NEW YORK STATE | Commission of Correction

Final Report of the New York State Commission of Correction:

In the Matter of the Death of

William Brown, an incarcerated individual of the Anna M. Kross Center

September 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 William Brown, who died on December 15, 2021, 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. William Brown was a 55-year-old male who died on 12/15/21 from Acute MDMB-4EN-PINACA (Synthetic Cannabinoid) Intoxication while in the custody of the New York City Department of Correction (NYC DOC) at the Anna M. Kross Center (AMKC). The Medical Review Board finds that the repeated failures to produce Brown for 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] On 11/12/21, Brown was arrested and charged with Petit Larceny and CPSP 5th Degree. On 11/13/21, Brown was arrested and charged with Robbery 3rd Degree, Assault 3rd Degree, Petit Larceny, and CPSP 5th Degree. On 11/14/21, Brown was arraigned on charges of Assault 3rd Degree, 2 counts of Petit Larceny, 2 counts of CPSP 5th Degree, Attempted Assault 3rd Degree, Menacing 3rd Degree, and Harassment 2nd Degree. All of these charges were abated by his death.

3. [redacted]

4. On 11/14/21, Brown refused to answer the questions on his suicide screening but the officer noted that Brown appeared “ok”. [redacted]

[redacted]

5. [redacted]

6. [redacted]

7. [redacted]

8. [redacted]

9. [redacted]

10. [redacted].

11. [redacted].

12. [redacted]

13. [redacted]

14. [redacted]

15. [redacted]

16. [redacted]

17. [redacted].

18. [redacted]

19. [redacted]

20. [redacted]

21. [redacted] The Medical Review Board opines that a 12-day delay in completing a stat mental health referral for an individual with a documented mental health history is a failure to provide adequate care.

22. [redacted]

23. [redacted]

24. [redacted]

25. [redacted]

26. On 12/14/21 at 10:43 p.m., a medical response was called for Brown on West 17 Lower B dayroom. [redacted] At 11:15 p.m., EMS arrived [redacted]

27. Per the NYC DOC Callout and Checklist report, a review of the Genetec cameras revealed that on 12/14/21 from 7:00 p.m. until 10:32 p.m., there were no corrections officer (CO) on the housing unit West 17 Lower B post. CO N.H. was assigned to the post. A review of the Genetec camera footage revealed that three incarcerated individuals were on the floor and were vomiting after they had been seen on camera smoking in the dayroom. When CO N.H. went into the doorway of the dayroom and noted that other incarcerated individuals were attempting to assist the individuals that were on the floor, CO N.H. did not immediately assist but waited approximately five minutes before notifying the A post officer of the emergency and then returned and began CPR.

28. CO N.H. documented in the B logbook the following:

At 7:00 p.m., active supervision tour of area completed.
At 7:30 p.m., active supervision tour of area completed.
At 8:00 p.m., active supervision tour of the area completed. Institutional standing count conducted and verified with total count 48, All In.
At 8:10 p.m., individual returns from court and new count 49.
At 8:30 p.m., active supervision tour of area completed.
At 9:00 p.m., active supervision tour of area completed institutional lock in in "p". This writer is off post for a personal this writer isn't feeling well.
At 9:30 p.m., active supervision tour of area completed.
At 10:00 p.m., active supervision tour of area completed.

The Medical Review Board finds that CO N.H. failed to maintain active supervision of the housing area in accordance with the requirements of 9 NYCRR §7003.3(a) 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.*

Additionally, the Board also finds that CO N.H. falsified logbook entries for completing supervisory visits that were not conducted.

29. A Memorandum of Complaint was filed against CO N.H. on seven violations of NYC DOC Department Rules and Regulations. CO N.H. was issued a 30 day suspension on 11/9/21 for an Absence Without Leave charge. CO N.H. has since returned to duty.

ACTIONS REQUIRED:

TO THE COMMISSIONER OF NYC DEPT. OF CORRECTION:

The Commissioner shall note the findings of the Commission regarding the failure of staff to maintain compliance with 9 NYCRR §7003.3(a) and shall review with all command staff to assure that compliance with supervision requirements is maintained and any issues are addressed when found to be deficient.

In a response dated 8/19/24 to the Commission's preliminary report, NYC DOC indicated that a review with all senior staff including the commanding officers at all facilities of the SCOC and NYC DOC supervision requirements was completed.

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 Brown did not have the ordered electrocardiogram completed.

2. Correctional Health Services shall conduct a quality assurance review to determine why Brown did not have the ordered ultrasound completed.

3. Correctional Health Services shall conduct a quality assurance review to determine why Brown was not seen timely for his stat mental health referral.

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

In a response dated 8/12/24 to the Commission's preliminary report, CHS indicated that the requested reviews were completed. The response states that "the care that CHS provided to Mr. Brown was appropriately prioritized and rendered given his clinical presentation and information available at the time. The SCOC report, issued years later following a retrospective review, fails to both note this fact and the reality that this care was provided in the midst of a global, lethal pandemic. It additionally disregards facility, operational and clinical realities during a period of publicly documented crisis in the NYC jail system. It also neglects to consider approaches to care that incorporate individual clinical need and priorities". The Medical Review Board notes the response of CHS but remains affirmed in their opinion and findings regarding William Brown.

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 September 2024.

Yolanda Canty
Commissioner
Commission of Correction

YC:DC:vc
2021-M-0167
September 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
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NYC Board of Correction