NEW YORK STATE | Commission of Correction

Final Report of the New York State Commission of Correction:

In the Matter of the Death of

Thomas Braunson, an incarcerated individual of the Eric M. Taylor Center

June 28, 2023

To: Commissioner Louis Molina
NYC Department of Correction
75-20 Astoria Blvd., Suite 100
East Elmhurst, NY 11370

Allen Riley
Chairman

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 Thomas Braunson who died on April 19, 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. Thomas Braunson was a 35-year-old male who died on 4/19/21 due to acute intoxication from the combines effects of fentanyl, heroin, and phencyclidine while in the custody of the New York City Department Of Corrections (NYC DOC) at the Eric M. Taylor Center (EMTC). The Medical Review Board has found that there was substantial non-compliance to minimum standards pertaining to security and supervision that lead to Braunson not being discovered until hours after his death. The Medical Review Board opines that had minimum standards been properly followed and had Braunson been properly supervised by DOC staff, his death could have been prevented.

2. Braunson was born in Manhattan, NY. Braunson was survived by his child, his parents, and five siblings. Braunson received his GED and was employed in construction. There was no further demographic or social history pertaining to Braunson available to the Commission.

3. [redacted].

4. [redacted]

5. [redacted]

6. On 4/16/21 at 12:06 p.m., Braunson was admitted into NYC DOC from Queens Criminal Court for a parole violation after being charged with Criminal Trespass. Braunson was a NYS DOCCS parolee and was being held on a warrant. Braunson's parole hearing was scheduled for 4/29/21. Braunson scored a two on the Suicide Prevention Screening for experiencing a significant loss within the last six months and appearing overly anxious, panicked, afraid, or angry.

7. [redacted]

[redacted].

8. [redacted].

9. [redacted].

10. On 4/18/21 at 12:40 am, Braunson was transferred from intake to Housing Unit 9 Main. This housing unit is used for general population of new admissions. Braunson was assigned to bed #33.

11. [redacted]

12. On 4/18/21, per the Callout Report from the NYC DOC Investigation Division and a review of the video recording of 9 Main B post by Commission staff, the following was observed:

At approximately 8:00 p.m., Braunson is observed sitting on the side of his bed.

At approximately 8:03 p.m., Braunson is observed walking towards the front of the unit and returns to his bed and lays down at 8:05 p.m.

At approximately 8:15 p.m., Braunson was observed standing up from his bed and reached into his personal property bucket that was placed on the floor next to his bed. Braunson then walked towards the front of the unit and returned to his bucket and reached in it at 8:18 p.m. Braunson then walked back to the front of the unit and returned to his bed and sat down at 8:20 p.m. where he was observed removing a plastic bag from his bucket and placing it under his pillow/blanket before laying down on the bed.

At approximately 8:24 p.m., Braunson reached in his bucket and then sat up on the edge of his bed. Braunson put his hand in his left front pant pocket and then laid back down on the bed.

At approximately 8:26 p.m., Braunson was observed getting out of the bed and walking towards the left side of the unit where he conversed with another individual and then walked to the front of the unit, and then back to his bed at 8:30 p.m. Braunson continued

to walk from his bed to the front of the unit three additional times over the next 33 minutes.

At approximately 9:03 p.m., Braunson was observed walking towards his bucket. Braunson reached into the bucket and lifted his hand towards his nose and then he sat down on his bed.

At approximately 9:05 p.m., an unidentified Incarcerated Individual (II) from two beds away from Braunson's bed was observed removing his sheet from his bed and walking over to Braunson's bed. Braunson was observed taking the sheet from the unidentified II and placing the sheet on his bed. Braunson then adjusted his left pant pocket/waistband and sat down on his bed. The other II sat down on the bed directly across from Braunson's bed. Braunson reached into his bucket and pulled out a plastic bag. Braunson placed an unknown substance into the other II's hand. The other II raised his hand with the unknown substance towards his nose three times and shortly after walked away to talk to other IIs.

