NEW YORK STATE | Commission of Correction

Final Report of the New York State Commission of Correction:

In the Matter of the Death of

Robert Jackson, 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 Robert Jackson who died on June 20, 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. Robert Jackson was a 42-year-old male who died on 6/30/21 from Hypertensive and Atherosclerotic Cardiovascular Disease 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 chronic staffing issues and a failure to provide facility supervision in accordance with NYS Minimum Standards has jeopardized the safety the incarcerated individuals in NYC DOC's custody and constitutes a violation of Correction Law §500-c(4) that requires the Department to keep incarcerated individuals safe. Furthermore, the Medical Review Board has found that there was an unacceptable delay of medical staff's response to Jackson's medical emergency. The Medical Review Board opines that had there been a timely response to Jackson's medical emergency, his death could have been prevented.

2. [redacted] On 10/19/20, Jackson was charged with Burglary 3rd Degree. Jackson's next court appearance prior to his terminal event was scheduled for 7/13/21.

3. [redacted]

4. On 10/20/20, Jackson was received at NYC DOC. [redacted]

[redacted]

5. [redacted]

6. [redacted]

7. [redacted]

8. [redacted]

9. [redacted]

10. [redacted]

11. [redacted]

[redacted]

12. [redacted]

13. [redacted]

14. [redacted]

15. [redacted]

16. [redacted]

[redacted]

17. [redacted]

18. [redacted]

19. [redacted]

20. [redacted]

21. [redacted]

22. [redacted]

[redacted]

23. [redacted]

24. [redacted]

25. [redacted]

26. [redacted]

27. [redacted]

[redacted]

28. [redacted]

29. [redacted]

30. [redacted]

31. [redacted]

32. [redacted]

33. [redacted]

34. [redacted]

35. [redacted]

36. [redacted]

37. On 6/30/21 at 8:10 pm., Correction Officer (CO) T.S. was performing a supervisory tour and noted that Jackson was sitting in his cell with another incarcerated individual and noted that both were appearing sluggish and incoherent. CO T.S. requested that a medical emergency be called and then returned to the cell. At 8:30 p.m., per the housing logbook, the A officer called another medical emergency, however there was still no medical team on post. Per the housing logbook, it was noted that active supervision of area was maintained and there was nothing unusual to report. Per the quad upper 10/12 A logbook at 9:00 p.m., active supervision of area continued with nothing to report. A medical emergency was called via the control room at this time. At 9:24 p.m., it was documented that medical staff was on post for Jackson. [redacted]

38. A review of the medical clinic logbook revealed:
At 8:06 p.m., a medical emergency was called for Quad 10/12 and that medical staff were notified.
At 8:22 p.m., a Level B was in progress.
At 8:30 p.m., active supervision tour of the area occurred and all appeared to be secure.
At 9:00 p.m., active supervision tour of area all occurred and appears secure. A 3rd medical emergency for Quad 10 was called and medical staff was notified.
At 9:20 p.m., medical staff departed.

39. During an interview with Commission staff, CO C.M., who was assigned to the medical clinic, stated that as the A post officer, he would receive the call for the medical emergency and that he would notify the medical staff to respond. CO C.M. stated that if medical staff did not respond, he had the ability to let the supervisor or captain know and the captain would notify operations. There was no indication in the logbook that this occurred. During an interview with Commission staff, CO S.G. stated that the process for a medical emergency is to call the main clinic and advise the officer. CO S.G. stated that if medical does not respond, they can call the clinic again and can call the control room. CO S.G. stated that the control room was called and that the captain was notified by the control room via the radio as there are no radios on the housing unit post. During an interview with Commission staff, Dr. [redacted] stated that she was not aware of any delay in the response by medical. Dr. [redacted] stated that when medical was notified of the emergency, the medical staff responded. Dr. [redacted] was asked by a captain why there was a delay. Dr. [redacted] contacted the nurse from the day shift to see if she was aware of any emergency occurring before she left medical at the end of her shift. The nurse informed

Dr. [redacted] that there was no medical response called. Dr. [redacted] stated that the officer in the medical clinic allowed the day nurse to leave at approximately 8:30 p.m. and did not tell the nurse that there was an emergency. During an interview with Commission staff, PA [redacted] and PA [redacted] both stated that they were unaware of any delay in the medical response and that the medical department was fully staffed at that time.

