NEW YORK STATE | Commission of Correction

Final Report of the New York State Commission of Correction:

In the Matter of the Death of

Malcolm Boatwright, an incarcerated individual of the Anna M. Kross 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 Malcolm Boatwright who died on December 10, 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. Malcolm Boatwright was a 28-year-old male who died on 12/10/21 from Complications of Nontraumatic Seizure Disorder of undetermined etiology while in the custody of the New York City Department of Corrections (NYC DOC) at the Anna M. Kross Center (AMKC). The investigation by the Medical Review Board has revealed that Boatwright's death was attributed to a medication error by attending medical staff at Bellevue Hospital who administered a high level of an antipsychotic medication to Boatwright without reviewing his correctional health records and establishing that he was not current with the medication and needed a titration to prevent toxicity and adverse reactions including seizures from occurring. Additionally, the Board has found that there was a mismanagement of Boatwright's prescribed benzodiazepine taper by medical staff from Correctional Health Services (CHS) and an unacceptable delay by NYC DOC staff in obtaining a security escort for Boatwright to be transported to the hospital. The Board opines that had Boatwright been properly medically managed, his death would have been preventable.

2. [redacted] On November 11, 2021, Boatwright was arrested and charged with Sexual Abuse 1st Degree and Act in Manner to Injure Child Less than 17. Boatwright was arraigned on the charges of Sexual Abuse 1st and 2nd Degrees, Forcible Touching, and Act in Manner to Injure Child Less than 17. Boatwright was remanded without bail. These charges were abated by his death.

3. [redacted]

4. On 11/12/21, Boatwright was committed to NYC DOC. Per the arraignment and classification risk screening, Boatwright noted that he felt pain near his left eye and had bruise there.

5. [redacted]

[redacted] During an interview with Commission staff, [redacted] Dr. [redacted] further explained that when an incarcerated individual is placed on a Clonazepam taper, a Clinical Institute Withdrawal Assessment (CIWA) assessment is completed prior to administering the medication.

6. [redacted]

7. [redacted]

8. [redacted]

9. [redacted]

10. [redacted]

11. [redacted]

12. [redacted]

13. [redacted]

14. [redacted]

[redacted]

15. [redacted]

16. [redacted]

17. [redacted] Per the movement record, Boatwright transferred to AMKC C-71 at 6:41 p.m.

18. [redacted]

19. [redacted]

20. [redacted]

21. [redacted]

22. [redacted] Boatwright was locked in for security reasons per DOC. Boatwright was informed that when everyone on the unit locked in, DOC would work with him so he could shower. Boatwright was amendable to this. An ESO was still not assigned to Boatwright [redacted]

23. [redacted]

24. [redacted]

[redacted]

25. [redacted]

26. [redacted]

27. [redacted]

28. [redacted]

29. [redacted]

30. [redacted]

31. [redacted]

32. [redacted]

33. [redacted]

[redacted]

34. [redacted]

35. [redacted]

36. [redacted]

37. [redacted]

38. [redacted]

39. [redacted]

40. [redacted]

41. [redacted]

42. [redacted]

43. [redacted]

[redacted]

44. [redacted]

45. [redacted]

46. [redacted]

47. [redacted]

48. [redacted]

49. [redacted]

50. [redacted]

51. [redacted]

52. [redacted]

53. [redacted]

54. [redacted]

55. [redacted]

56. [redacted]

57. [redacted]

58. [redacted].

59. [redacted]

60. [redacted]

61. [redacted]

62. [redacted]

63. [redacted]

64. [redacted]

65. [redacted]

66. [redacted] The Medical Review Board finds that there was an inconsistent administration of the [redacted] taper ordered for Boatwright with 11 documented occasions where the medication was not delivered. The Medical Review Board opines that the inconsistent taper of the benzodiazepine could have been contributory to Boatwright's new onset seizures.

67. [redacted]

68. [redacted] During an interview with Commission Staff, [redacted] Dr. [redacted] stated that the medical providers would write orders to taper individuals off benzodiazepines at their intake and that they could be restarted if needed. Dr. [redacted] stated that [redacted] and that the Bellevue Hospital providers had access to CHS records.

69. [redacted]

70. [redacted]

71. [redacted]

72. [redacted]

73. [redacted]

74. [redacted]

75. [redacted] Per the clinic logbook, there was no DOC escort available for the EMS. EMS was reactivated. The second EMS came at 4:30 p.m. and [redacted]

76. A Review of the Fire Department New York (FDNY) EMS report indicated that the initial call was received at 2:34 p.m. and EMS arrived at 2:37 p.m. [redacted]

[redacted] and they spoke with Dr. [redacted] from their control center who authorized them to leave Boatwright with the medical staff until such time as DOC was able to provide staff to escort him to the hospital. EMS left the scene at 4:15 p.m. Per documentation from FDNY EMS on 12/8/21 at 4:53 p.m., EMS was activated for Boatwright. [redacted] The Medical Review Board finds that the lack of adequate staff to escort Boatwright to the hospital with EMS at 2:34 p.m. was an unacceptable delay in providing medical care and was in violation on 9 NYCRR §7010.2(g) & (h) which states:

(g) Definite arrangements shall be made to insure the prompt transportation of an inmate to a hospital or other appropriate medical facility in emergency situations.