At approximately 9:20 p.m., Braunson laid down on his bed.

At approximately 9:42 p.m., Braunson reached into his bucket.

At approximately 9:45 p.m., Braunson laid down on the bed and pulled the blanket up over himself. Shortly after this, the housing area lights were turned off. There was slight movement of Braunson's blanket observed right after the housing area lights were turned off. There was no further movement of Braunson observed during the rest of the shift until the terminal event.

13. On 4/18/21 at 8:00 p.m., Correction Officer (CO) A.G. documented in the 9 Main B post logbook, "Active supervision tour of area. Nothing unusual to report".

14. On 4/18/21 at 8:30 p.m., CO A.G. documented in the 9 Main B post logbook, "Active supervision tour of area. Nothing unusual to report".

15. On 4/18/21 at 9:00 p.m., CO A.G. documented in the 9 Main B post logbook, "Active supervision tour of area. Nothing unusual to report".

16. On 4/18/21 at 9:30 p.m., CO A.G. documented in the 9 Main B post logbook, "Active supervision tour of area. Nothing unusual to report".

17. On 4/18/21 at 10:00 p.m., CO A.G. documented in the 9 Main B post logbook, "Active supervision tour of area. Nothing unusual to report".

18. On 4/18/21 at 10:30 p.m., CO A.G. documented in the 9 Main B post logbook, "Active supervision tour of area. Nothing unusual to report".

19. On 4/18/21 at 10:40 p.m., an unidentified II was observed ripping a bedsheet and tying one end of the torn sheet to the base of his bed and affixing the other end of the torn sheet to the bed directly across from his, obstructing entrance into the housing area that also housed Braunson.

20. On 4/18/21 at 11:00 p.m., CO A.G. documented in the 9 Main B post logbook, "Active

supervision tour of area. Nothing unusual to report".

21. On 4/18/21 at 11:20 p.m., CO D.A. documented in the 9 Main B post logbook, "CO D.A. on post 9 Main A relieves CO L.W.

22. On 4/18/21 at 11:30 p.m., CO A.G. documented in the 9 Main B post logbook, "Active supervision tour of area. Nothing unusual to report".

23. On 4/19/21 at 12:10 a.m., CO A.G. documented in the 9 Main B post logbook, "sign off of post".

24. Per the Callout Report from the NYC DOC Investigation Division and a review of the video recording of 9 Main B post by Commission staff, CO A.G. did not perform 30-minute active supervision tours of the unit. CO A.G. did not go to each bed to perform a proper tour nor did CO A.G. tour the back right area of the post that housed Braunson when completing rounds on the 9 Main B post on 4/18/21 between the hours of 8:00 p.m. and 12:10 a.m. on 4/19/21. CO A.G. failed to observe the torn sheet that was tied to the bottom of the beds that obstructed entrance to the area that Braunson was housed. CO A.G. also exited the post from 10:21 p.m. until 11:32 p.m. No relief CO took the post in the absence of CO A.G. during that time. CO A.G. did not perform a complete tour of the area upon return to the unit or before signing off duty from the post on 4/19/21 at 12:10 a.m. The entries into the 9 Main B post logbook at 10:30 p.m. and 11:00 p.m. were falsified.

    This is a violation of 9 NYCRR §7003.3(a) Supervision of prisoners in facility housing areas which states:
    Active supervision shall be maintained in all facility housing areas, including multiple occupancy housing units, when any prisoners are confined in such area but not secured in their individual housing units.

    This is also a violation of 9 NYCRR §7003.5(a)(1) and (2) Prisoner population counts which states:
    Prisoner population counts shall: be conducted at the completion and commencement of each regularly scheduled shift; be conducted by the facility staff member completed such regularly scheduled shift.

