake was arrested and charged with Criminal Possession Controlled Substance 7th Degree, and a warrant from New York State Community Supervision.

3. .

4. On 3/12/21 at 12:18 p.m., Blake was admitted to NYC DOC.

5. [redacted].

6. [redacted].

7. [redacted].

8. [redacted].

9. [redacted].

10. [redacted]

11. [redacted].

12. [redacted]

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29. [redacted]

30. [redacted].

31. [redacted]

32. [redacted]

33. [redacted]

34. [redacted]

35. According to a statement provided by CO V.B., on 4/30/21 at approximately 9:40 p.m., Blake had completed a chess game, spoke to CO V.B. and then went to his cell. CO V.B. noted that at 10:45 p.m., he was called to Blake's cell due to Blake having a possible seizure. Blake appeared to be breathing and a medical response was called. CO H.D. responded to Blake's cell to assist. Blake stopped breathing and CO H.D. began CPR and CO V.B. made a notification to medical that CPR was in progress and then went to retrieve equipment. During this time, other incarcerated individuals who were in the area failed to respond to direct orders to clear the area and displayed signs of aggression toward the officers. When medical arrived, CO V.B. and CO H.D. were escorted off the housing area and the Probe Team was activated. During an interview with Commission staff, CO V.B. stated that the incarcerated individuals felt not enough was being done and that medical was taking too long to respond. The incarcerated individuals wanted to carry Blake to medical and the officers were not allowing that to occur.

36. On 4/30/21 at 10:50 p.m., a medical response was called and medical staff were notified. [redacted]

37. A review of the recorded video of the housing area on 4/30/21 revealed that:
At 8:42 p.m., Bake walked from his bed to the shower area brushing his teeth
At 8:44 p.m., Blake returned to his bed and laid down

At 10:47 p.m., Blake was seen on video twisting and turning.
At 10:48 p.m., another incarcerated individual approached Blake and appeared to be rubbing his back and then called for the officer for assistance. Officer V.B. arrived and checked Blake. Officer V.B. then turned to the A station officer to signal them to make a call. A medical response was called.

38. Per the 5/6 Lower A post logbook, the following was documented regarding the 3:00 p.m. to 11:30 p.m. tour on 4/30/21:
At 7:30 p.m., 8:30 p.m., 9:00 p.m., 9:30 p.m., 10:00 p.m., and 10:30 p.m., active supervision tours were completed with nothing unusual to report.
At 10:49 p.m., medical emergency was notified for 5 lower.

There were no further entries regarding the medical emergency noted in the logbook The next entry in the logbook was for the change of tour on May 1st, 2021 for 11:00 pm to 7:00 a.m. tour. The following entries were noted during that shift:
At 1:30 a.m., officer assumed Post 5 and 6 lower "A". Count for 5 lower 33. Count for 6 lower 31 living bodies and 1 unresponsive in the vestibule at this time.
The one unresponsive individual in the vestibule was documented at 1:30 a.m., 2:00 a.m., 2:30 a.m. 3:00 a.m., and 3:30 a.m. at which time the documentation ends.

This 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.

39. Per the 6 Lower B logbook, an institutional count was conducted at 8:15 p.m. by CO V.B. At 8:30 p.m., 9:00 p.m., and 9:30 p.m. active supervision tours of the area were conducted and there was nothing unusual to report.
At 9:50 p.m., one individual was out to sanitation and the new count was 32 with 31 in and 1 out.

There was no documentation regarding the medical emergency. This is a violation of 9 NYCRR § 7003.3 (j)(6) 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;

There were no additional entries in the logbook indicating that active supervision was being maintained until an entry for the change of the tour on Saturday May 1, 2021 at 12:40 a.m. with the CO on Post 6 Lower as per the control room captain. This is in 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.

During an interview with Commission Staff, CO V.B. stated that he responded to the medical emergency and remained with Blake until medical staff arrived. At that time, CO V.B. and CO H.D. were then escorted off the housing unit and were not returned to the

unit for safety reasons. CO V.B. stated that the Captain would send another officer to the housing area to cover his post.

ACTIONS REQUIRED:

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

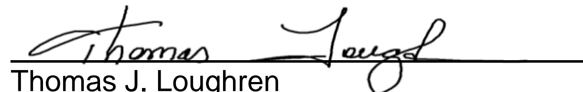
1. The Commissioner shall conduct an investigation into the actions of the DOC officers assigned to supervise the housing unit and who failed to follow the requirements of 9 NYCRR §7003.3(j)(6)(i), (ii), (iii), and (iv). Administrative action should be taken if the officers are found to be in violation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

2. 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 § 7003.3(a), which states that 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.

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

In a response dated 8/15/22 to the Commission's preliminary report, NYC DOC indicated that both issues have been referred to the NYC DOC Investigative Division for further investigation and follow up.

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 27th day of September, 2022



Thomas J. Loughren
Commissioner & Chair
Medical Review Board

TJL:DC:jdb
2021-M-0063
September 2022

cc Kat Thomson, Chief of Staff
Melissa Guillaume, Deputy General Counsel
Patricia Yang, DrPH, Senior Vice President
Correctional Health Services
Bipin Subedi, MD, Chief Medical Officer
Correctional Health Services
Ronald Greenberg, Director, Compliance and Inspections

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Amanda Masters, Executive Director
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