



**Commission of
Correction**

**Final Report of the
New York State Commission of Correction:**

In the Matter of the Death of

**Tarz Youngblood,
an incarcerated individual of the
George R. Vierno 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 Tarz Youngblood who died on February 27, 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. Tarz Youngblood was a 38-year-old male who died on 2/27/22 from Acute Intoxication due to combined effects of Fentanyl and Heroin while in the custody of the New York City Department of Correction (NYC DOC) at the George R. Vierno Center (GRVC). The Medical Review Board has found that there was a failure by NYC DOC staff to appropriately supervise the housing unit in accordance with NYS minimum standards which allowed Youngblood to use illicit substances which resulted in his death.

2. [REDACTED]

In June 2021, Youngblood was arraigned for Stalking 1st Degree, Tampering with Witness 3rd Degree, Intimidating a Witness 3rd Degree, Criminal Contempt 1st Degree, and Assault 3rd Degree which were abated by his death. [REDACTED]

3. [REDACTED]

4. On 9/5/21, a suicide screen was completed and all responses were listed as “no”. The Arraignment and Classification form was completed at that time and Youngblood reported that he needed medical attention. The NYC DOC Discharge Planning Questionnaire was completed by the officer at that time. The Arraignment form indicated

that there were no medical issues noted. Per the inmate movement activity record, Youngblood was received at Otis Bantum Correctional Center (OBCC) on 9/5/21.

5. On 9/8/21, 9/10/21, and 9/20/21, per the Inmate Movement Activity Record, Youngblood was seen at court.

6. [REDACTED]

7. [REDACTED]

There was no documentation of Youngblood being seen by medical from 9/5/21 until 10/7/21. This is a violation of 9 NYCRR §7010.2(b)(1) which states that each prisoner shall be examined by a physician or other authorized medical personnel legally authorized to perform such examination at the time of admission or as soon thereafter as possible, but no later than 14 days after admission.

8. [REDACTED]

9. [REDACTED]

10. [REDACTED]

11. [REDACTED]

12. [REDACTED]

13. [REDACTED]

14. [REDACTED]

15. On 1/6/22, [REDACTED]
[REDACTED] Youngblood was housed in Otis Bantum Correctional Center (OBCC) on 3SW.

16. On 1/11/22, [REDACTED]
[REDACTED] Youngblood was transferred to GRVC
8B.

17. [REDACTED]

18. [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

19. [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

20. [REDACTED]
[REDACTED]

21. [REDACTED]
[REDACTED]
[REDACTED]

22. [REDACTED]
[REDACTED]
[REDACTED]

23. [REDACTED]
[REDACTED]
[REDACTED]

24. A review of the 9A logbook noted that on 2/25/22 at 4:30 p.m., CO S. noted that they were entering into their third working tour in excess of 16 hours. At 7:30 p.m., CO S. noted they were off post after completing 20 hours working.

25. On 2/27/22 at 10:35 a.m., Corrections Officer (CO) A.D. responded to the center of the housing unit after multiple incarcerated individuals (II) carried Youngblood down the stairs from cell #32 and placed him on the table. CO A.D. went to check Youngblood and

noted that he was “responsive” (sic). A medical emergency was called by the control room officer. Captain K.P. arrived and cardiopulmonary resuscitation (CPR) was initiated. CO J.V. responded and assisted CO A.D. and Captain M.I. with compressions until medical staff arrived. Dr. [REDACTED] and medical responded. Medical staff arrived to the housing area [REDACTED]

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] EMS arrived at 10:56 a.m. [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

26. A review of the 9A logbook by the Commission noted that on 2/27/22:
At 7:30 a.m., CO R. assumed the post
At 7:50 a.m. CO R. noted that the first security inspection was completed and that multiple cell doors were manipulated by inmates.
At 8:00 a.m., 8:30 a.m., 9:00 a.m., 9:30 a.m., and 10:00 a.m., CO R noted that the active supervision tour of the area was completed and that multiple cell doors were manipulated.
At 10:00 a.m., CO A.D. relieved CO R. from post.
At 10:15 a.m., the food wagon was on post.
At 10:35 a.m., a medical emergency was called.
27. A review of the Gentech video by Commission staff revealed that from 9:20 a.m. until 10:36 a.m. on 2/27/22 there were no supervisory tours completed on the 2nd floor of the tier. From 9:20 a.m. until 10:22 a.m., Youngblood and another II were in cell 32. Youngblood was assigned to cell 25.
At 10:22 a.m., one II came out of cell 32 and looked over the railing and walked up the tier and returned to cell 32.
At 10:25 a.m., the same II came out of the cell and waited for his meal tray to be brought to him. When the meal tray was delivered, he and another II went into cell 32. The II that delivered the meal tray exited the cell at 10:27 a.m.
At 10:29 a.m., another II entered cell 32.
At 10:30 a.m., another II entered cell 32.
At 10:30 a.m., another II knocked on cell 32 and stood in the doorway with the cell door open.
At 10:31 a.m., two II's exited the cell briefly and reentered the cell.
At 10:32 a.m., another II entered the cell while another II was outside the cell. The II that entered the cell exited the cell at 10:33 a.m. and went down to the first floor and got on the phone.
At 10:34 a.m., another II entered cell 32 while numerous II's were standing around cell 32. That II exited the cell at 10:36 a.m. and three other II's carried Youngblood down the stairs and placed him on the table.

The Medical Review Board has found that the absence of complete supervisory visits for

the times documented in the housing area logbook as listed in Finding 26 were falsified entries by corrections staff and was in violation of 9 NYCRR §7003.3(a) Supervision of incarcerated individuals 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 areas but not secured in their individual housing units*

ACTIONS REQUIRED:

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

1. The Commissioner shall conduct an investigation as to why the housing unit was not properly supervised in compartment with 9 NYCRR §7003.3(a) and why staff falsified logbook entries indicating supervisory visits were completed at times that video recording of the housing area confirmed that they were not completed.
2. The Commissioner shall conduct an investigation as to why Youngblood was not produced to medical for his intake in compartment with 9 NYCRR §7010.2(b)(1).

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 for #1 that the cited officer failed to perform duties of care, custody and control and will be subject to administrative action. For #2 NYC DOC indicated that an investigation will be conducted but the results of such were not provided. This will be subject to further review by the Commission.


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

The Senior Vice President for Correctional Health Services shall conduct a quality assurance review to determine why Youngblood was not produced to medical for his intake in compartment with 9 NYCRR §7010.2(b)(1).

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 reported that NYC DOC is responsible for custody management and the production of patients for evaluations and will defer to DOC's investigative findings. The Commission remains affirmed that this chronic systemic issue which requires the attention of both NYC DOC and CHS and be subject to further review by the Commission.

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 20^h day of December, 2023.



Allen Riley
Chairman
Commission of Correction

AR:DC:vc
2022-M-0026
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