    The failure to properly address the security risk of the torn sheet obstructing a pathway in the housing area is a violation of 9 NYCRR §7003.6(c) which states:
    Where a facility member's assignment to a facility area is scheduled to exceed one hour, such facility staff member shall, upon assuming responsibilities in the assigned facility area and following the completion of duties set forth in subdivision (b) of this section, inspect all supplies, equipment, locks, gates, bars, screens, security windows and other security devices, and perform any other necessary security functions as determined by the chief administrative officer.

25. On 4/19/21 at 12:10 a.m., CO J.B. documented in the 9 Main B post logbook, "CO J.B. assumed the duty of housing area 9 Main B post. Physical count taken and verified". During an interview with Commission staff, CO J.B. explained that the 9 Main B post was a newly made unit that was designated for Security Risk Groups (SRG) and began housing gang related groups two days prior to his assignment to the unit on 4/19/21. CO J.B. was asked to describe what his duties were when he reported to the unit. CO J.B.

reported that his duties were to do a security inspection of the unit, conduct a count of the IIs in the area, and to check with the off going officer regarding any issues or occurrences on the previous shift. CO J.B. reported that he would get a physical count of the number of IIs in the area and to the best of his ability, ensure that they were alive and well at the time he assumed the post. CO J.B. was asked how he was able to ensure that the IIs were alive and well. CO J.B. reported, "I get up and walk and count the IIs individually and I look for signs of life or any signs of distress at the same time". CO J.B. was asked what signs of life he would look for. CO J.B. reported, "If they are up and around, movement, and signs of breathing with a chest rise and fall. CO J.B. was asked if he did anything different once the lights were off for the night and the unit was darker. CO J.B. reported, "usually we use our flashlights when we walk around and check the area and the individuals".

26. On 4/19/21 at 12:30 a.m., CO J.B. documented in the 9 Main B post logbook, "Active supervision tour of area complete, nothing to report".

27. On 4/19/21 at 12:40 a.m., CO J.B. documented in the 9 Main B post logbook, "First security inspection complete. All doors, locks, walls, floors, vents, windows, ceilings appear to be secure at this time".

28. On 4/19/21 at 1:00 a.m., CO J.B. documented in the 9 Main B post logbook, "Active supervision tour of area complete, nothing to report".

29. On 4/19/21 at 1:30 a.m., CO J.B. documented in the 9 Main B post logbook, "Active supervision tour of area complete, nothing to report".

30. On 4/19/21 at 1:52 a.m., CO J.B. documented in the 9 Main B post logbook, "CO Brown of post to meal".

31. On 4/19/21 at 1:52 a.m., CO C.C. documented in the 9 Main B post logbook, "CO Canada on post for meal relief for CO Brown. Physical count taken and verified of live breathing bodies".

32. On 4/19/21 at 2:00 a.m., CO C.C. documented in the 9 Main B post logbook, "Active supervision tour of area complete, nothing unusual to report".

33. On 4/19/21 at 2:18 a.m. video recording of 9 Main B unit showed CO C.C. walking down the main isle to the back of the housing area with a flashlight. CO C.C. did not enter the area that Braunson was housed.

34. On 4/19/21 at 2:30 a.m., CO C.C. documented in the 9 Main B post logbook, "Active supervision tour of area complete, nothing unusual to report. CO Canada off post M/R (Meal Relief) completed".

35. Per the Callout Report from the NYC DOC Investigation Division and a review of the video recording of 9 Main B post by Commission staff, CO C.C. did not perform 30-minute active supervision tours of the unit. CO C.C. did not go to each bed to perform a proper tour, nor did CO C.C. tour the back right area of the post that housed Braunson when completing rounds on the 9 Main B post on 4/19/21 from 1:52 a.m. through 2:30 a.m.

