NEW YORK STATE | Commission of Correction

Final Report of the New York State Commission of Correction:

In the Matter of the Death of

DeShaun Carter, an incarcerated individual of the Anna M. Kross Center

December 20, 2023

To: Commissioner Lynelle Maginley-Liddie
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 DeShaun Carter who died on May 7, 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. Dashawn Carter was a 25-year-old male who died on 5/7/22 from a suicidal hanging while in the custody of the New York City Department of Correction (NYC DOC) at the Anna M. Kross Center (AMKC). The Medical Review Board has found that failure to provide facility supervision in accordance with NYS Minimum Standards has jeopardized the safety of 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.

2. [redacted] In February 2021, Carter was arrested for Assault in the 2nd Degree and Criminal Possession of a Weapon in the 4th Degree which were abated by his death.

3. Carter denied having any chronic medical conditions and stated that he was not prescribed any medications. Carter denied having any mental health history and stated that he was not prescribed any medication.

4. On 4/12/21, the judge at the Supreme Court in Richmond County ordered Carter to undergo an examination per Criminal Procedure Law (CPL) Article 730 due to, “disruptive, confused, or bizarre behavior, threatening or violent behavior, suicidal behavior, appeared to not understand his charges or the court process, history of past psychiatric problems, history of drug or alcohol abuse, history of suicidal behavior, extreme or bizarre type or offense”. At the Richmond County Court, a suicide prevention screen was completed, and Carter responded no to all questions. The officer noted that Carter appeared, “ok”.

5. On 4/12/21, Carter was received at the Eric M. Taylor Center. [redacted]

6. [redacted]. If there is a request for a 730 evaluation, a mental health referral is submitted at the time of the medical examination. PA [redacted] stated that CPL 730 evaluation requests are kept in

the intake paperwork. [redacted].

7. [redacted]

8. [redacted]

9. [redacted]

10. [redacted]

11. [redacted]

12. [redacted]

13. [redacted]

14. [redacted]

15. [redacted] It was unclear from a review of the documentation as to the specific location of the inoperable cells or how they were affecting facility operation.

16. [redacted]

17. [redacted]

18. [redacted]

19. [redacted] The documentation noted that per DOC, there were security reasons as Carter was splashing liquids out of his cell.

20. [redacted]

21. [redacted]

22. [redacted]

23. On 7/15/21, a medical response was called by DOC staff for Carter. [redacted] During an interview with Commission Staff, Dr. [redacted] stated that mental health would normally see the individual within 24 to 72 hours unless it is a stat mental health referral.

24. [redacted]

25. [redacted]

26. [redacted]

27. [redacted]

28. [redacted]

29. [redacted]

30. [redacted]

31. [redacted] The Medical Review Board has found that there were significant failures by Correctional Health Services to provide adequate mental health care to Carter. [redacted] However, a review of Carter's clinical care by the Medical Review Board reveals that there was no clear procedural notification system as Carter would not be assessed by mental health until approximately four months after his admission into NYC DOC. The Medical Review Board has also found that LCSW [redacted] failed to perform an adequate assessment of Carter and failed to review his records and PSYCKES which would have shown past treatment in NYC DOC.

32. [redacted]

33. [redacted]

34. [redacted]

35. [redacted]

36. [redacted]

[redacted]

37. [redacted]

38. [redacted]

39. [redacted]

40. [redacted]

41. [redacted]

42. [redacted]

43. [redacted]

44. [redacted]

45. [redacted]

46. A review of Carter's medical records revealed that Carter had not been produced for medical or mental health appointments or had those appointments cancelled a total of 54 times between 5/17/21 and 12/31/21. [redacted] The Medical Review Board finds that the repeated failures to produce Carter for medical appointments is unacceptable and constitutes a failure to provide adequate medical care.

47. [redacted]

48. [redacted]

49. On 5/5/22, Carter returned to the custody of NYC DOC. [redacted]

50. [redacted]

51. On 5/7/22 at 5:05 p.m., a medical emergency response was called for Carter in Quad 12 cell 14. Per DOC staff, Carter was unresponsive. [redacted] DOC staff reported that Carter was found in a standing position at the window with his feet flat on the floor and a ligature around his neck. The ligature was removed, and Carter was placed on the bed. Urgicare Dr. [redacted] responded [redacted] The Medical Review Board opines that the documented extent of rigor mortis found on Carter by the medical staff indicate that he had been deceased in excess of four hours before being discovered.

52. A review of the housing logbook revealed that Correction Officer (CO) E.G. noted that at: At 12:00 p.m., an institutional standing count was completed. At 12:30 p.m., 1:00 p.m., 1:30 p.m., 2:00 p.m., 2:30 p.m., 3:00 p.m., 3:30 p.m. 4:00 p.m., 4:30 p.m., CO E.G. documented that he completed supervisory tours and there was nothing to report.

53. A review of the Gentech video by Commission staff revealed that: At 12:37 p.m., CO E.G. made a supervisory tour and did not look in all the cells. At 1:06 p.m., CO E.G. made a supervisory tour and did not look in all the cells. At 2:01 p.m., CO E.G. made a supervisory tour and did not look in all the cells. At 4:47 p.m., CO E.G. made a supervisory tour and did not look in all the cells. At 4:57. p.m., CO E.G. was notified by other incarcerated individuals that he was needed in Carter's cell. CO E.G. responded and stood outside the cell with the other incarcerated individuals. CO E.G. then walked to the front of the housing area and then returned to the cell and entered as CO G. responded and entered the cell before running to the front of the block to call the medical emergency.

54. CO E.G.'s failure to complete proper supervisory tours was 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*.

ACTIONS REQUIRED:

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

The Commissioner shall conduct an investigation into the security staff's failure to complete adequate supervisory tours in comportment with 9 NYCRR §7003.3(a) and failed to identify that Carter had hung himself inside his cell and was deceased in excess of four hours before being discovered. Staff should be subject to administrative action if found to be in violation of department directives.

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

In a response dated 11/21/23 to the Commission's preliminary report, NYC DOC indicated that an investigation was completed and that cited a staff were found to have violated department rules and regulations. They were referred for administrative action to be taken.

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

1. Correctional Health Services shall conduct a quality assurance review of the mental health assessment completed on Carter on 8/10/21 and the failure of the staff to review his prior records and appropriately address Carter's mental health needs.

2. Correctional Health Services shall conduct a quality assurance review of the 54 missed appointments for Carter and determine a plan of action when individuals are not

produced.

3. Correctional Health Services shall conduct a procedural review with DOC regarding incarcerated individuals who have been court ordered for psychiatric competency evaluations to assure that mental health clinical staff are notified at the time of admission and that proper screening and follow-up of the incarcerated individuals can be scheduled.

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

In a response dated 11/14/23 to the Commission's preliminary report, CHS indicated that the requested quality assurance reviews were completed.

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 20h day of December, 2023.

Allen Riley
Chairman
Commission of Correction

AR:DC:vc
2022-M-0053
December 20, 2023

cc: Deputy Commissioner of Legal Matters/General Counsel
Deputy Commissioner of Security Operations
Deputy Commissioner of Health Affairs
Director of Compliance
Patricia Yang, DrPH, Senior Vice President
Correctional Health Services
Bipin Subedi, MD, Chief Medical Officer
Correctional Health Services
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NYC Board of Correction