NEW YORK STATE | Commission of Correction

Final Report of the New York State Commission of Correction:

In the Matter of the Death of

Esias Johnson, 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 Esias Johnson who died on September 7, 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. Esias Johnson was a 24-year-old male who died on 9/7/21 due to Acute Methadone Intoxication 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 opines that despite the postmortem changes noted by medical and EMS staff, the NYS DOC security staff failed to perform any life saving measures prior to medical staff arrival. The Medical Review Board has also found that there was a failure by Correctional Health Services (CHS) to properly notify NYC DOC administration of Johnson admitting to using illicitly obtained Methadone and then prescribing methadone to Johnson without initiating any investigation into the reports. The failure to properly notify NYC DOC of the potentially harmful illicit medication that Johnson reported obtaining was in violation minimum standards that requires such notification be made. The Medical Review Board opines that had CHS staff properly notified NYC DOC of Johnson's reported illicit medication use and deferred prescribing methadone to Johnson until an investigation and intervention could have been completed, Johnson's death may have been prevented.

2. [redacted] In August 2021, Johnson was arrested for Menacing in the 2nd Degree and Criminal Possession of a Weapon 4th in the Degree. Johnson was committed to NYC DOC. [redacted]

3. [redacted]

4. [redacted]

[redacted]

5. [redacted]

6. [redacted]

7. On 8/9/21 at 3:40 a.m., per the inmate movement report, Johnson was transferred to Mod 9B.

8. [redacted]

9. [redacted]

10. [redacted]

11. [redacted]

12. [redacted]

13. [redacted]

[redacted]

14. [redacted]

15. [redacted]

16. [redacted]

17. [redacted]

18. [redacted]

19. [redacted]

20. [redacted]

21. [redacted]

[redacted] During an interview with Commission staff, Dr. [redacted] stated that the KEEP staff would do the consent for treatment and all follow-up related to the Methadone. [redacted] The Medical Review Board finds that there was a failure by CHS providers to assure Johnson's safety by failing to notify NYC DOC administration of the illicit medication use and by prescribing Methadone to Johnson when he was admittedly obtaining it illegally. The failure to properly notify NYC DOC of the situation was a violation of 9 NYCRR §7013.10(c) Confidentiality and disclosure of inmate medical and psychiatric records information which states:

(*c) Except as otherwise prohibited or restricted by law, the facility medical director of each facility shall promptly disclose to the chief administrative officer information which he/she receives concerning an inmate which is or may be relevant in determining the inmate's classification status or may affect the life, safety or welfare of the inmate or any other person. The chief administrative officer shall then promptly disclose information as appropriate to facility staff responsible for making classification decisions*.

The Medical Review Board opines that had CHS providers properly notified NYC DOC of the illicit methadone issue and deferred prescribing it to Johnson until the investigation and interventions could have been initiated, Johnson death may have been prevented.

22. [redacted]

23. [redacted]

24. [redacted]

25. [redacted]

26. [redacted]

27. [redacted]

28. On 9/7/21 at 9:17 a.m., Correction Officer (CO) K.L. was making a supervisory tour and noted that Johnson was unresponsive. A medical response was activated and at 9:20 a.m., medical staff arrived. Upon medical staff arrival, there was no cardiopulmonary resuscitation (CPR) being performed. Johnson was found on his bunk lying on his stomach and was covered by a blanket. Johnson was noted to be unresponsive and cold. His lips were pale, and his pupils were fixed and dilated. [redacted] During an interview with Commission staff, CO K.L. stated that she had not started CPR as she was in a panic attack after finding Johnson.

29. A review of the 9B log for 9/7/21 by Commission staff revealed:

At 3:15 a.m., CO K.L. assumed the post. Total count was recorded as 38.
At 3:30 a.m., 4:00 a.m., 4:30 a.m., and 5:00 a.m., CO K.L. documented active supervision with nothing to report.
At 5:00 a.m., “feeding in progress institutional lock out dayroom open”.
At 5:30 a.m., “active supervision and feeding completed courts awakened and sanitation in progress”.
At 6:00 a.m., “active supervision one out to court and new count 37”.
At 6:30 a.m., “active supervision”.
At 7:00 a.m., “institutional lock in at this time”.
At 7:30 a.m., “active supervision”.
At 7:30 a.m., CO K.L. remained on post.
At 7:45 a.m., Captain was on rounds.

At 8:00 a.m. and 8:30 a.m., CO K.L. documented active supervision with nothing to report.
At 9:00 a.m., a medical emergency was called for Johnson.
At 9:15 a.m., medical staff on were post.
At 10:00 a.m., CO K.L. was off post at that time.

30. A review of the 9/7/21 Gentech video by Commission staff revealed:

At 9:11 a.m., an officer was standing at the foot of Johnson's bed looking at Johnson.
At 9:12 a.m., a second officer comes over to check on Johnson and walks toward the control room.
At 9:13 a.m., another II tried to wake Johnson.
At 9:15 a.m., other II's on the unit started waking up and tried to wake Johnson up.
At 9:17 a.m., another II covered Johnson with a blanket.
At 9: 20 a.m., two captains arrived.
At 9:22 a.m., medical staff arrived.
At 9:25 a.m., Johnson was moved onto a board and CPR was initiated.
At 9:34 a.m., additional security staff arrived and began moving IIs off the unit.
At 9:43 a.m., Johnson was pronounced dead.

31. A review of the Pod 9 a logbook noted that on 9/5/21:

CO C. was on post at 12 p.m.
At 3:31 p.m., CO C. noted they were conducting their third tour of duty.
At 8:15 p.m., CO A. was on post to relieve CO C.

ACTIONS REQUIRED:

TO THE COMMISSIONER OF THE NEW YORK CITY DEPARTMENT OF CORRECTIONS AND TO THE SENIOR VICE PRESIDENT OF CORRECTIONAL HEALTH SERVICES, NYC HEALTH AND HOSPITALS:

A joint review by CHS and NYC DOC shall be conducted into the failure to comply with 9 NYCRR §7013.10(c) whereby notification was not made regarding Johnson's reported illicit methadone use. A procedure shall be developed and implemented to address the issue of reported illicit and contraband medications that pose a safety risk to any of the incarcerated population and to assure that proper notifications have been made in comportment with minimum standard requirements.

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

CHS and NYC DOC provided separate dated responses to the Commission's preliminary report. CHS indicated that providers are required to escalate any firsthand observation of illicit substance use in the housing areas and report them to DOC but federal regulations do not allow for the disclosure of substance abuse treatment to DOC without patient consent. NYC DOC indicated that they will meet with CHS however specific corrective actions or plans were provided. The Commission finds the responses to be unacceptable as Johnson's illicit

methadone use constituted a threat to the safety and security of others and possible criminal activity that is permissible to notify NYC DOC of and should have occurred in this instance.

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

1. The Commissioner shall conduct an investigation into the actions of all responding security staff to determine why CPR was not initiated prior to medical staff arrival.
2. The Commissioner will take note of the postmortem changes noted and take appropriate action.
3. The Commissioner shall note the officer assigned to Pod 9 on 9/5/21 was on post for over 24 hours.

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 cited officers were found to have violated department rules and regulations and were referred for administrative action.

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

1. Correctional Health Services shall conduct a quality assurance review to determine why Johnson was not seen for his KEEP initial evaluation.
2. Correctional Health Services shall conduct a quality assurance review to determine why the urine toxicology test ordered on 9/1/21 was not completed.

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

In a response dated 11/14/23 to the Commission's preliminary report CHS indicated that Johnson was not produced by DOC for his KEEP appointment and the [redacted]

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
2021-M-0117
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