36. On 4/19/21 at 2:30 a.m., CO J.B. documented in the 9 Main B post logbook, "on post from meal".

37. On 4/19/21 at 2:45 a.m., Captain (Cpt.) N.T. documented in the 9 Main B post logbook, "On post conducting a tour area. Officer been instructed to remain on post until properly relieved. Follow all D.O.C. rules, regulations, and policies. Maintain an accurate count. Conduct "2" tours of inspection in addition to frequent tours. Notify this writer of any unusual incidents. Keep all doors and gates secured".

38. On 4/19/21 at 3:00 a.m., CO J.B. documented in the 9 Main B post logbook, "Active supervision tour of area complete, nothing to report".

39. On 4/19/21 at 3:16 a.m., video recording showed a captain walking down the main corridor of the unit and checking the fire door. The captain did not notice the torn sheet that was obstructing entrance into the area that Braunson was housed.

40. On 4/19/21 at 3:26 a.m., an unidentified II untied the torn sheet that was fastened between the base of the beds.

41. On 4/19/21 at 3:30 a.m., CO J.B. documented in the 9 Main B post logbook, "Active supervision tour of area complete, nothing to report".

42. On 4/19/21 at 4:00 a.m., CO J.B. documented in the 9 Main B post logbook, "Active supervision tour of area complete, nothing to report".

43. On 4/19/21 at 4:30 a.m., CO J.B. documented in the 9 Main B post logbook, "Active supervision tour of area complete, nothing to report".

44. On 4/19/21 at 5:00 a.m., CO J.B. documented in the 9 Main B post logbook, "Active supervision tour of area complete, nothing to report".

45. On 4/19/21 at 5:20 a.m., CO J.B. documented in the 9 Main B post logbook, "Institutional feeding in progress".

46. On 4/19/21 at 5:30 a.m., CO J.B. documented in the 9 Main B post logbook, "Active supervision tour of area complete, nothing to report".

47. On 4/19/21 at 5:50 a.m., CO J.B. documented in the 9 Main B post logbook, "Level "B" activated at this time, inmate on inmate fight".

48. On 4/19/21 at 6:00 a.m., CO J.B. documented in the 9 Main B post logbook, "Level "B" abated at this time".

49. On 4/19/21 at 7:00 a.m., CO J.B. documented in the 9 Main B post logbook, "Active supervision tour of area complete, nothing to report".

50. On 4/19/21 at 7:30 a.m., CO J.B. documented in the 9 Main B post logbook, "Active supervision tour of area complete, nothing to report. Institutional count taken and verified".

51. On 4/19/21 at 7:31 a.m., CO J.B. documented in the 9 Main B post logbook, "Remains

on post awaiting relief of duties. Physical count taken and verified".

52. On 4/19/21 at 7:40 a.m., CO J.B. documented in the 9 Main B post logbook, "1st security inspection in progress".

53. On 4/19/21 at 7:50 a.m., CO J.B. documented in the 9 Main B post logbook, "1st security inspection completed at this time. All doors, locks, walls, floors, vents, ceilings appear secure, common areas appear secure at this time. Previous tour logbook entries read, nothing to report at this time".

54. On 4/19/21 at 8:00 a.m., CO J.B. documented in the 9 Main B post logbook, "Active supervision tour of area complete, nothing to report".

55. Per the Callout Report from the NYC DOC Investigation Division and a review of the video recording of 9 Main B post by Commission staff, CO J.B. failed to observe the torn sheet that was tied to the bottom of the beds that obstructed entrance to the area that Braunson was housed. CO J.B. did not perform 30-minute active supervision tours of the unit. CO J.B. did not go to each bed to perform a proper tour, nor did CO J.B. tour the back right area of the post that housed Braunson when rounding on the 9 Main B post on 4/19/21 between the hours of 12:10 a.m. through 8:00 a.m. This was a violation of 9 NYCRR §7003.6(c) Requirements of facility staff members prior to assuming responsibilities in an assigned facility area, 9 NYCRR §7003.3(a) Supervision of prisoners in facility housing areas, and 9 NYCRR §7003.5(a)(1)(2) Prisoner population counts.

