Commission of
Correction

Final Report of the
New York State Commission of Correction:

In the Matter of the Death of

Abel Rosas (DIN 99A4567), an incarcerated individual of the Green Haven Correctional Facility

December 20, 2023

**To: Honorable Daniel F. Martuscello, III,
Commissioner
NYS Department of Corrections
And Community Supervision
The Harriman State Campus
1220 Washington Avenue
Albany, New York 12226**

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 Abel Rosas who died on August 28, 2021, while an incarcerated individual in the custody of the NYS Department of Corrections and Community Supervision at the Green Haven Correctional Facility, the Commission has determined that the following final report be issued.

FINDINGS:

1. Abel Rosas was a 55-year-old male who died on 8/28/21 due to Acute Fentanyl Intoxication while in the custody of the New York State Department of Corrections and Community Supervision (NYS DOCCS) at the Green Haven Correctional Facility (CF). There were issues with the terminal event identified by the NYS DOCCS Office of Special Investigations (OSI) that were administratively addressed by NYS DOCCS.

2. The instant offense was Rosas' first contact with the criminal justice system. On 3/30/97, Rosas shot and killed his ex-girlfriend and her husband as they lay sleeping in their bed. On 3/31/97, Rosas voluntarily went to the police to discuss his past relationship with the female victim. Rosas made a full written confession, in which he confessed that he had gone to the couple's apartment after a night out drinking. Rosas was convicted of the Murder 1st Degree and Criminal Possession of a Weapon 2nd Degree and sentenced to Life in prison after a second trial.

3.

4. On 8/18/99, Rosas was received at Downstate CF. In May 2000, Rosas was transferred to Green Haven CF. Rosas remained at Green Haven CF for the remainder of his incarceration.

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9. On 8/28/21, CO J.B. assumed the F block housing unit and noted that he was the only officer for the block. CO J.B. noted in the F block housing unit log that supervisory tours were completed at 11:05 p.m., 12:05 a.m., 1:05 a.m. 2:05 a.m., 3:05 a.m., 4:05 a.m.,

and 5:05 a.m. CO J.B. noted that the count was called in at 4:15 a.m.

10. On 8/28/21 at 6:10 a.m., CO J.B. was making a supervisory tour and noted that Rosas was on his bunk with his tablet on his chest. CO J.B. attempted to get a response from Rosas but received no response. A medical response was called. At approximately 6:13 a.m., CO N.D. and Sgt. T.J. arrived. CO N.D. applied the AED without a shock advised. CPR was initiated. Sgt. R.C arrived, and Sgt. T.J. left to contact Lt. N.V. Sgt. T.J. reported in his statement that he advised Lt. N.V. that an ambulance was needed for an unresponsive individual and provided LT. N.V. with the individuals information. EMS however was not activated. At 6:25 a.m., RN ███ responded. ████████████████████

11. DOCCS Office of Special Investigations did locate a piece of paper with a white powdery substance in Rosas's cell during a search.

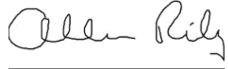
12. The Office of Special Investigations interviewed all medical and security staff that were involved in the medical response. Lt. N.V. submitted a memo indicating that she was unaware of any protocols to call EMS as the watch commander and that she thought that medical was the one who requested EMS. OSI found that Lt N.V. did not activate EMS which was a violation of Directive 2124. A memo written by Sgt. T.J. indicated that the Sgt. T.J. called Lt N.V. and relayed that an ambulance was needed to be called and that Lt. N.V. was given all the information. OSI found that Sgt. T.J. failed to administer or direct staff to administer Narcan. This was a violation of NYS DOCCS Directive 2124 and 4059. OSI also found that Sgt. R.C. did not administer or direct staff to administer Narcan. This was a violation of NYS DOCCS per Directive 2124 and 4059. Sgt. R.C. noted that it took 10 minutes for medical to respond and that Rosas had rigor. Rosas had to be turned on his side in order to be removed from the cell due to the level of rigor mortis that had set in. OSI found that CO J.B. failed to conduct proper rounds and failed to administer Narcan. OSI also found that CO J.B. did not conduct any life saving measures. CO M.V. and CO A.B. assisted with rounds and reported that they did not know pipe rounds were to be completed. OSI found that CO J.B., CO M.V. and CO A.B. all failed to complete adequate rounds as they did not ensure that Rosas was alive and breathing. This was a violation of NYS DOCCS Directive 4945 and 4941. OSI also found that CO S.C. did not possess a radio which delayed the medical response as another officer had to respond to medical in order to notify the medical staff of the need of a medical response. OSI found that RN ███ responded to the medical call after first going to bathroom and did not administer Narcan. This was found to be a violation of NYS DOCCS Directive 4059. OSI found that CO N.D. and CO K did not administer Narcan. This was a NYS DOCCS violation of Directive 4059.

13. As a result of the OSI investigation, Lt. N.V.'s probation was extended for an additional six months, was reassigned to another facility and is not to request to be assigned to Green Haven CF until 12 months after the probation is completed. The remainder of the security staff were retrained on various topics.

ACTIONS REQUIRED:

This case be closed as an overdose.

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-0112
December 20, 2023

cc: Dr. Carol Moores, Deputy Commissioner Chief Medical Officer
James Donahue, Associate Commissioner of Mental Health
Superintendent Mark Miller, Green Haven CF