NEW YORK STATE | Commission of Correction

Final Report of the New York State Commission of Correction:

In the Matter of the Death of

Anibal Carrasquillo, an incarcerated individual of the George R. Vierno 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 Anibal Carrasquillo, who died on June 20, 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. Anibal Carrasquillo was a 39-year-old male who died on 6/20/22 from an Acute Fentanyl Intoxication while in the custody of the New York City Department of Corrections (NYC DOC) at the George R. Vierno Center (GRVC). Carrasquillo was incarcerated for 33 months and during that time, he had numerous incidents where he appeared to or admitted to being under the influence of illicit substances or had otherwise unexplained episodes of altered mental status. The Medical Review Board has found that there were multiple failures of Correctional Health Services regarding the care provided to Carrasquillo punctuated with failures to adequately coordinate care, properly follow up on appointments and referrals, and the overall supervision of clinical staff. Additionally, 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.

2. [redacted]. On 9/27/19, Carrasquillo was charged with Robbery 1st, 2nd, and 3rd Degrees, Grand Larceny 4th Degree, Assault 3rd Degree, CPW 4th Degree, CPCS 7th Degree, Petit Larceny, Possession of a Forged Instrument 3rd Degree, Attempted Assault 3rd Degree, Menacing 3rd Degree, and Harassment 2nd Degree. Carrasquillo was arraigned and remanded to the custody of NYC DOC. The charges were abated by his death.

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[redacted]

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15. [redacted]. Dr. [redacted]. was getting Carrasquillo's history when the corrections officer (CO) called for the incarcerated individuals to go back to the housing unit and Carrasquillo stated that he had to go and left the room. [redacted]. The Medical Review Board opines that Carrasquillo should have been allowed to remain in medical in order to be evaluated by the specialist given his medical

condition and due to DOC's failure to produce Carrasquillo for his initial evaluation on 9/30/19.

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93. [redacted]. The Medical Review Board opines that Carrasquillo should have been seen prior to 14 days after his initial complaint of a reaction. Additionally, the Medical Review Board has found that there was a lack of leadership and overall lack of coordination in Carrasquillo's psychiatric care. Carrasquillo had been seen by four different psychiatric providers with four different changes to his therapy regimens in just over a 90 day period.

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154. [redacted]

155. [redacted] The Medical Review Board finds that there was a failure by LCSW M.S. and Unit Chief E.B to have Carrasquillo's documented altered mental status addressed by medical. Additionally, there was no indication in the documentation provide to the Commission that any correctional health services staff made any recommendation to increase the supervision on Carrasquillo per 9 NYCRR §7003.3(h) which states:

The chief administrative officer and/or the facility physician shall determine whether a prisoner requires additional supervision based on the prisoner's condition, illness or injury, and the chief administrative officer shall order such supervision if warranted. Additional supervision may include:
(1) more frequent supervisory visits;
(2) active supervision when only general supervision is required; or
(3) constant supervision.

The Medical Review opines that Carrasquillo's condition warranted additional supervision that should have been requested by CHS staff to DOC staff to implement.

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172. [redacted].

173. [redacted] The Medical Review Board finds that there was a failure to have Carrasquillo's altered mental status properly addressed and a lack of adequate supervision of the physician assistant by the supervising physician.

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189. [redacted].

190. [redacted] There was no reportable incident related to this event. This is a violation of 9 NYCRR §7022.2(a)*: the following general categories of incidents shall be reported to the commission pursuant to the requirements of this Part: (1) assaults.*

191. [redacted]

192. [redacted]

193. From July 2021 through December 2021, Carrasquillo was not produced for 26 appointments.

194. [redacted].

195. [redacted]

196. [redacted].

197. [redacted] There was no reportable incident related to this event. This is a violation of 9 NYCRR §7022.29(a)(1). [redacted]

[redacted].

198. [redacted]

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210. [redacted].

211. [redacted].

212. [redacted]

213. [redacted]

214. [redacted].

215. [redacted] The Medical Review Board finds that an over 17 month lapse in psychiatric provider appointments was a gross failure to properly follow up on an active caseload patient and represents a lack of coordination of care and ineffective supervision of clinical staff.

216. [redacted]

217. [redacted]

218. [redacted].