56. On 4/19/21 at 8:20 a.m., from a review of video recording of 9 Main B post by Commission staff, it was observed that three unidentified IIs approach Braunson's bed and turn around and walk away. At 8:21 a.m., another unidentified II approached Braunson's bed and looked closely at Braunson, placed his hands on the top of his head and walked away from Braunson's bed and walked to the front of the unit. At 8:21 a.m., the unidentified II returned to Braunson's bed with CO J.B. CO J.B. walked over to Braunson's bed and then walked to the front of the unit. CO J.B. returned to Braunson at 8:23 a.m. and kicked the bedframe of Braunson's bed with no response or movement from Braunson. CO J.B. walked to the front of the unit and back to Braunson's bed. Many IIs were observed going to Braunson's bed to observe him without any instruction from CO J.B. to remove themselves from the area. CO J.B. walked to the front of the unit again and was observed talking to other IIs.

57. At 8:27 a.m., Captain N.T. arrived at the scene and walked over to Braunson's bed. At that time, other unidentified staff wearing white shirts arrived at the scene. The Medical Review Board finds that CO J.B., Captain N.T., and the other unidentified staff did not initiate Cardiopulmonary Resuscitation (CPR) on Braunson. A medical emergency was called at 8:30 a.m. Unidentified staff with white shirts arrived on the unit and went to Braunson's bed.

58. On 4/19/21 at 8:38 a.m., medical staff RN [redacted], PA [redacted]. and Dr. [redacted] arrived at the scene. [redacted]

[redacted]

59. Medicolegal Investigator [redacted]. from the Office of Chief Medical Examiners arrived at the scene and uncovered a clear plastic bag containing a beige grainy substance hidden in Braunson's groin area. The substance was suspected to be heroin and was pending verification from drug testing.

60. After a review of the 9 Main B post logbook by Commission staff, there was no documentation on 9/19/21 that a medical emergency had taken place for Braunson. This is a violation of 9 NYCRR §7003.3(j)(6)(i) to (iv): which states:
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: any significant events and activities occurring during supervision including: the date and time of such event or problem; the names of all incarcerated individuals and/or staff involved; facility staff response to such events or problem, including a summary of what occurred; a description of the condition of any incarcerated individuals involved.

ACTIONS REQUIRED:

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

1. The Commissioner shall note the findings of the Commission's report as official notice that facility staff were found to be repeatedly out of compliance with basic fundamental security and supervision standards including:
9 NYCRR §7003.3(a) Supervision of prisoners in facility housing areas;
9 NYCRR §7003.3(j)(6)(i), (ii), (iii), (iv) Supervision of prisoners in facility housing areas;
9 NYCRR §7003.5(a) Prisoner population counts;
9 NYCRR §7003.5(a)(2) and (3) Prisoner population counts;
9 NYCRR§7003.6(c) Requirements of facility staff members prior to assuming responsibilities in an assigned facility area.

2. The Commissioner shall conduct a thorough review and investigation into the staff assigned to Braunson's housing area and the staff responsible for supervising the housing area staff. If staff are found to be in violation of Department directives, staff should be the subject of administrative action(s).

3. The Commissioner shall conduct an investigation into the actions of the DOC Captain and Officer assigned to supervise Braunson and the unidentified uniformed command staff in order to determine why CPR was not initiated on Braunson.

4. The Commissioner shall prepare and provide a comprehensive corrective action plan to assure compliance with the cited minimum standards.

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

WITNESS, HONORABLE ALLEN RILEY, Chairman, 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, 2023.

Allen Riley
Chairman
Commission of Correction

AR:BB:jdb
2021-M-0058
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cc: Paul Shechtman, Deputy Commissioner of Legal Matters/General Counsel
Ronald Brereton, Deputy Commissioner of Security Operations
James Saunders, Deputy Commissioner of Health Affairs
Ronald Greenberg, Director of Compliance
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