NEW YORK STATE | Commission of Correction

Final Report of the New York State Commission of Correction:

In the Matter of the Death of

Brian Bishop, an incarcerated individual of the Albany County Jail

March 27, 2024

To: Sheriff Craig D. Apple
Albany County Sheriff's Office
Courthouse
Albany, New York 12207

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 Brian Bishop, who died on October 31, 2021, as a result of circumstances which occurred while an incarcerated individual in the custody of the Albany County Sheriff at the Albany County Jail, the Commission has determined that the following final report be issued.

FINDINGS:

1. Brian Bishop was a 43-year-old male who died on 10/31/21 from an overdose involving Methamphetamine and Fentanyl while in the custody of the Albany County Sheriff at the Albany County Jail (CJ). The Medical Review Board opines that the security staff failed to properly conduct constant supervision as required by Minimum Standards as evidenced by the presence of postmortem changes when Bishop was discovered.

2. [redacted]

3. [redacted]

4. [redacted] At 12:21 a.m., Bishop was booked into the Albany CJ. Bishop was charged with Petit Larceny. At 12:30 a.m., Bishop's suicide prevention screening was completed by Correction Officer (CO) J.S. Bishop scored a 'seven'. CO J.S. documented that Bishop was currently on "metha". During an interview with Commission staff, CO J.S. stated that the documentation was probably referring to Methadone. CO J.S. documented on Bishop's suicide prevention screening that Bishop admitted that he was worried about making bail and that his brother had recently passed away. CO J.S. also documented that Bishop had previously been incarcerated at the Albany CJ in 2016. CO J.S. documented that Bishop could not stand still but was alert. Bishop was semi-cooperative with the intake process and suicide prevention screening. Bishop admitted that he was withdrawing from Methadone. Bishop was placed on [redacted] by CO J.S based on his presentation. During an interview with Commission staff, CO J.S. stated that Bishop had difficulty standing and being still and that Bishop stated that he had too much back pain. CO J.S. stated that Bishop arched his back when taking his booking photo and was unable to complete his finger printing during his admission. CO J.S. stated that while he escorted Bishop to medical, Bishop was not steady on his feet and was clearly under the

influence of something.

5. [redacted]

6. At approximately 1:05 a.m., Bishop was brought to his cell, 5 East Left 3. CO T.B. was assigned as the [redacted] officer. CO T.B. documented that Bishop was loud and screaming. CO T.B. gave Bishop an order to stop yelling but Bishop refused. Bishop continued to yell insults, curse words and nonsense for approximately two hours. CO T.B. gave Bishop several orders to stop his actions, but Bishop continued with racial and homophobic slurs directed at another incarcerated individual (II) as well as CO T.B. Bishop stated that he would attack CO T.B. should he be allowed out of the cell. Eventually Bishop tired, became quiet and laid down on his bunk then appeared to go to sleep. During an interview with Commission staff, CO T.B. stated that he was unsure what time Bishop finally laid down for good after going between laying down and standing. CO T.B. stated that Bishop stated that he was done yelling and he was going to bed. CO T.B. stated that the behavior witnessed was nothing out of the ordinary for someone who had just been admitted to the jail with an altered mental status or who appeared to be under the influence. CO T.B. stated that he continued to document his observations of Bishop every 15 minutes while Bishop appeared to be asleep. At the time of this incident, the [redacted] cells had plexiglass against the bars. CO T.B. stated that arrangement made it difficult to confirm 100% that Bishop was breathing but he appeared to be alive and asleep. CO T.B. stated to Commission staff that he maintained [redacted] of Bishop until he was relieved by CO B.D.

