Commission of Correction

Final Report of the
New York State Commission of Correction:

In the Matter of the Death of

Herman Diaz,
an incarcerated individual of the
Eric M. Taylor Center

September 27, 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 Herman Diaz who died on March 18, 2022, 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. Herman Diaz was a 52-year-old male who died on 3/18/22 as a result of asphyxia due to aspiration of bolus of food (orange slice) 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 delayed Diaz's immediate access to medical care and life saving treatment while he was choking.

2. Diaz was born in Brooklyn, NY. Diaz was survived by his five siblings. Diaz had a 9th grade education and was unemployed. There was no further demographic or social history available to the Commission for Diaz.

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6. On 2/27/22 at 12:06 p.m., Diaz was admitted into NYC DOC custody from New York County Criminal Court after being charged with Robbery 1st Degree, Criminal Possession Weapon 3rd Degree, Criminal Possession Stolen Property 5th Degree, and Menacing 1st Degree. Diaz scored a zero on the Suicide Prevention Screening. Diaz's next court date was scheduled for March 29, 2022.

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11. On 3/2/22 Diaz was transferred from the EMTC reception area to EMTC 5 Upper that housed new admissions for COVID-19 quarantine. Per his request, Diaz was rehoused to 6 Upper that housed new admissions for COVID-19 quarantine.

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14. Diaz was discharged from EMTC admission to EMTC general population (GP).

15. Documentation from NYC DOC Investigation Division indicated that in the 6 Upper B post logbook on 3/15/22 at 9:30 p.m., Corrections Officer (CO) E.O. assumed the post. On 3/15/22 at 11:05 p.m., CO E.O. signed off the post to assume 6 Upper B. There were no other entries made in the 6 Upper B post logbook after 3/15/22.

16. On 3/15/22 at 7:01 a.m., CO B. documented in the 6 Upper A Post logbook, "No B post officer on post".

17. On 3/15/22 at 8:15 a.m., CO B. documented in the 6 Upper A Logbook, "Diaz, Herman notified of West Facility (WF) - Refused West Facility".

18. On 3/15/22 at 12:00 p.m., CO B. signed off the 6 Upper A post and CO N. signed on the 6 Upper A post.

19. On 3/15/22 at 2:55 p.m., Assistant Warden (AW) H. documented in the 6 Upper A Post logbook that a tour of the area was completed.

20. On 3/15/22 at 3:30 p.m., CO N. documented in the 6 Upper A Post logbook, "Remains on Post. There is no floor officer on post".

21. On 3/16/22 at 11:31 p.m., CO N.R. documented in the 6 Upper A Post logbook being on post and properly relieving CO N. CO N.R. documented, "No "B" officer on post at this time".

22. On 3/16/22 at 1:39 a.m., Captain C. documented in the 6 Upper A Post logbook, "Conducting a Prison Rape Elimination Act (PREA) unannounced tour of the area". Documentation indicated that the officer on post appeared alert and that there was no "B" officer on post.

23. On 3/16/22 at 7:31 a.m., CO N.R. documented in the 6 Upper A Post logbook, "Remains on post 6 Upper "A". No "B" officer on post at this time".

24. On 3/16/22 at 9:05 a.m., CO N.R. documented in the 6 Upper A Post logbook, "Individual Diaz, Herman refused West Facility".

25. On 3/16/22 at 10:00 a.m., CO N.R. documented in the 6 Upper A Post logbook, "B officer on post by CO P".

26. [redacted]

27. On 3/16/22 at 3:28 p.m., CO P. documented in the 6 Upper A Post logbook, "assumes post".

28. On 3/16/22 at 3:30 p.m., CO P. documented in the 6 Upper A Post logbook, "Visual Supervision tour of area appears normal. No "B" officer on post".

29. On 3/16/22 at 11:10 p.m., CO O. documented in the 6 Upper A Post logbook, "Assume 6 Upper A relieving CO P." Note: There is no officer assigned to 6 Upper B".

30. On 3/17/22 at 2:17 a.m., Captain (Cpt.) C. documented in the 6 Upper Post logbook being on post for a PREA announcement. Cpt. C. documented, "No B officer on post".

31. On 3/17/22 at 7:30 a.m., CO Mo. documented in the 6 Upper A Post logbook, "Assuming "A" post upper with no "B" officer.

32. On 3/17/22 at 5:31 p.m., CO Me. documented in the 6 Upper A Post logbook, "On Post".

33. On 3/17/22 at 11:01 p.m., CO Me. documented in the 6 Upper A Post logbook, "On Post".

34. On 3/18/22 at 1:49 a.m., Cpt. D. documented in the 6 Upper Post logbook being on post for a tour. "No B officer on post".

35. On 3/18/22 at 7:01 a.m., CO Me. documented in the 6 Upper A Post logbook, "On Post". Entering 3rd tour. Control room notified. No "B" officer."

