Commission of Correction

Final Report of the New York State Commission of Correction:

In the Matter of the Death of

Kevin Bryan,
an incarcerated individual of the
Eric M. Taylor Center

March 27, 2024

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

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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 Kevin Bryan, who died on September 14, 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. Kevin Bryan was a 35-year-old male who died on 9/14/22 due a suicidal hanging while in the custody of the New York City Department of Correction (NYC DOC) at the Eric M. Taylor Center (EMTC). The Medical Review Board has found that a failure to supervise the facility in accordance with NYS Minimum Standards has jeopardized the safety of the incarcerated individuals in NYC DOC's custody and constitutes a violation of Correction Law §500-c(4) that requires the Department to keep incarcerated individuals safe. There was no officer assigned to supervise Bryan's housing area at the time of his terminal event.

2. [redacted] On 3/24/22, Bryan was arrested and charged with Burglary 3rd Degree. On 5/10/22, Bryan was arrested for two counts of Burglary and Criminal Possession Stolen Property 5th Degree. On 5/24/22, Bryan was arrested and charged with Burglary. On 8/16/22, Bryan was arrested and charged with Burglary 3rd Degree. On 9/7/22, Bryan was arrested and charged with Burglary and Possession of Burglar Tools. All of these charges were abated by his death. Bryan was due to return to court for these charges on 11/10/22.

3. Bryan denied having any medical or mental health conditions and was not prescribed any medications.

4. On 9/8/22 at 9:39 p.m., Bryan was received at the Eric M. Taylor Center. [redacted]

5. On 9/9/12 and 9/12/22, Bryan was at court.

6. On 9/14/22 Corrections Office (CO) K.G. was assigned to the 10 Main housing area for the 11:00 p.m. to 7:00 a.m. shift on the A control post. A logbook entry was made on 9/13/22 at 10:30 p.m. indicating that a security inspection was completed on all doors, locks, windows, vent screens, and gates reporting that all appeared secure. There was no B post officer assigned to supervise the housing area on that shift. The Commission has found that when there is no staff assigned to the B post, basic supervision of the housing area cannot be conducted in accordance with the requirements 9 NYCRR

§7003.3(c) which states:
At minimum, general supervision shall be maintained in all facility housing areas when all incarcerated individuals are secured in their individual housing units.

7. On 9/14/22 at approximately 5:20 a.m., an incarcerated individual (II) on 10 Main housing area reported to CO K.G. that he had not slept in weeks. CO K.G. advised the II to contact medical. The II was not satisfied with the response and stated that he was going to create a disturbance to get attention. Bryan was near the 10 Main A post at that time and the II started to throw punches at Bryan and threatened him. At approximately 5:24 a.m., CO K.G. allowed Bryan to exit the housing area and to go to the vestibule area. CO K.G. reported that she called for the captain and arranged for Bryan to move to another housing area. During this time, the other II continued to create a disturbance inside the housing area. CO K.G. called control and advised them that she needed a supervisor to escort Bryan to another housing area. At approximately 6:14 a.m. while in the vestibule, Bryan entered a staff bathroom that was not secured with his mattress.

8. At approximately 6:25 a.m., per CO K.G., the other II began to fill a large garbage can with water. CO K.G. called a Level A response to the unit. CO K.G. was unable to leave the A Post that she was assigned to in order to check on Bryan. At approximately 6:36 a.m., Captain S.R. arrived on the housing area. At that time, Bryan was noted to be in the staff bathroom and the door was locked from the inside. CO K.G. attempted unsuccessfully to open the door. At 6:49 a.m., ADW A. arrived and along with CO J.M. and attempted to open the door. At 7:04 a.m., ADW A. gained entry to the bathroom and found Bryan hanging. A medical emergency was called. The Medical Review Board finds that there was a failure to maintain safety and security of the vestibule area by the staff bathroom not being properly locked. The failure to assure the bathroom door was locked indicates that the documented security inspection was not completed in accordance with the requirements of 9 NYCRR §7003.6(c) which states:
Where a facility member's assignment to a facility area is scheduled to exceed one hour, such facility staff member shall, upon assuming responsibilities in the assigned facility area and following the completion of duties set forth in subdivision (b) of this section, inspect all supplies, equipment, locks, gates, bars, screens, security windows and other securing devices, and perform any other necessary security functions as determined by the chief administrative officer.

