NEW YORK STATE | Commission of Correction

Final Report of the New York State Commission of Correction:

In the Matter of the Death of

Segundo Guallpa, an incarcerated individual of the West Facility

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 Segundo Gaullpa who died on August 30, 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. Segundo Guallpa was a 58-year-old male who died on 8/30/21 from a suicide hanging while in the custody of the New York City Department of Correction (NYC DOC) at the West Facility (WF). The Medical Review Board has found that there was substantial non-compliance to minimum standards pertaining to security and supervision that led to Guallpa not being discovered until hours after his death.

2. Guallpa was born in Ecuador. Guallpa was survived by his wife and four children. Guallpa reported having a 6th grade education and was unemployed. There was no further demographic or social history pertaining to Guallpa available to the Commission.

3. [redacted]

4. [redacted]

5. Guallpa's first contact with the criminal justice system was the instant offence in August 2021 after being charged with Strangulation 1st Degree and Assault 3rd Degree. In the instant offense on 8/18/21 in Queens, NY, Guallpa was arrested by the New York City Police Department after he attempted to strangle his wife. Guallpa was arraigned on 8/19/21 and charged with Strangulation 2nd Degree, Assault 3rd Degree, Criminal Obstruction Of Breathing or Blood Circulation, Criminal Mischief, and Harassment 2nd Degree. Guallpa was remanded to the NYC DOC and was being held on a $7,500 bond. Guallpa's next court date was scheduled for 8/23/21.

6. On 8/19/21 at 11:11 a.m., Guallpa was admitted into NYC DOC WF Sprung 7 cell # 710 from Queens Criminal Court after being charged with Strangulation 2nd Degree, Assault 3rd Degree, Criminal Obstruction Of Breathing Or Blood Circulation, Criminal Mischief, and Harassment 2nd Degree. Guallpa scored a zero on the Suicide Prevention Screening.

7. [redacted]

8. [redacted]

[redacted]

9. [redacted]

10. [redacted]

11. [redacted]

12. [redacted]

13. [redacted]

14. On 8/23/21 at 10:00 a.m., Captain J. documented in the Sprung 7B logbook that Guallpa was going off the unit to court. Guallpa was taken off of the unit count.

15. [redacted]

16. On 8/23/21 at 6:10 p.m., documentation in the Sprung 7B logbook indicated that Guallpa returned from court. Guallpa was added back on the unit count.

17. On 8/23/21, Criminal Court documentation indicated that Guallpa was seen by Judge N. and his case was adjourned until 9/1/21.

18. [redacted]

19. [redacted]

20. [redacted]

[redacted]

21. [redacted]

22. [redacted]

23. [redacted]

24. [redacted]

25. [redacted]

26. [redacted]

27. [redacted]

28. [redacted]

29. [redacted]

30. On 8/29/21 at 3:15 p.m., documentation in the Sprung 7B logbook indicated that Correction Officer (CO) T.H. relieved CO B.N. and assumed Sprung 7 with a total count of 12 alive and breathing incarcerated individuals.

31. On 8/29/21 at 3:30 p.m., CO T.H. documented in the Sprung 7B logbook, "General supervision tour. Nothing to report".

32. On 8/29/21 at 4:00 p.m., CO T.H. documented in the Sprung 7B logbook, "General supervision tour. Nothing to report".

33. On 8/29/21 at 4:30 p.m., CO T.H. documented in the Sprung 7B logbook, "General supervision tour. Nothing to report".

34. On 8/29/21 at 5:00 p.m., CO T.H. documented in the Sprung 7B logbook, "General supervision tour. Nothing to report".

35. On 8/29/21 at 5:00 p.m., Captain (Cpt.) H.J. documented in the Sprung 7B logbook that a routine tour was conducted. Documentation from the NYC DOC Investigation Division indicated that per the video recording of 7B, Cpt. H.J. arrived on Sprung 7B, signed the logbook, and walked out of the area without touring the tier.

