NEW YORK STATE | Commission of Correction

Final Report of the New York State Commission of Correction:

In the Matter of the Death of

Javier Velasco, an incarcerated individual of the Anna M. Kross Center

June 28, 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 Javier Velasco who died on March 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. Javier Velasco was a 37-year-old male who died on 3/19/21 due to a suicidal hanging while in the custody of the New York City Department of Corrections (NYC DOC) at the Anna M. Kross Center (AMKC). The Medical Review Board has found that Correctional Health Services (CHS) failed to recognize Velasco's acute suicidal ideation and refer him for psychiatric hospitalization after a serious suicide attempt and then removed suicide watch measures prematurely without proper psychiatric consultation. The Medical Review Board opines that Velasco's death was preventable had his suicidal ideation been properly identified and treated. Additionally, the Medical Review Board has found that NYC DOC staff failed to comport with the requirements of 9 NYCRR §7003.3 due to failing to conduct adequate supervisory tours of the housing area where Velasco resided.

2. Velasco was incarcerated on 3/5/21 on a charge of Criminal Contempt 1st Degree with $10,000 bail and was awaiting court. Additionally, Velasco had a parole violation detainer. In May 2016, Velasco, while on probation, operated a motor vehicle in an intoxicated condition on a public road. Velasco was initially sentenced to five years of probation on 4/20/17 and one year of confinement.

3. [redacted].

4. On 3/5/21 at 3:19 p.m., Velasco was received in NYC DOC at the Eric M. Taylor Center (EMTC). [redacted].

5. [redacted].

6. On 3/16/21 at 4:00 a.m., Velasco tied a bed sheet around his neck and attached it to the toilet door in the shower area. Velasco then climbed on the toilet and attempted to jump off. CO D.M. reported hearing a loud bang from the bathroom, urgently responded and saw Velasco with the sheet around the neck. CO D.M. cut the sheet from Velasco's neck

and laid Velasco on his side. [redacted]. During an interview with Commission staff, CO D.M. reported that Velasco was very upset with the officer for cutting him down stating that he just wanted to die. The Medical Review Board notes that supervision and actions by the officer most likely prevented Velasco's death at that time.

7. [redacted].

8. [redacted]. The Medical Review Board opines that Velasco had a serious suicide attempt and had acute suicidal ideation that warranted consideration of forensic hospitalization.

9. [redacted].

10. [redacted]. The Medical Review Board opines that decision to remove Velasco from suicide watch was premature given the seriousness of his attempt, without having received a follow-up psychiatric consultation, and not having established his history of prior suicide attempts by hanging.

11. [redacted]

12. [redacted].

13. On 3/18/21, Velasco locked in his cell at 8:57 p.m. CO A.I. and CO A.A. were on duty at that time. At 11:05 p.m., Captain S. completed a supervisory tour.

14. On 3/19/21 at 2:45 a.m., CO S.B. relieved CO A.A. for Enhanced Suicide Observation (ESO) watch of cell number one which housed another incarcerated individual. At 3:01 a.m., CO V.C. relieved CO A.I. Per the DOC investigation report, CO V.C. did not make adequate supervisory tours as evidenced by the failure to look in the cells during his rounds and CO V.C. did not complete the 15-minute supervisory rounds after the suicide prevention aide (SPA) completed his shift.

15. On 3/19/21 at 5:18 a.m., CO G.M. stated that Velasco was found hanging in his cell via a bed sheet affixed to the air vent. CO V.C. and CO S.B. entered the cell and cut the sheet from around Velasco's neck. Velasco was placed on the bed and CPR was initiated by the CO's and a pocket mask was utilized for rescue breaths. The officer's body camera was activated upon the entry into the cell. The officer on A post was advised to call a medical emergency but was unfamiliar with the process and CO G.M. returned to the desk to activate a medical response. [redacted]. Captain M. was the Bravo house supervisor and was advised of a medical response ton quad lower 8. Upon arrival, Captain M. noted that medical staff were in cell #29 and were performing CPR. [redacted]

[redacted]. During an interview with Commission staff several different procedures were given as to whose responsibility it was to activate EMS. CO V.C. stated that the Captain calls EMS. Captain U.M. stated that the A post staff in the clinic or tour commander's office calls EMS but did not designate who should make the call. Another CO reported that the medical clinic activates EMS. An RN stated that the nurses call EMS. RN [redacted]. stated that they are unsure who calls EMS. P.A. [redacted]. stated that one of the nurses calls EMS. The Medical Review Board opines that there was a lack of clear direction and policy regarding the activation of EMS and this resulted in a failure of timely activation.

16. Per a review the QL8 logbook entry by CO V.C., a medical response was called at 5:09 a.m. for Velasco. Per the Quad 6/8/A post log, the medical response was called at 5:20 a.m. per CO K.

17. A review of recorded video footage for 3/19/21 revealed:

At 12:01 a.m., CO performed a supervisory tour and looked in the cells with a flashlight.

