NEW YORK STATE | Commission of Correction

Final Report of the New York State Commission of Correction:

In the Matter of the Death of

Hector Rodriguez aka Herminio Villanueva, an incarcerated individual of the Robert N. Davoren Center

March 29, 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 Hector Rodriguez aka Herminio Villanueva who died on June 21, 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. Hector Rodriguez was a 61-year-old Hispanic male who died on 6/21/20 of bronchial asthma with contributing pulmonary emphysema while in the custody of the New York City Department of Correctional Services (NYC DOCS) at the Robert N. Davoren Center (RNDC). The Medical Review Board has found that there was a failure of corrections staff to provide first aid and cardiopulmonary resuscitation to Rodriguez which led to his death. Additionally, the Medical Review Board found that there was inadequate monitoring and assessment of Rodriguez's health during his incarceration. Remote to Rodriguez's cause of the death, the Medical Review Board also found that there was a lack of adequate documentation of health care, violations of basic security standards and infection control directives to prevent the spread of COVID-19.

2. Rodriguez was admitted to NYC DOC custody on 3/2/20 directly from the Manhattan Supreme Court with the charge of failure to register or verify as a sex offender. He was sentenced to one year in jail.

3. Rodriguez was taken into NYC DOC custody at 1:35 p.m. and his medical triage on the Arraignment and Classification Risk Screening Form was documented as "Normal". [redacted] Rodriguez reported having no next of kin. [redacted] No special housing considerations were required and Rodriguez had no gang affiliations. Rodriguez scored a zero on his Suicide Prevention Screening Guidelines and no referrals were made.

4. On 3/3/20 at 3:32 a.m., Rodriguez was transferred to the Anna M. Kross Center (AMKC). [redacted]

[redacted] At 9:37 p.m., Rodriguez was moved to housing on W18LB.

5. [redacted].

6. [redacted]

7. [redacted]

8. [redacted]

9. [redacted].

10. [redacted]

11. [redacted]

12. [redacted].

13. [redacted],

[redacted]. The Medical Review Board finds that there was a failure to adequately document patient encounter, to include any treatment provided or justification for not providing treatment which is a violation of 9 NYCRR §7010.2(j) which states that adequate medical records must be maintained for incarcerated individuals.

14. [redacted]

15. [redacted]

16. [redacted]

17. [redacted]

18. [redacted]. According to the Inmate Movement Activity Report, Rodriguez was moved to an intake cell at EMTC at 6:30 p.m. [redacted]

19. [redacted]

[redacted]

20. On 4/2/20 at 10:04 a.m., as per the Inmate Movement Activity Report, Rodriguez was moved to housing area 5M. [redacted]. The Medical Review Board finds there was a pattern of missed medications with no documentation in the health record regarding a reason doses were missed or any evidence that contact to the ordering prescriber was made.

21. On 4/3/20, it was documented on the Inmate Movement History Report that Rodriguez was moved to housing area 3U at 5:57 a.m. [redacted]

22. [redacted].

23. [redacted] The Medical Review Board finds that there was a failure to provide adequate monitoring of a patient with positive COVID-19 who had a history of abnormal vital signs and a underlying respiratory disease.

24. [redacted] The Medical Review Board finds that there was a failure by Dr. [redacted]. and Dr. [redacted]. to adequately assess a patient with a history of COVID-19 infection and an underlying lung disease evidenced by a failure to perform and document auscultation of lung and heart sounds.

25. On 4/8/20, Rodriguez was transferred back to RNDC and placed on the M4SL housing unit.

26. [redacted].

27. [redacted].

28. [redacted] The Medical Review Board finds that there was an eight-day lapse in the Methadone treatment with no documented evidence of a reason for missed doses or any notification to the medical provider.

29. On 5/9/20 at 8:45 a.m., health staff responded to a call from the housing unit for an emergency response. PA [redacted]. documented that the health staff arrived at 8:52 a.m. and [redacted]

30. [redacted].

31. [redacted]

32. [redacted]

[redacted]

33. [redacted]

34. [redacted].

35. [redacted].

36. [redacted].