36. Documentation in the Sprung 7B logbook indicated that there was no general supervision tour completed on the unit between 5:00 p.m. and 6:00 p.m. This is a violation of 9 NYCRR §7003.3(c) 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* .

37. On 8/29/21 at 6:00 p.m., CO T.H. documented in the Sprung 7B logbook, "General supervision tour. Nothing to report".

38. On 8/29/21 at 6:05 p.m., CO T.H. documented in the Sprung 7B logbook, "Off post to meal".

39. On 8/29/21 at 6:05 p.m., CO R.B. documented in the Sprung 7B logbook, "On post for (M/R) meal relief."

40. On 8/29/21 at 6:30 p.m., CO R.B. documented in the Sprung 7B logbook, "General supervision tour of area. Nothing to report".

41. On 8/29/21 at 6:55 p.m., CO R.B. documented in the Sprung 7B logbook, "Off post".

42. On 8/29/21 at 6:55 p.m., CO T.H. documented in the Sprung 7B logbook, "Back on post from meal".

43. On 8/29/21 at 7:00 p.m., CO T.H. documented in the Sprung 7B logbook, "General supervision tour. Nothing to report".

44. On 8/29/21 at 7:30 p.m., CO T.H. documented in the Sprung 7B logbook, "General supervision tour. Nothing to report".

45. On 8/29/21 at 7:45 p.m., Capt. M.T. documented in the Sprung 7B logbook. "Tour of area all appears secure". Documentation from the NYC DOC Investigation Division indicated that per the video recording of 7B, Capt. M.T. arrived on Sprung 7B, signed the logbook, and walked out of the area without touring the tier. The Medical Review Board finds that Capt. M.T. made a false entry into the housing area logbook indicating that a

tour of the area was completed whereby the video recording showed that a tour was not completed.

46. On 8/29/21 at 8:00 p.m., CO T.H. documented in the Sprung 7B logbook, "General supervision tour. Nothing to report".

47. On 8/29/21 at 8:30 p.m., CO T.H. documented in the Sprung 7B logbook, "General supervision tour. Nothing to report".

48. On 8/29/21 at 9:00 p.m., CO T.H. documented in the Sprung 7B logbook, "General supervision tour. Nothing to report".

49. On 8/29/21 at 9:30 p.m., CO T.H. documented in the Sprung 7B logbook, "General supervision tour. Nothing to report".

50. On 8/29/21 at 10:00 p.m., CO T.H. documented in the Sprung 7B logbook, "General supervision tour. Nothing to report".

51. On 8/29/21 at 10:30 p.m., CO T.H. documented in the Sprung 7B logbook, "General supervision tour. Nothing to report".

52. On 8/29/21 at 11:00 p.m., CO T.H. documented in the Sprung 7B logbook, "General supervision tour. Nothing to report".

53. Per the Closing Report from the NYC DOC Investigation Division, the video recording of Guallpa's cell on 8/29/21 showed the following:

    At 9:22 p.m., "Guallpa was drinking out of a green cup".

    At 9:23 p.m., "Guallpa turned off the lights in his cell".

    At 9:30 p.m., "Guallpa turned the lights back on inside of his cell. Guallpa was walking around in his cell".

    At 9:34 p.m., "Guallpa turned his lights off again".

    At 10:04 p.m. "Guallpa's lights were still off, but the TV appeared to be on.

    At 11:07 p.m., “Guallpa's lights remained off, but TV still appeared to be on.” This was the last documented entry of any occurrence in Guallpa's cell in the Closing Report by the NYC DOC.

54. On 8/29/21 at 11:00 p.m., CO T.H. documented in the Sprung 7B logbook, "Off post". CO A.T. documented in the Sprung 7B logbook, "On post Sprung 7B. Count taken and total count (TC) 13, all in". Per the Closing Report from the NYC DOC Investigation Division, CO T.H. did not conduct a prisoner population count at the completion of the shift, and CO A.T. did not conduct a prisoner population count at the commencement of the shift. This is a violation of 9 NYCRR §7003.5(a)(1) Prisoner population counts which states: *Prisoner population counts shall: be conducted at the completion and commencement of each regularly scheduled shift; be conducted by the facility staff member completed such regularly scheduled shift.*

55. On 8/29/21 at 11:30 p.m., CO A.T. documented in the Sprung 7B logbook, "General supervision tour of area. Nothing to report".