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37. On 3/18/22 at 9:55 a.m., CO A.H. documented in the 6 Upper A Post logbook, "Signed on post Upper A". During an interview with Commission staff, CO A.H. reported that she performed a unit count on 6 upper before the other officer left the A post. CO A.H. reported that the only time an officer can go onto the unit is if there is a second officer present on the unit. The Medical Review Board finds that the repeated absence of a B post officer constitutes a violation of 9 NYCRR §7003.3(a) Active supervision as active supervision cannot properly be maintained.

38. On 3/18/22 at 10:15 a.m., CO S.M. documented in the EMTC old clinic logbook that a medical emergency was activated for Diaz by CO A.H. and that the medical staff was notified.

39. On 3/18/22, from a review of video recording of 6 Upper by Commission staff, the following was observed:

    At 10:16 a.m., Diaz was observed walking by the 6 Upper A post station and he began to fall to his left side landing on his left buttocks. Diaz then rolled over to the supine position on the floor with his arms extended outwardly. An unidentified incarcerated individual (II) quickly went to Diaz and rolled him on to his left side. Two more unidentified II's went to help with Diaz as the first unidentified II rolled Diaz to the prone position and attempted to lift Diaz up under his arms. Diaz appeared to be struggling and his body began to shake, and he was lowered back down to the ground and positioned on his left side. The unidentified II's attempted to aid Diaz by rubbing his back and chest area.

    At 10:17 a.m., Diaz remained laying on the floor while four unidentified II's attempted to help him by rubbing his back and chest area.

    At 10:18 a.m., the II's again attempted to hold Diaz up and one II attempted what appeared to be the Heimlich maneuver without success. Diaz was lowered back down to the floor. CO A.H. was observed leaving the 6 Upper A post and unlocking the unit exit door. CO A.H. then returned to the 6 Upper A post and did not enter into the 6 Upper unit to provide Basic Life Support (BLS) measures that include the heimlich maneuver to Diaz. During an interview with Commission staff, CO A.H. reported that due to security measures, she did not enter the 6 Upper unit to assist with Diaz as she was the only officer on the unit.

    At 10:19 a.m., four unidentified II's lifted Diaz up off of the floor and carried him towards

the 6 Upper unit door. CO A.H. was observed opening the 6 Upper unit door to let the four II's out that were carrying Diaz. CO A.H. walked towards the 6 Upper exit door and opened the door to the foyer to let the four II's carry Diaz off the 6 Upper unit to the medical unit. During an interview with Commission staff, CO A.H. was asked if she attempted to stop the II's so she could help Diaz. CO A.H. reported that she did not stop the II's because at that moment it wasn't just her and Diaz, it was her, Diaz, and maybe four or five II's that could have done anything to her. CO A.H. reported that her only thought was to get Diaz to the clinic for help because no one responded to the medical emergency, and she wanted Diaz to live.

At 10:21 a.m., per a review of the video recording of EMTC main old clinic corridor by Commission staff, four unidentified II's are observed carrying Diaz into the clinic area escorted by Assistant Deputy Warden (ADW) M.A. Diaz was carried to one of the clinic rooms. There was no camera recording in the clinic room. During an interview with Commission staff, ADW M.A. was asked if he was aware of a medical emergency being called for Diaz. ADW M.A. reported that he was not aware that a medical emergency had been called for Diaz. ADW M.A. reported that he heard a noise in the corridor and as he was coming out of his office, he observed several II's carrying Diaz past him to the clinic. ADW M.A. reported that he did not know why the II's were taking Diaz to the clinic but that he followed behind them to the clinic that was approximately 75 feet to 100 feet away from his office. The Medical Review Board finds that the lack of required security staff to supervise the housing area and to respond to emergencies constitutes a violation of Correction Law §500-c(4) that requires to keep incarcerated individuals safe.

40. On 3/18/22 at 10:20 a.m., CO A.H. documented in the 6 Upper A Post logbook, "Medical emergency called to 6 Upper".

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ACTIONS REQUIRED:

TO THE COMMISSIONER OF THE NYC 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.

2. The Commissioner shall prepare and provide a comprehensive corrective action plan to assure compliance with the cited minimum standard and to provide sufficient staffing to assure incarcerated individuals safekeeping in accordance with Correction Law §500-c (4).

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

In a response to the Commission's preliminary report dated 6/28/23 NYC DOC indicated that an Operations Memorandum was issued at EMTC addressing active supervision requirements, logbook entry requirements, captain tour requirements, and verification of captain and tour commander inspections. Additionally NYC DOC reported current recruitment, staff redeployment, and sick leave policy monitoring to address facility staffing needs. The Commission will continue to monitor and follow up on the minimum standard violations and facility staffing coverage.

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 27th day of September, 2023.

Allen Riley
Chairman
Commission of Correction

AR:BB;vc
2022-M-0032
September 27, 2023

cc: 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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NYC Board of Correction