At 12:04 a.m., CO and SPA performed supervisory tours and looked in the cells with a flashlight.

At 12:17 a.m., SPA performed rounds and looked in all cells.

At 12:28 a.m., CO performed a supervisory tour and looked in the cells.

At 12:29 a.m. and 12:46 a.m., the SPA performed rounds and looked in the cells.

At 1:00 a.m. and 1:24 a.m., the CO performed a supervisory tour and looked in the cells.

At 1:33 a.m., the CO performed an inadequate supervisory tour and failed to look in all the cells .

At 2:00 a.m., the SPA completed his shift and returned to the cell and from that time, supervisory tours should have been completed every 15 minutes.

At 2:21 a.m., the CO and ADW M.O. performed a supervisory tour and looked in the Cells.

At 3:09 a.m., 3:30 a.m., 4:00 a.m., and 4:34 a.m., CO V.C. performed inadequate supervisory tours and failed to look in all the cells.

At 4:39 a.m., CO V.C. walked to cell 14.

At 5:10 a.m., CO G.M. performed supervisory rounds carrying a meal tray and looked in all cells and looked in cells 27 and 28 twice. CO G.M. also went back to cell 29 twice.

At 5:14 a.m., CO G.M. walked down the housing unit again and stopped and looked in

cell 29. The video then showed CO G.W. and CO V.C. enter cell 29. Two more CO's arrived and responded to cell 29.

At 5:18 a.m., a CO exits cell 29 and runs to the front of block.

At 5:27 a.m., medical arrived.

At 5:29 a.m., a female with a white shirt arrived.

At 5:35 a.m., a male with a white shirt arrived.

At 5:36 a.m., more medical staff arrived with a video recorder.

At 5:46 a.m., Urgicare arrived.

The failure of the security staff to perform adequate supervisory tours was in violation of 9 NYCRR §7003.3(c), Supervision of prisoners in facility housing areas which states: "At a minimum, general supervision shall be maintained in all facility housing areas when all prisoners are secured in their individual housing units".

18. There were suicide letters given to another incarcerated individual from Velasco which stated that Velasco intended to kill himself and the letter stated what to do after his death. These letters were to be given to the family upon the individual's release and were not opened.

19. A review of phone calls made by Velasco prior to his death revealed that Velasco had indicated an intent to kill himself, however, this information was not relayed to any NYC DOC staff.

20. On 3/19/21 at 2:08 p.m., CHS staff N.J. noted that Velasco missed a nursing follow-up appointment as there was no escort available and the patient was not produced. However, it is noted that Velasco was deceased at that time.

21. On 3/20/21 at 3:22 p.m. and 3/21/21 at 3:05 p.m., CHS staff member P.S. noted that Velasco had a missed a nursing appointment for follow-up and that DOC stated the patient did not want to come to the clinic, that patient would remain on the transportation list and the area captain was notified. However, it is noted that Velasco was deceased at that time.

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 Velasco and their failure to complete required security rounds in comportment with the requirements of 9 NYCRR §7003.3. Administrative action should be taken if the officers are found to be in violation of department directives.

2. The Commissioner shall review the policies and procedures regarding the supervision of incarcerated individuals. A copy of any revisions shall be forwarded to the Board to

assure compliance with 9 NYCRR §7003.3.

3. The Commissioner shall review all policies and procedures regarding activation of EMS and assure that all medical and security staff are aware of the procedure and that they follow policy and procedure to ensure timely activation of EMS.

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

In a response dated 6/17/22 to the Commission's preliminary report, NYC DOC administration indicated that all requested reviews were completed. Investigation of the cited DOC officers has been referred to the Bronx District Attorney's Office.

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

1. Correctional Health Services shall conduct an investigation into the documentation in Velasco's record which indicated that he missed scheduled appointments when he was already deceased.

2. Correctional Health Services shall conduct a review of the mental health care provided to Velasco with a review of his removal from suicide watch after less than 36 hours after a serious attempt by hanging, without having a follow-up psychiatric review, and not having established Velasco's history of prior suicide attempts by hanging.

3. Correctional Health Services shall conduct a review of the mental health care provided to Velasco regarding why forensic hospitalization was not considered for a patient with acute suicidal ideation and post serious suicide attempt by hanging.

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

In a response dated 5/16/22 to the Commission's preliminary report Correctional Health Services indicated the following:

[redacted]

[redacted]

The Medical Review Board does not accept the response received regarding why Velasco remained on medical callouts after his death with documented indications that the he "did not want to come to the clinic". The Board opines that this is demonstrative of a deficient population management and accountability system. The Medical Review Board also remains opined that Velasco had significant past history of suicide attempts by hanging that were not adequately accounted for during his mental health assessment nor was the lethality of his most recent attempt and that he should not have been removed from observation.

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 28th day of June, 2022.

Thomas J. Loughren
Commissioner & Chair
Medical Review Board

TJL:DC:jdb
2021-M-0043
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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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