(h) Each facility shall provide the necessary security and supervision during the period of hospitalization and in the course of transportation to and from a medical facility.

77. [redacted], DOC officers noted that Boatwright started to have minor trembling of his body and then began to have more intense movement. [redacted]

78. [redacted]

79. [redacted]

80. [redacted]

81. [redacted] The Medical Review Board finds that there was a systemic failure of the REMS program at Bellevue Hospital. Although Boatwright was registered in the REMS database, there was a failure by the pharmacy to verify that his medication was current while in custody of NYC DOC.

82. [redacted]

83. [redacted]

84. [redacted]

85. [redacted]

86. [redacted]

[redacted]

The Medical Review Board has found that there was a substantial medication error committed by the attending physician, resident physician, and medical staff at Bellevue Hospital. The information that indicated that Boatwright was currently taking [redacted] was based on Boatwright's community records and was not current nor correct. The attending physician, attending psychiatrist, and resident physician failed to obtain and review Boatwright's medical records from Correctional Health Services which clearly indicated that [redacted] had not been continued since his admission to NYC DOC on 11/11/2021 and was pending further study before being administered again. Clozapine is known to cause seizures if not properly titrated. The [redacted] dose of [redacted] that was given was a toxic level as Boatwright had not received the medication for nearly 30 days and was the likely catalyst for his terminal seizure nearly 5 hours later.

87. On 12/10/21 at approximately 3:56 a.m., CO K. reported that while making a supervisory tour, Boatwright was found on the floor next to his bed in 19S Room 32. CO K. notified the nurse to check on Boatwright. [redacted]

88. [redacted]

89. [redacted]

[redacted]

The Medical Review Board opines that although the level of [redacted] found in Boatwright's system was within accepted therapeutic ranges, the rapid change in [redacted] blood levels from [redacted] after administering a single [redacted] dose of [redacted] on 12/9/21 without proper titration (a titration level that would have needed 30 days or more to achieve) was contributory to his terminal seizure

ACTIONS REQUIRED:

TO THE DIRECTOR OF MEDICINE FOR BELLEVUE HOSPITAL:

1. A comprehensive investigation shall be conducted regarding the attending physician, attending psychiatrist, and resident physician Dr. [redacted]. as to how orders were made to administer a high level of [redacted] to Boatwright without proper titration and without verification from Correctional Health Services if he was currently prescribed the medication prior to hospitalization.

2. A comprehensive investigation shall be conducted regarding the pharmacy and REMS system for failure to identify that Boatwright was not current on his [redacted] medication prior to fulfilling the prescription order.

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

The Commission did not receive a response from Bellevue Hospital in the matter.

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

The Vice President for Correctional Health Services shall conduct a quality assurance review to determine why Boatwright did not receive his [redacted] taper as ordered with 11 documented missed medication administrations and why on 11/23/21, Boatwright was given [redacted] two hours apart.

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

In a response dated 8/14/23 to the Commissions preliminary report, Correctional Health Services (CHS) indicated that there is a process to escalate situations where patients are not escorted for administration of taper medications. CHS also states that the Commission was incorrect in the finding [redacted] *The Commission does not accept this response as no documentation was provided that indicates such and the documentation provided to the Commission at the onset of the investigation by CHS clearly indicated* [redacted] *As there was no information provided as to why there is a discrepancy in the reported times, the Commission will remain affirmed in their findings.*

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

1. The Commissioner shall conduct an investigation as to why Boatwright was not promptly escorted to the hospital on 12/8/21 in comportment with 9 NYCRR §7010.2(g) & (h).

2. The Commissioner shall conduct an investigation into the failure of the Department to assign ESO staff to Boatwright when he was placed on a one to one for suicidal ideations.

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

In a response dated 6/28/23 to the Commission's preliminary report, NYC DOC indicated that the actions required were referred to the Special Investigation Unit for investigation. The Commission will continue to follow up on the investigation findings and cited violations of minimum standards.

TO THE NYC MEDICAL EXAMINERS OFFICE:

The Medical Review Board requests that NYC Medical Examiner conduct a review of Boatwright's cause and manner of death in view of the Board's findings to include the [redacted] medication error as contributory.

In a response to the Commission's preliminary report dated 8/14/23, the NYC Medical Examiner reported that the requested review was completed and concluded that the [redacted] medication error was not contributory. The Medical Review Board accepts the NYC Medical Examiner's response but remains affirmed in their opinion that the [redacted] medication error at Bellevue Hospital was significantly contributory to Boatwright's cause of death.

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 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:DC;vc
2021-M-0165
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
Patricia Yang, DrPH, Senior Vice President
Correctional Health Services
Bipin Subedi, MD, Chief Medical Officer
Correctional Health Services
Jasmine Georges-Yilla, Executive Director
NYC Board of Correction