56. On 8/30/21 at 12:00 a.m., CO A.T. documented in the Sprung 7B logbook, "General supervision tour of area. Nothing to report".

57. On 8/30/21 at 12:00 a.m., CO D.H. documented in the Sprung 7B logbook, "On post for Enhanced Supervision Officer (ESO) suicide watch".

58. On 8/30/21 at 12:30 a.m., CO A.T. documented in the Sprung 7B logbook, "General supervision tour of area. Nothing to report".

59. On 8/30/21 at 1:00 a.m., CO A.T. documented in the Sprung 7B logbook, "General supervision tour of area. Nothing to report".

60. Per the Closing Report from the NYC DOC Investigation Division, documentation indicated, ”It should be noted that no direct observation of Person in Custody (PIC) Guallpa's cell was made by any of the staff on post".

61. On 8/30/21, per the Closing Report from the NYC DOC Investigation Division and from a review of the video recording of Sprung 7 by Commission staff, the following was observed:

    At 1:10 a.m., Cpt. M.T. and CO A.T. were performing rounds on Sprung 7. As they approached cell # 710 that housed Guallpa, CO A.T. turned the light on in Guallpa's cell. Cpt. M.T. and CO A. T. both looked into Guallpa's cell and were about to walk away, when Cpt. M.T. bent down and looked through the cell window and observed Guallpa sitting on the floor between his bed frame and the shower area. CO A.T. returned to his desk to retrieve the key to open Guallpa's cell door. CO A.T. returned to Guallpa's cell accompanied by CO D.H.

    At 1:11 a.m., Cpt. M.T. and COs A.T. and D.H. enter Guallpa's cell. Cpt. M.T. pointed down to the floor on the side of Guallpa's bed. CO A.T. left the cell and CO D.H. retrieved an unidentified object from his belt and handed it to Cpt. M.T. Guallpa was not visible on the video recording. Per the NYC DOC Incident Report Form, Cpt. M.T. documented that he instructed CO A.T. to open the cell door at which time he observed that "Guallpa had a ligature made of socks that was affixed to the bed frame and placed around his neck area". Cpt. M.T. instructed CO D.H. to pass him the 911 (cutdown) device and Cpt. M.T. cut the socks from the gap between Guallpa's bedframe and Guallpa's neck area freeing Guallpa from the ligature. Cpt. M.T. placed his hand on Guallpa's chest area in efforts to detect any signs of life to which no signs of life were detected. Cpt. M.T. then utilized his portable radio to request medical assistance.

    At 1:12 a.m., Cpt. M.T. was observed talking on the radio. Cpt. M.T., CO A.T., and CO D.H. did not initiate Cardiopulmonary Resuscitation (CPR) on Guallpa. During an interview with Commission staff on 7/10/23, Cpt. M.T. reported that at the time of Guallpa's death he could not recall the last time that he had received CPR training, and that since Guallpa's death, he has not received CPR training. This is a violation of 9 NYCRR §7010.2(f) which states: *Facility personnel shall receive training and maintain certification in approved first aid and emergency life saving techniques including the use*

of emergency equipment.

At 1:13 a.m., Cpt. M.T. was observed leaving the cell and COs A.T. and D.H. were observed standing in the cell.

At 1:14 a.m., Cpt. M.T. returned to the cell and Cpt. M.T. and COs A.T. and D.H. were observed standing in the cell.

At 1:15 a.m., CO A.T. left the cell and Cpt. M.T. and CO D.H. continued to stand in the cell.

At 1:16 a.m., Cpt. M.T. was observed on the radio and CO A.T. returned to the cell with medical personnel.