37. [redacted] During an interview with Commission staff, Dr. [redacted] reported that the telemedicine equipment is only a camera. During these encounters, the physician relies on the report of the health staff with for the patient's diagnostic data such as lung sounds, [redacted]. The Medical Review Board finds that RN [redacted]. and Dr. [redacted] H. failed to adequately assess a patient returning from the hospital for an acute respiratory episode prior to returning the patient to the housing unit.

38. [redacted] The Medical Review Board opines that there was an unnecessary delay, approximately 3 months, in addressing Rodriguez's HCV who presented at the time of admission with active disease given his measured viral load.

39. [redacted]

40. [redacted]

41. [redacted]

42. [redacted]

43. [redacted]

44. [redacted].

45. On 6/20/20 at 6:08 p.m., it was documented in the Mod 4 A post logbook that a medical emergency was called for Rodriguez. Capt. S.S. logged that she responded to the medical emergency at 6:18 p.m. At 6:18 p.m., it was logged in the housing unit logbook that Rodriguez was escorted to the clinic. Per the Medical Clinic logbook, the medical emergency was called at 6:01 p.m. and a clinic escort was enroute to pick up Rodriguez. At 6:25 p.m. in the clinic logbook, it stated “Medical Emergency stand down at this time”. There was no documentation that Rodriguez ever arrived in the medical department. There were no clinic notes indicating that Rodriguez was seen by any health staff. There was no documentation in the housing unit log that Rodriguez ever returned. The only staff member available to the Commission to interview regarding this incident was CO R.A. who was on duty in the housing unit security booth. CO R.A. stated that Rodriguez came to the security booth and stated that he was having difficulty breathing. CO R.A. stated that he called the clinic and an escort came to get Rodriguez. CO R.A. stated that he did not recall what time Rodriguez came back. CO R.A. stated that he recalled that Rodriguez was often sick and did spend time at the hospital. The Medical Review Board finds that Rodriguez had presented again with acute respiratory symptoms but was not provided with proper medical attention. Additionally, there was an absence of documentation regarding a patient that was presented to the medical area for respiratory distress. The Medical Review Board opines that had Rodriguez been provided timely medical care on the evening on 6/20/20, his terminal event during the

morning hours of 6/21/20 may have been prevented.

46. On 6/21/20 at 5:10 a.m., CO K.J. assumed the C post on the Mod 4 Lower unit. A total count of 22 was noted.

47. At 6:23 a.m., it was documented that a captain was on post and all appeared secure. At 7:00 a.m., CO K.J. documented that institutional lock in occurred and that all was secure.

48. At 7:25 a.m. it was documented by CO K.J. that a medical emergency was called for "inmate with breathing issues. At 7:30 a.m., CO K.J. documented that a supervisory tour was conducted and there was nothing to report.

49. A review of recorded video of the area showed that at 7:25 a.m., Rodriguez was sitting on his bunk talking to another incarcerated individual. Rodriguez can be seen motioning to his chest. At 7:26 a.m., an incarcerated individual approached Rodriguez to assist Rodriguez by rubbing his back. At 7:27 a.m., CO K.J. approached the area and stopped one bed away from Rodriguez. CO K.J. paused then turned and walked away. CO K.J. can be seen speaking to the officer in the booth. At 7:28 a.m., Rodriguez appeared to collapse forward and was caught by the incarcerated individual who was rubbing his back. At 7:29 a.m., CO K.J. can be seen writing in the logbook. CO K.J. documented that active supervision was completed with "Nothing to report". The Medical Review Board finds that CO K.J. failed to accurately document a significant incident which is a violation of 9 NYCRR §7003.3(j)(6)(i-iv). At 7:30 a.m., an incarcerated individual is seen speaking to the security booth officer. At 7:32 a.m., CO K.J. walked toward Rodriguez and stopped two beds away from the area and watched for one minute. CO K.J. walked to where the logbook was near the booth window. CO K.J. stretched and turned toward the booth making a gesture to the booth officer of waiving his open hand from one side of his neck to the other. At 7:35 a.m., Rodriguez can be seen slumping to one side and was helped upright by an incarcerated individual. CO K.J. can be seen observing the incident. CO K.J. can be seen leaving the housing unit, leaving the door ajar and going into the vestibule area. At 7:36 a.m., it appeared that incarcerated individuals were calling for help. At 7:37 a.m., CO K.J. returned to the housing area. At 7:38 a.m. another incarcerated individual approached Rodriguez and tried to wake him. An incarcerated individual then picked Rodriguez up and carried him up to the vestibule. Rodriguez appeared to be limp in the individual's arms. A group of incarcerated individuals went to the vestibule with the incarcerated individual carrying Rodriguez. They remain there for less than one minute and turn around and place Rodriguez on the first bed inside the living unit. Officer K.J. stood nearby observing. Incarcerated individuals can be seen getting a pillow and a blanket for Rodriguez. An incarcerated individual can also be seen attempting to comfort Rodriguez by rubbing his arm and chest.