40. During an interview with Commission staff, CO T.S. stated that he arrived at the B post which was unmanned. On a supervisory tour, he noted that Jackson was sitting in his cell with another incarcerated individual and noted that both were sluggish and incoherent. CO T.S was familiar with the individuals and this was not their baseline mental status. CO T.S. requested a medical emergency be called and returned to the cell with the individuals. CO T.S. stated that a second medical emergency was called and while one individual improved, Jackson continued to deteriorate and necessitated CPR which CO T.S. performed until medical arrived. CO T.S. stated that there was a significant delay in the medical response, and this was due to staffing shortage. The Medical Review Board finds that the system for the notification and activation of a medical emergency at AMKC is ineffective and subject to failure. The lack of an effective alert and response system lead to an unacceptable delay in obtaining emergent care for Jackson. The Medical Review Board opines that had there been a timely response to Jackson's medical emergency, proper care could have been rendered and his death preventable.

41. A review of the quad upper 10/12 A post log on 6/30/21 revealed:
At 7:30 a.m., CO S.G. noted that there was no B officer on post at that time and that the control room was notified.
At 7:45 a.m., the area supervisor was notified that incarcerated individuals were covering the camera in quad 10.
At 8:00 a.m., CO S. assumed the A post and CO S.G. left the post. CO S. noted the camera was obstructed.
At 8:10 a.m., the officer noted that there was no B officer on post and that the control room was notified.
At 9:30 a.m., the officer noted that there was no B officer on post.
At 1:00 p.m., the officer noted that there was no B officer on post and that the control room was notified.
At 2:00 p.m., the officer noted that the probe team was instructed to proceed with moving bodies on Quad 10 without a floor officer on post.
At 3:00 p.m., the officer noted that there was no B officer on post.
At 6:30 p.m., the officer noted that CO T.S. was assigned to the Quad Upper 10 B post.
At 8:00 p.m., CO S.G. signed into the A post and the standing count was completed.
At 8:10 p.m., CO S.G. noted that medications were announced for Quad U12.
At 8:10 p.m., CO S.G. noted that a medical emergency was called for Quad U10.
At 8:30 p.m., CO S.G. noted that an active supervision tour of the area was completed with nothing to report.
At 9:00 p.m., CO S.G. noted that an active supervision tour of the area was completed with nothing to report. A medical emergency was called via the control room at this time.
At 9:10 p.m., Captain B. was on post for the medical emergency.
At 9:24 p.m., CO S.G. noted that medical staff were on post for Jackson.

The Medical Review Board finds that the Quad Upper 10 post was not properly staffed by NYC DOC between the hours of 7:30 a.m. and 6:30 p.m. on 6/30/21. Without staff manning the B-post position, active supervision was not maintained in 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*.

42. A review of the Quad Upper 10 B post logbook revealed:
On 6/27/21 at 10:40 p.m., the officer noted “this writer is now working third shift.”
On 6/28/21 at 1:34 a.m., the captain noted that no staff was assigned to the post and multiple inmates were seen on the post.
On 6/28/21 at 6:30 a.m., the captain noted a tour of area and no staff assigned to area.
On 6/28/21 at 8:00 a.m., an officer documented that they assumed the post and at 3:30 p.m., noted that they remained on post on a triple until relieved. The logbook noted that the officer was relieved at 4:40 p.m. At 5:00 p.m., another officer was assigned.
On 6/29/21 at 8:00 a.m., the same officer noted that they remained on post on a triple. The officer left the post at 9:16 a.m.
On 6/29/21 at 10:10 a.m., CO S.F. assumed that post and remained until 3:30 a.m. on 6/30/21.
On 6/29/21 at 11:40 p.m., CO S.F. noted that the count was 21. This was the last count completed until 6/30/21 at 8:00 p.m.
From 6/30/21 at 3:30 a.m. until 6/30/21 at 7:00 p.m., the post was not staffed by DOC staff.
On 6/30/21 at 7:00 p.m., CO T.S. assumed B post. There was no count completed at that time.

The Medical Review Board finds that the abandonment of security staffing posts for the housing areas is a violation of 9 NYCRR §7003.3(a) Supervision of prisoners in facility housing areas and had fostered unsafe conditions of confinement in violation Correction Law §500-c(4).

The failure to properly complete population counts is a violation of 9 NYCRR §7003.5 Prisoner Population counts which states:
(a) Prisoner population counts shall:
(1) be conducted at the completion and commencement of each regularly scheduled shift;
(2) be conducted by the facility staff member completing such regularly scheduled shift;
(3) be conducted by the facility staff member beginning the next regularly scheduled shift; and
(4) include an accounting of all prisoners housed in or otherwise assigned to the facility area in which such count is conducted.

This is also a violation of 9 NYCRR §7003.5(b) which states:
The results of each prisoner population count conducted pursuant to paragraphs (a)(2) and (3) of this section shall be recorded in writing. Such written records shall include the:
(1) date and time of the count;
(2) facility area in which the count was conducted;
(3) number of prisoners accounted for; and
(4) name of facility staff member conducting the count.

