NEW YORK STATE | Commission of Correction

Final Report of the New York State Commission of Correction:

In the Matter of the Death of

Erick Tavira, an incarcerated individual of the George R. Vierno Center

June 25, 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

Elizabeth Gaynes
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 Erick Tavira, who died on October 22, 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. Erick Tavira was a 28-year-old male who died from a suicidal hanging on 10/22/22 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 found that Tavira had an excessive number of medical and mental health callouts that he was not produced for during his incarceration and had inconsistent access to medication. The Medical Review Board finds that the repeated failures to produce Tavira for medical and mental health appointments, a chronic issue the Medical Review Board has previously identified in multiple mortality reviews, is unacceptable and constitutes a failure to provide adequate care.

2. [redacted]. In June 2021, Tavira was arrested and charged with Assault of a Police Officer/Fireman/EMT, Resisting Arrest, and Disorderly Conduct. Tavira was arraigned on a charge of Assault 2nd Degree which was abated by his death. In June 2021, Tavira was arrested and charged with Strangulation 2nd Degree and Acting in a Manner injurious to a Child Less than 17 and was arraigned on charges of Strangulation 2nd Degree, Acting in a Manner injurious to a Child Less than 17, and Assault 3rd Degree which were abated by his death.

3. [redacted].

4. On 6/15/21, Tavira was received at the Otis Bantum Correctional Center (OBCC). [redacted] During the intake process, in the main clinic, Tavira walked out of the room and stepped into another cubicle and assaulted another incarcerated individual (II). [redacted]

[redacted]

5. [redacted]

6. [redacted]

7. [redacted].

8. [redacted]

9. [redacted].

10. [redacted]
11. [redacted].
12. [redacted]
13. [redacted]ssment.
14. [redacted]
15. [redacted]
16. [redacted].
17. [redacted].
18. [redacted]
19. [redacted].
20. [redacted]
21. [redacted]
22. [redacted].
23. [redacted].
24. [redacted].
25. [redacted]

[redacted]

26. [redacted]

27. [redacted]

28. [redacted]

29. [redacted].

30. [redacted]

31. [redacted].

32. [redacted].

33. [redacted].

34. [redacted].

35. [redacted].

36. [redacted].

37. [redacted]

38. [redacted].

39. [redacted]

[redacted]

40. [redacted]

41. [redacted].

42. [redacted].

43. [redacted]

44. [redacted]

45. [redacted]

46. [redacted]

47. [redacted]

48. [redacted]

49. [redacted].

50. [redacted]

[redacted].

51. [redacted]

52. [redacted]

53. [redacted]

54. [redacted] During an interview with Commission staff, LCSW [redacted]. reported that when individuals are suspected to be under the influence of substances, the housing officer would be notified as well as the treatment team.

55. [redacted].

56. [redacted]

57. [redacted]

58. [redacted]

59. [redacted].

60. [redacted].

61. [redacted]

62. [redacted].

63. [redacted].

64. [redacted]

65. [redacted]

66. [redacted]

67. [redacted]

68. [redacted].

69. [redacted]

70. [redacted] During an interview with Commission staff, Dr. [redacted] was asked if staff would go to the housing units when individuals were not produced. Dr. [redacted]. stated that in the past, this might have been done but at that time, due to safety issues, it was no longer done.

71. [redacted]

72. [redacted]. The Medical Review Board finds that the repeated failures by DOC to produce Tavira for his mental health appointments is unacceptable and constitutes a failure to provide adequate care.

73. [redacted].

74. [redacted]

75. [redacted]

76. [redacted].

77. [redacted]

78. [redacted]

79. [redacted]

80. [redacted]

[redacted]. The Medical Review Board found that between 6/16/21 and 12/16/21, Tavira did not receive 51 doses of medication, was not produced for 8 mental health callouts, and was not produced for 21 nursing callouts to include seven CIWA assessments.

81. [redacted].

82. [redacted].

83. [redacted]

84. [redacted]. During an interview with Commission staff, RN [redacted]. stated that if individuals request sick call, they are seen within three days. If the individual is not produced for three consecutive days, then the sick call is cancelled. The list of individuals not produced is forwarded to the administration and to DOC and another list of individuals is generated for the next shift. This list is continued for three days unless the individual is produced. The list is also forwarded to the medical providers so they are aware. There was no information provided in the records received to indicate why Tavira had not been seen for his sick call request.

85. [redacted].

86. [redacted].

87. [redacted]

88. [redacted]

89. [redacted]

90. [redacted].

91. [redacted]

92. [redacted].

93. [redacted]

94. [redacted].

95. [redacted].

96. [redacted].

97. [redacted]

98. [redacted]

99. [redacted]

100. [redacted].

101. [redacted]

102. [redacted].

103. [redacted].

104. [redacted]

[redacted]

105. [redacted].

106. [redacted].

107. [redacted]

108. [redacted]

109. [redacted]

110. [redacted].

111. [redacted]

112. [redacted].

113. [redacted].

114. [redacted]

115. [redacted]

The Medical Review Board has found that from 12/22/21 through 6/13/22, Tavira did not receive 21 doses of medications, was not produced for one mental health callout, and was not produced for eight nursing callouts.

116. [redacted]

117. [redacted].

118. [redacted]

119. [redacted].

120. [redacted].

121. [redacted]

122. [redacted].