7. CO E.G. documented housing unit supervisory tours at 1:30 a.m., 2:00 a.m., 2:30 a.m.,

3:00 a.m., 3:30 a.m., 4:00 a.m., 4:30 a.m., 5:00 a.m., 5:30 a.m., 6:00 a.m. and 6:30 a.m. with a mid-shift count confirmed with booking at 2:03 a.m. During an interview with Commission staff, CO E.G. stated that Bishop did not appear to be sober and that it took him a while to settle down from his yelling. CO E.G. stated that during his housing unit supervisory tours and counts, Bishop looked like a man sleeping in a cell.

8. On 10/31/21 at 6:50 a.m., CO E.G. and CO M.S. made a supervisory tour for shift change and both observed Bishop who appeared to be awake laying on his bunk with his eyes open. CO M.S. documented that when he came on post, he completed a security round and verified that five incarcerated individuals were physically present. During an interview with Commission staff, CO M.S. stated that on his housing unit supervisory rounds Bishop appeared to be alive and laying on his bunk with his eyes open. CO M.S. stated that from the information he received from the off going unit officer, CO E.G., Bishop had a rough night with him being up and ranting and raving for a few hours and then finally quieting down around 3:00 a.m.

9. On 10/31/21 at 6:55 a.m., CO B.D. assumed control of the [redacted] post and documented that the off going officer reported no issues and that all appeared secure. CO B.D. documented that when he came on post, he conducted a round to visually spot check the [redacted] cells and all appeared secured. During an interview with Commission staff, CO B.D. stated that when he arrived on post, he looked across the three [redacted] cells and observed the incarcerated individual in the left cell sitting, Bishop was laying down and the incarcerated individual in the right cell was standing at his gate. All of the individuals appeared to be fine. CO B.D. stated that during his observations, it appeared that Bishop's eyes were open but the way that the plexiglass was hung on the cell bars, made it difficult to tell for sure and that nothing seemed out of the ordinary.

10. At 7:24 a.m., another incarcerated individual notified CO B.D. that Bishop did not respond to his meal tray being passed and the individual stated that Bishop did not look good. CO B.D. observed that Bishop was not responsive and informed CO M.S. that they needed to check on Bishop. CO M.S. observed that Bishop was unresponsive with his eyes open and activated a medical emergency. CO B.D. entered the housing unit cell block and entered Bishop's cell. CO B.D. performed a sternal rub with no effect. Bishop was placed on the floor just outside of his cell. Bishop had no respirations or pulse. CO B.D. began chest compressions. At 7:26 a.m., RNs [redacted], [redacted], [redacted] and Licensed Practical Nurse [redacted] arrived. [redacted]

11. [redacted] At 7:44 a.m., Colonie EMS arrived and assumed care of Bishop. [redacted] CO B.D. stated that he did not observe any obvious injuries to Bishop but he appeared pale.

12. Per Chairman's Memorandum 3-2016 dated December 21, 2016, an officer conducting constant supervision must periodically verify that the individual is exhibiting "signs of life" including, but not limited to, any observable bodily movement or audible speech, breathing or snoring. Such periodic observations of the individual's condition shall be documented in the supervision logbook, located at the constant supervision post, as required by 9 NYCRR §7003.3(j)(5)(vi). The Medical Review Board opines that the Constant Supervision provided to Bishop was not performed in accordance with this requirement given the postmortem changes in Bishop that were identified by facility nursing staff and EMS.

ACTIONS REQUIRED:

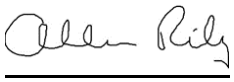
TO THE OFFICE OF THE ALBANY COUNTY SHERIFF:

The Sheriff shall take notice of the Medical Review Boards finding of the presence of postmortem changes as observed by the nursing staff as well as EMS and initiate an investigation into the conduct of the officers who were assigned to the constant supervision within the housing area. Administrative action should be taken if found to be in violation of department directives.

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

In a response dated 2/1/2024 to the Commission's preliminary report the Albany County Sheriff Office indicated that an internal investigation was completed and the officers were not found to be in violation of department directives.

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 27 h day of March 2024.



Allen Riley
Chairman
Commission of Correction

AR:MB:vc
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