50. In a written statement, CO K.J. stated that she observed Rodriguez struggling to breathe and coughing. She stated that she went back and forth between Rodriguez and the booth to check his breathing and to inform CO T.C. of the condition. CO K.J. documented that the incarcerated individuals were stating that Rodriguez did not belong on the living unit because he was sick, and they just keep sending him back to the unit after sick call. CO K.J. documented that after five minutes, CO T.C. called a medical emergency over the radio. CO K.J. wrote that the incarcerated individuals carried

Rodriguez to the front of the housing unit because health staff did not come timely. CO K.J. stated that the incarcerated individuals placed Rodriguez on the bed and while the incarcerated individual was rubbing Rodriguez's chest, Rodriguez was breathing "faintly". CO K.J. was unavailable for interview by Commission staff. The Medical Review Board finds that there was a gross failure to adequately respond to an imminent medical emergency. CO K.J. failed to provide first aid to an incarcerated person with difficulty breathing and failed to provide cardiopulmonary resuscitation to an incarcerated person in her care. As a result of CO K.J.'s lack of response, cardiopulmonary resuscitation was delayed by approximately 19 minutes.

51. During this incident at 7:26 a.m., the security booth can be seen on the video with the door propped open. At 7:34 a.m., an incarcerated individual can be seen leaving the housing unit and entering the security booth. During this time, the security booth door is open, and the living unit door is unsecured. The individual removes a large coffee pot and takes it to the living unit. During an interview with Commission staff, CO T.C. stated that at approximately 7:29 a.m., CO K.J. knocked on the window and stated that an incarcerated individual was having difficulty breathing. CO T.C. stated that the incarcerated individuals were yelling for help. CO T.C. stated a call was made to the clinic and CO. V.C. answered the phone. CO T.C. stated that she also radioed to medical and was informed that health staff were enroute. CO T.C. did not mention that the incarcerated individuals were moving Rodriguez when asked to describe the incident. When asked if Rodriguez was moved, CO T.C. stated that the incarcerated individuals moved Rodriguez closer to the door for health staff and that she could hear them yelling for CO K.J. to assist. When CO T.C. was asked about the process for the doors and allowing incarcerated individuals in the security booth, she stated that the doors must be secured tightly but an incarcerated individual could be in the booth if they needed to give her something. The Medical Review Board finds that there was a failure by officers to maintain the safety and security of the unit due to failing to secure the living unit door, security booth door, and allowing an incarcerated individual into the security booth area. These are all in violation of 9 NYCRR §7003.1 which states that the facility must develop and employ procedures to ensure that proper facility safety, security, and supervision is maintained.

52. [redacted]

53. Per a video review, two health staff arrive in the living unit at 7:42 a.m. At the same time, Capt. T.J. arrives. Capt. T.J. enters the area without a mask. Two health staff attempted to obtain a radial pulse and place an automated external defibrillator on Rodriguez. Two officers and Capt. T.J. are standing nearby watching the health staff. At 7: 45 a.m., health staff begin chest compressions. At 7:56 a.m., health staff place a

nasal cannula on Rodriguez with oxygen. At this time, there are three officers and Capt. T.J. standing in the area observing the situation without masks. The Medical Review Board finds that NYC DOC staff failed to follow proper infection control practices as per Chairman's Memorandum 6-2020 and Executive Order 202.16 which states that employees shall wear face coverings when in direct contact with customers or members of the public. At 7:56 a.m., health staff place a non-rebreather on Rodriguez while chest compressions continue. Several officers and captains enter the area. Most of the security staff are not wearing masks. At 7:58 a.m., health staff attach an ambu bag to the oxygen and begin to bag Rodriguez. The Medical Review Board finds that health staff failed to perform adequate CPR by not initiating the use of an ambu-bag for a patient without respirations. During the incident, health staff took turns performing chest compressions. One officer enters the area and assists with CPR. At 8:04 a.m., Urgicare physician [redacted]. can be seen entering the area and examining Rodriguez.