219. A review of the Genetec video revealed that on 6/19/22, CO S.A., who was assigned to the 5B post, exited the housing area from 10:45 p.m. to 11:09 p.m. and again from 11:49 p.m. to 12:31 a.m. NYC DOC closing report noted that the tours that were completed were not adequate and that CO S.A. did not assure that there were living bodies in the cells. Charges were filed against CO S.A. NYC DOC noted that CO E.S. was assigned to the Building 5 control post and failed to enter the housing area to conduct a count. Charges were filed against CO E.S.

220. On 6/19/22 at 11:00 p.m., CO S.A. documented that a count was completed on housing unit 5B with 44 living bodies noted. CO S.A. documented that a general supervisory tour was completed at 11:30 p.m. On 6/20/22 at 12:01 a.m., CO S.A. documented that a general supervisory tour was completed with nothing to report. At 12:30 a.m., CO S.A. documented that a general supervisory tour was completed and noted that multiple cells were unsecured, and that CO S.A. was awaiting the area supervisor due to incarcerated individuals refusing to lock in. At 12:45 a.m., CO S.A. documented that a medical emergency was called for Carrasquillo.

221. On 6/20/22 at 12:56 a.m., Carrasquillo was found on his cell floor unresponsive, and a medical response was called. DOC staff administered two doses of Narcan and initiated Cardiopulmonary Resuscitation (CPR). Medical staff arrived and at 12:57 a.m., [redacted]

[redacted] Emergency Medical Services (EMS) was activated. [redacted]

222. [redacted]

ACTIONS REQUIRED:

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 Carrasquillo was not seen by the medical provider on 10/1/19 for his low blood pressure.

2. Correctional Health Services shall conduct a quality assurance review to determine why Carrasquillo was not produced for three CIWA evaluations.

3. Correctional Health Services shall conduct a quality assurance review to determine why Carrasquillo was sent back to a housing area with no medical evaluation on 8/11/21 and why Carrasquillo was not seen again by staff until 8/27/21.

4. Correctional Health Services shall conduct a quality assurance review to determine why Carrasquillo was not referred to KEEP despite his request and evidence of Benzodiazepine use during his incarceration.

5. Correctional Health Services shall conduct a quality assurance review to determine if DOC was notified of the repeated instances of Carrasquillo's suspected drug use.

6. Correctional Health Services shall conduct a quality assurance review to determine why there were no records of the emergency room visit on 10/28/21.

7. Correctional Health Services shall conduct a quality assurance review to determine why Carrasquillo's appointments for psychiatric medication re-evaluation were cancelled by CHS on 12/24/19, 4/13/20, 8/22/20, 9/20/20, 11/9/20, 12/2/20, 12/17/20, and 1/5/21.

8. Correctional Health Services shall conduct a quality assurance review to determine why Carrasquillo was not seen by mental health or referred to C-71 during a potential acute psychiatric episode on 9/8/21.

9. Correctional Health Services shall conduct a quality assurance review to determine why Carrasquillo was not followed up by psychiatric providers for an over 17 month period between January 2021 and June 2022.

10. Correctional Health Services shall conduct a quality assurance review to determine why multiple observed and documented incidents of altered mental status with Carrasquillo

were not referred to medical for assessment including a referral to be sent to the hospital on 10/28/21.

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, Correctional Health Services indicated the requested reviews were completed. Corrective actions were not indicated as being needed by CHS. The Medical Review Board remains affirmed in its findings.

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

1. The Commissioner shall conduct an investigation into why there were no Reportable Incident submitted for the assaults on Carrasquillo in comportment with 9 NYCRR §7022.2(a).

2. The Commissioner shall conduct an investigation into the failure of DOC staff to produce Carrasquillo for multiple sick call appointments, providers appointments and medication distribution during his 33 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.

3. The Commissioner shall conduct an investigation into the failure of DOC staff to address illicit substance use on the housing units.

4. The Commissioner shall conduct an investigation into the disruption of medical care resulting in shortened appointments.

5. The Commissioner shall conduct an investigation into the failure to maintain adequate staffing to provide escorts to mental health appointments.

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

In a response to the Commissions preliminary report dated 8/19/24, NYC DOC indicated that the requested investigations would be conducted. However the Medical Review Board was not provided with results of those investigations nor the reasons to the cited failures occurred.

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
2022-M-0071
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
Executive Director
NYC Board of Correction