At 1:18 a.m., Guallpa was repositioned by medical staff and his feet were observed at the end of his bed.

62. On 8/30/21, RN [redacted] documented receiving an emergency call to WF CDU 7 at 1:20 a.m. RN [redacted] documented arriving on the WF CDU 7 cell # 710 at 1:22 a.m. [redacted]

63. On 8/30/21, Dr. [redacted] documented arriving at Guallpa's bedside at 1:23 a.m. [redacted]

64. Per the Closing Report from the NYC DOC Investigation Division and from a review of photographs of Sprung 7 cell # 710 by Commission staff, Guallpa wrote a suicide note to his wife in Spanish on the wall of his cell. In summary, the note indicated that Guallpa loved his wife, he had lost his memory completely, and he was accused by his wife without knowing what happened.

65. After a review of video recording of Sprung 7B by Commission staff, it was observed that CO D.H. left his assigned post of ESO suicide watch to respond to cell # 710. The Medical Review Board finds that CO D.H. failed to provide constant supervision as defined by 9 NYCRR §7003.2(d)(1)(2) as: *Constant supervision shall mean the uninterrupted personal visual observation of prisoners by facility staff responsible for the care and custody of such prisoners without the aid of any electrical or mechanical surveillance devices. Facility staff shall provide continuous and direct supervision by permanently occupying an established post in close proximity to the prisoners under supervision which shall provide staff with: a continuous clear view of all prisoners under*

supervision; and the ability to immediately and directly intervene in response to situations or behavior observed which threaten the health or safety of prisoners or the good order of the facility.

66. After a review of the Sprung 7 B post logbook by Commission staff, there was no documentation on 8/30/21 that a medical emergency had taken place for Guallpa. This is a violation of 9 NYCRR §7003.3(j)(6)(i) to (iv) which states: *All written records pertaining to facility housing supervision required pursuant to this section shall be recorded in ink in a bound ledger of consecutively numbered pages which shall be maintained in each housing area. Such records shall include, but not be limited to, the following information: any significant events and activities occurring during supervision including: the date and time of such event or problem; the names of all incarcerated individuals and/or staff involved; facility staff response to such events or problem, including a summary of what occurred; a description of the condition of any incarcerated individuals involved.*

ACTIONS REQUIRED:

TO THE COMMISSIONER OF THE NEW YORK CITY DEPARTMENT OF CORRECTIONS

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(c) Supervision of prisoners in facility housing areas;
   9 NYCRR §7003.2(d)(1)(2) Constant Supervision;
   9 NYCRR §7003.3(j)(6)(i) to (iv) Supervision of prisoners in facility housing areas;
   9 NYCRR §7003.5(a)(1) Prisoners population counts;
   9 NYCRR §7010.2(f) Health Services

2. The Commissioner shall conduct a thorough review and investigation into the staff assigned to Guallpa's housing area and their failure to properly maintain supervision. If staff are found to be in violation of Department directives, staff should be subject of administrative action.

3. The Commissioner shall conduct an investigation into the actions of the DOC Captain and officer assigned to supervise Guallpa to determine why CPR was not initiated on Guallpa.

4. The Commissioner shall conduct an investigation into why CO D.H. left his assigned constant supervision post and failed to continuously provide constant supervision as ordered for an incarcerated individual.

5. The Commissioner shall conduct an investigation into the actions of Capt. M.T. who falsified a logbook entry on 8/29/21 indicating a housing are tour was completed. If staff are found to be in violation of Department directives, staff should be subject of administrative action.

6. The Commissioner shall prepare and provide a comprehensive corrective action plan to assure compliance with cited minimum standards.

A report of the findings and any corrective actions taken shall be provided to the Medical

Review Board upon completion.

In a response dated 11/21/23 to the Commission's preliminary report, NYC DOC indicated that the requested reviews and investigations were completed. Four members of services were found to have violated department rules and regulations. Two members retired from service and two members were served formal disciplinary charges.

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:BB:vc
2021-M-0113
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
Executive Director
NYC Board of Correction