123. [redacted]

124. [redacted]

125. [redacted]

[redacted]

126. [redacted]

127. [redacted]

128. [redacted]

129. [redacted]

130. [redacted].

131. [redacted]

132. [redacted].

133. [redacted].

134. [redacted].

135. [redacted]

[redacted].

136. [redacted].

137. [redacted]

138. [redacted]

139. On 8/20/22 at 9:05 p.m., Tavira was involved in a fight with another incarcerated individual and chemical agents were deployed. [redacted]

140. [redacted]

141. [redacted].

142. [redacted].

143. [redacted].

144. [redacted]

145. [redacted].

146. [redacted]

[redacted].

147. A[redacted]

148. [redacted].

149. [redacted].

150. [redacted]

151. [redacted].

152. [redacted]

153. [redacted].

154. [redacted].

155. [redacted].

156. On 9/20/22 at 5:55 p.m., Tavira was involved in a use of force with DOC staff. Tavira was sprayed with Oleoresin Capsicum (OC). [redacted]

[redacted].

157. [redacted].

158. [redacted].

159. [redacted]

160. [redacted].

161. [redacted].

162. [redacted].

163. [redacted].

164. [redacted].

165. [redacted]

166. [redacted]

167. [redacted]

168. [redacted]

169. [redacted]

170. On 10/18/22, Tavira had a phone call with has aunt. They discussed feelings and their future. There was no conversation related to suicidal ideation.

171. [redacted].

172. [redacted]

173. A[redacted].

The Medical Review Board has found that from 6/14/22 until 10/22/22, Tavira did not receive 57 doses of medication, was not produced for two mental health callouts, and was not produced for 10 nursing callouts.

174. During an interview with Commission staff, Correction Officer (CO) G.D. stated that on 10/22/22 at approximately 1:00 a.m., while he was conducting a tour of the housing area, Tavira asked him what time it was. Tavira was told the time. At approximately 1:55

a.m., CO G.D. was conducting a tour and noted that Tavira was hanging in his cell with a sheet tied around his neck. CO G.D. gave an order for the sheet to be removed and Tavira did not respond. CO G.D. requested control to call a medical emergency and at 1:56 a.m., CO G.D. entered the cell and cut Tavira down. CO G.D. initiated cardiopulmonary resuscitation (CPR) and CO G.W. assisted with CPR. At approximately 2:05 a.m., medical staff arrived. [redacted]

175. In review of Tavira's death, the Medical Review Board analyzed data produced by Correctional Health Services for the New York City Board of Correction regarding Access to Health Services (https://www.nyc.gov/site/boc/reports/correctional-health-authority-reports.page). In the three reporting periods up to Tavira's date of death 10/22/22, GRVC had an average of 38% of incarcerated individuals either not produced or rescheduled for nursing appointments and 31% of mental health appointments, consistent with the Board's findings on Tavira. Systemwide in NYC DOC 35% of all medical appointments, 27% of nursing appointments and 44% of mental health appointments were not completed. The Medical Review Board remains highly concerned of the number of individuals not produced for appointments, especially the near 50% of all mental health cases.

ACTIONS REQUIRED:

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

The Medical Review Board requests that a comprehensive review and report regarding the systemic issues of incarcerated individuals not produced and or not receiving scheduled medical and mental health services be conducted with the development of specific corrective action plans that demonstrate mechanisms to improve outcome and accountability.

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

1. The Commissioner shall conduct an investigation into the failure of DOC staff to produce Tavira for multiple sick call appointments, providers appointments and medication distribution during his 16 months of incarceration. The Commissioner shall provide the Board with a comprehensive correction action plan to address this issue, an issue the Board has cited numerous times regarding in-custody mortalities, with a system of individual and staff accountability when medical appointments are missed.

2. The Commissioner shall conduct an investigation into the failure of DOC staff to have Tavira seen in medical following a fight on 8/23/22.

A report of the findings and any corrective actions taken shall be provided to the Medical

Review Board upon completion.

In a response dated 2/12/2024 NYC DOC indicated that the requested investigations were requested to be completed from the Health Affairs Division and Office of Policy and Compliance. The Commission will further follow up on the matter at later scheduled site visits and evaluations.

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 Tavira did not receive any doses of Librium after the initial dose was given.

2. Correctional Health Services shall conduct a quality assurance review to determine why Tavira was not scheduled in a timely manner for his sick call requests in January and February 2022.

3. Correctional Health Services shall conduct a quality assurance review to determine why Tavira's appointments for psychiatric medication re-evaluation were cancelled by CHS on 9/27/21, 10/4/21, 6/13/22, and 8/28/22.

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

In a response dated 4/4/2024 to the Commission's preliminary report Correctional Health Services indicated that requested reviews were completed.

TO THE OFFICE OF THE NYC COUNCIL SPEAKER:

As the appointing authority for the delivery of correctional health services pursuant to Correction Law section 501, the City Council shall review the above findings and conduct an inquiry into the fitness of the currently designated provider.

WITNESS, HONORABLE YOLANDA CANTY, Commissioner, 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 25th day of June 2024.

Yolanda Canty
Commissioner
Commission of Correction

YC:DC:vc
2022-M-0117
June 25, 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
Correctional Health Services
Bipin Subedi, MD, Chief Medical Officer
Correctional Health Services
Executive Director
NYC Board of Correction