At 7:30 p.m., CO T.S. documented "active supervision nothing unusual".
At 8:00 p.m., CO T.S. documented "institutional standing count, medical emergency called for Jackson" and an illegible name. Active supervision tour and nothing unusual to report were also documented.
At 8:30 p.m., CO T.S. noted that "the A officer called another medical emergency for said inmates and still no medical team on post. Active supervision of area and nothing unusual to report. This writer administered CPR multiple times inside cell."
At 9:00 p.m., CO T.S. documented "medical emergency called for inmates mentioned and still no medical has arrived. This writer administered CPR while waiting for medical to arrive".
There were no further entries written in the logbook.

43. A review of recorded video review of Quad 10 revealed:
At 7:57 p.m., CO T.S. went to a cell where numerous incarcerated individuals had convened. CO T.S. looked into the cell and then walked to the end of tier and back without looking in cells. This is a failure to perform an adequate supervisory tour due to failing to look into the cells and assure the presence of the incarcerated individuals.
At 8:00 p.m., CO T.S. walked to end of the tier and gave something to the incarcerated individuals in the cell near the end of tier. CO T.S. then went to cell 9.
At 8:01 p.m., CO T.S. utilized a phone on the wall for approximately three minutes.
At 8:04 p.m., CO T.S. went into cell 9 and exited the cell.
At 8:06 p.m., CO T.S. exited the housing area and went to the control room to retrieve the logbook and chair which he placed at the desk.
At 8:08 p.m., CO T.S. walked back to cell 9.
At 8:15 p.m., CO T.S. walked to front of tier and spoke to another incarcerated individual and walked back to cell 9.
At 8:21 p.m., CO T.S. returned to the desk and then went to front of tier to talk with the A post control officer until approximately 8:32 p.m.
At 8:34 p.m., CO T.S. walked down the tier and returned to the desk to talk to another incarcerated individual.
At 8:43 p.m., CO T.S. walked down tier and to the end of tier where he conversed with another incarcerated individual until returning to the front of tier.
At 8:51 p.m., CO T.S. was noted to be making logbook entries and went to the front of tier talking to the A post control officer then returned to cell 9 and remained there from 8:56 p.m. until 8:58 p.m.
At 9:02 p.m., CO T.S. was seen on the phone until 9:06 p.m. and again at 9:09 p.m.
At 9:10 p.m., CO T.S. was seen making logbook entries.
At 9:11 p.m., CO T.S. went to the gate near the A post control room and then went back to cell 9.
At 9:12 p.m., CO T.S. returned to the gate to get gloves from the control room
At 9:16 p.m., the captain was on the unit.
At 9:21 p.m., Jackson was dragged out of the cell and CO T.S. was doing compressions.
At 9:22 p.m. medical arrived.

44. During an interview with Commission staff, CO S.F. stated that on 6/30/21 at 3:30 a.m., when he called the control room to advise that he was on his 24th hour, he was told that he could leave and that someone would be sent to the post.

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 the housing unit and who failed to follow the requirements of 9 NYCRR §7003.5(a)(c) and (d) Prisoner Population Counts. Administrative action should be taken if the officers are found to be in violation of department directives.

2. The Commissioner shall conduct an investigation into the reported delay of the medical staff to respond to a medical emergency .

A report of the findings and 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 investigation was completed and the officer in question was found to be in violation of department directives. A Memorandum of Complaint was filed for the officer by NYC DOC administration. The cited violation of minimum standard will be forwarded to the Commission for further follow up.

TO THE COMMISSIONER OF THE NEW YORK CITY DEPARTMENT OF CORRECTIONS AND VICE PRESIDENT FOR CORRECTIONAL HEALTH SERVICES:

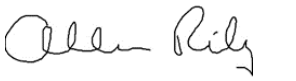
The Commissioner of DOC and Vice President of CHS shall commence a comprehensive review and revision to the medical emergency response procedures in order to establish a dedicated emergency notification line and notification system to assure that calls are properly triaged and resources are properly deployed.

In a response to the Commission's report dated 6/28/23 NYC DOC reported that their review revealed that there was a delay of approximately 83 minutes of medical staff responding to the medical emergency. In a response dated 8/14/23 Correctional Health Services (CHS) reported that there is a clear emergency notification and response system established. CHS also reported that the first call for the emergency was received at 9:08 p.m. and not 8:00 p.m. as stated in the NYC DOC records. The Commission notes that there is a of conflict of findings between DOC and CHS's responses and will require further follow up to assure the issue of emergency response has been adequately addressed.

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
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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
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Jasmine Georges-Yilla, Executive Director
NYC Board of Correction