54. [redacted]

55. EMS arrived at 8:15 a.m. [redacted]

[redacted] REQUIRED:

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

1. The Commissioner shall conduct an investigation into the conduct of Correction Officer K.J. and the failure to accurately document a significant incident, failure to provide first aid, and any life-saving interventions to an incarcerated individual in her care. The Commissioner shall provide the Board with a copy of the report findings and any corrective actions taken to assure compliance with 9 NYCRR §7003.3.

   In a response to the Commission's preliminary report dated 2/14/22, the NYC DOC Commissioner indicated that formal disciplinary charges were brought against the officer and the officer has resigned from NYC DOC.

2. The Commissioner shall conduct an investigation into the actions of Capt. T.J. and the other responding officers for failure to comply with infection control directives included in Chairman's Memorandum 6-2020 and Executive Order 202.6. The Commissioner shall provide the Board with a copy of the report findings and any corrective actions taken to assure compliance with Chairman's Memorandum 6-2020 and Executive Order 202.6.

   In a response to the Commission's preliminary report dated 2/14/22, the NYC DOC Commissioner indicated that staff violated infection control directives but would not be

formally disciplined due to statutory limitations on filing time requirements had expired. Teletypes with direction to NYC DOC regarding infection control compliance was issued to facility commands.

3. The Commissioner shall conduct an investigation into the actions of CO T.C. for failure to secure the doors to the housing unit security booth and allowing an incarcerated individual into a secure area. The Commissioner shall provide the Board with a copy of the report findings and any corrective actions taken to assure compliance with 9 NYCRR §7003.1.

   In a response to the Commission's preliminary report dated 2/14/22, the NYC DOC Commissioner indicated that the officer violated procedure but would not be formally disciplined due to statutory limitations on filing time requirements had expired. The officer was counseled on procedure regarding securing doors.

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

1. The Senior Vice President shall address and correct the ongoing pattern of missed medications without documentation of reason for missed doses and lack of notification to the ordering provider for missed doses. The Senior Vice President shall provide a copy of any corrective actions taken to assure adequate medication administration processes within the facility.

2. The Senior Vice President shall address the ongoing pattern of not documenting the time of patient encounters in the electronic health record. The Senior Vice President shall provide a copy of any corrective actions taken to assure adequate documentation of all patient encounters including the time of each encounter.

3. The Senior Vice President shall conduct a comprehensive investigation into the care provided to Rodriguez with a special focus on the inadequate documentation of encounters, inadequate and thorough assessment by health staff, inadequate monitoring of a COVID-19 positive individual with underlying lung disease, and inadequate cardiopulmonary resuscitation. The Senior Vice President shall provide a copy to the Board of the findings and any corrective actions taken.

4. The Senior Vice President shall conduct an investigation into why there was no clinical documentation for a clinic visit on 6/20/20 for Rodriguez when documentation in the housing unit logbook and the clinic logbook indicate that Rodriguez was transported to the medical area. The Senior Vice President shall provide a copy to the Board of the findings and any corrective actions taken.

5. The Senior Vice President shall conduct a comprehensive quality assurance review regarding Rodriguez's HCV care and why there was a significant and unnecessary delay in obtaining therapy for an individual who presented with high levels of active viral load at admission to DOC. The Senior Vice President shall provide a copy to the Board of the findings and any corrective actions 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 29th day of March, 2022.

Thomas J. Loughren
Commissioner & Chair
Medical Review Board

TJL:ET:jdb
2020-M-0075
March 2022

cc: Dana Wax, Acting Chief of Staff
Melissa Guillaume, Deputy General Counsel
Patricia Yang, DrPH, Senior Vice President
Correctional Health Services
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Correctional Health Services
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