9. At 7:05 a.m., medical staff responded to an emergency on the 10 Main housing area.

10. During an interview with Commission Staff, CO K.G. stated that Bryan was fearful and asked to be moved from the housing area. CO K.G. stated that she was the only officer assigned to 10 Main and called the captain three times for assistance without a response. CO K.G. stated that she also called control to request a supervisor.

11. During an interview with Commission staff, Captain S.R. stated that she did not receive any requests on the radio and stated that the officer must have called the office and the captain was not in the office.

12. A Review of the 10 Main A housing logbook revealed:

    From 9/11/23 at 11:30 p.m. through the terminal event, there was a note that there was no B officer assigned on 10 Main.

    On 9/14/22 at 5:30 a.m., CO K.G. noted a visual supervision tour of area with nothing unusual to report.
    At 5:35 a.m., CO K.G. noted that feeding was in progress.
    At 6:00 a.m., CO K.G. noted a visual supervision tour of area with nothing unusual to report and that feeding was complete.
    At 6:20 a.m., per CO K.G., a Level A response was called for a disruptive individual.
    At 6:30 a.m., CO K.G. noted a visual supervision tour of area with nothing unusual to report and that she was awaiting on level A.
    At 6:40 a.m., Captain S.R. was on post.

    There was no documentation regarding the incident with Bryan and the other II. There was no documentation regarding Bryan being removed from the housing area. This is a violation of 9 NYCRR §7003.3(j) 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: (6) any significant events and activities occurring during supervision, including: (i) the date and time of such event or problem; (ii) the names of all incarcerated individuals and/or staff involved; (iii) facility staff response to such event or problem, including a summary of what occurred*.

13. The 10 Main B logbook has an entry on 9/9/22 at 12:15 a.m. that stated that the control room supervisor authorized a walk off post. There were no counts noted after this entry.

    On 9/10/22 from 7:00 p.m. until 9:00 p.m., an officer was assigned to the B post. At 9:00 p.m., that officer assumed the 10 Main A post.

    There were no further entries made and no count documented until 9/13/22 at 4:00 p.m. which noted that there was no B post officer.

    On 9/13/22 at 5:52 p.m., a captain noted that there was no B post officer. There was no count noted.

    On 9/14/22 at 9:48 a.m., CO C. assumed the post.

    The Medical Review Board finds that the abandonment of security staffing posts for the housing areas is a violation of 9 NYCRR §7003.3(a)and had fostered unsafe conditions of confinement in violation Correction Law §500-c(4).

    The failure to properly complete population counts is a violation of 9 NYCRR §7003.5 which states:
    (a) Prisoner population counts shall:

(1) be conducted at the completion and commencement of each regularly scheduled shift;
(2) be conducted by the facility staff member completing such regularly scheduled shift;
(3) be conducted by the facility staff member beginning the next regularly scheduled shift; and
(4) include an accounting of all prisoners housed in or otherwise assigned to the facility area in which such count is conducted.

This is also a violation of 9 NYCRR §7003.5(b) which states:
The results of each prisoner population count conducted pursuant to paragraphs (a)(2) and (3) of this section shall be recorded in writing. Such written records shall include the:
(1) date and time of the count;
(2) facility area in which the count was conducted;
(3) number of prisoners accounted for; and
(4) name of facility staff member conducting the count.

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 staffed supervised in comportment with 9 NYCRR §7003.3(a),(b),(c), & (j) and why population counts were not properly completed in accordance with 9 NYCRR §7003.5.

2. The Commissioner shall conduct an investigation as to why the staff bathroom was not properly secured in the vestibule and not accounted for in the security inspection per the requirements of 9 NYCRR §7003.6(c).

3. The Commissioner shall inform the Commission on measures being taken by DOC to address the chronic staffing issues and safety conditions effecting EMTC.

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

In a response dated 2/12/2024 to the Commission's preliminary report NYC DOC Commissioner reported that security staffing at EMTC has increased from 231 available officers in September 2022 to 451 available officers as of February 2024. NYC DOC also indicated that the all staff bathroom locks in housing areas were repaired and that a security memorandum regarding inspections of locks was issued. The Commission will verify corrective actions taken at follow up site visits and inspections.

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:DC:vc
2022-M-0101
March 27, 2024

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
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NYC Board of Correction