NEW YORK STATE | Commission of Correction

Final Report of the New York State Commission of Correction:

In the Matter of the Death of

Teddy Love (22R0934), an incarcerated individual of the Great Meadow Correctional Facility

September 25, 2024

To: Honorable Daniel F. Martuscello, III
Commissioner
NYS Department of Corrections
And Community Supervision
The Harriman State Campus
1220 Washington Avenue
Albany, New York 12226

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 Teddy Love, who died on September 20, 2022, while an incarcerated individual in the custody of the NYS Department of Corrections and Community Supervision at the Great Meadow Correctional Facility, the Commission has determined that the following final report be issued.

FINDINGS:

1. Teddy Love was a 43-year-old male who died on 9/20/22 from a Cardiac Tamponade due to a rupture of a dissecting thoracic aortic aneurysm while in the custody of the New York State Department of Corrections and Community Supervision (NYS DOCCS) at the Great Meadow Correctional Facility (CF).

2. [redacted] In the instant offense, on 12/16/20, Love followed the victim in his car as she walked along the street. Love walked up behind the victim, tugged at her purse as she held on, pushed her to the ground and began dragging the victim along the ground. Love punched the victim in the face until she let go of her purse. Love was convicted of Robbery 2nd Degree and sentenced to eight years in DOCCS.

3. [redacted]

4. On 5/3/22, Love was received at Ulster CF. [redacted]

5. [redacted]

6. [redacted]

7. On 5/27/22, Love transferred to Great Meadow CF. [redacted].

8. [redacted].

9. [redacted] The Medical Review Board opines that Love should have been followed up earlier than December given his uncontrolled Hypertension and noted medication noncompliance with an abnormal EKG.

10. [redacted]

11. On 9/20/22 at 4:30 a.m., [redacted] Per the housing logbook, Love returned to the housing unit at 5:05 a.m.

12. [redacted] MS arrived at 7:22 a.m. [redacted]

[redacted]

13. Per the DOCCS Office of Special Investigations (OSI) final report: a review of the A-Block logbook from 9/15/22 to 9/20/22 and the pipe rounds on 9/21/22 from 12:00 a.m. until 5:30 a.m. revealed that Corrections Officer (CO) K.V. and all correction officers assigned to A-Block, during the aforementioned time period, failed to follow Directive 4091 Logbooks, Section III, Letter J, when they did not specifically document the gallery in which rounds were made, and the name of the staff member who conducted the rounds of the galleries on A-block. Additionally, logbook documentation, pipe rounds tracker, and previous OSI Internal Affairs investigations have revealed a commonality at Great Meadow Correctional Facility that security rounds were not being conducted between 10:00 p.m. and 12:00 a.m. Corrective Action was taken in December 2022 by Superintendent C.C. Correction Supervisors were advised to notify line staff and ensure security pipe rounds were conducted beginning at 11:00 p.m. on all companies. Additionally, correction staff were advised to document in the Block-logbooks the name of the staff who conducted the round, the time, and the company location where a security round was conducted. This matter was referred to the Bureau of Labor Relations (BLR). BLR indicated there would be no additional action taken outside of the corrective action taken by Superintendent C.C. and the updated memorandum issued by Deputy Commissioner J.N. regarding quality rounds.

14. Per the DOCCS Office of Special Investigations (OSI) final report: Corrective Action by Health Services recommended that Health Services should ensure that provider orders are obtained, and appropriately written, for finger stick glucose and intravenous prior to completion as directed by Health Services Policy Manual (HSPM) 1.16 Administering Medications and HSPM 3.02 Medication Orders Within DOCCS Facilities. It also indicated that nursing staff is required to complete and document a head-to-toe assessment during an emergency medical encounter as well as reassess abnormal vital signs as directed by HSPM 1.34 Sick Call and HSPM 4.06 Infirmary Records. Additionally, the Superintendent/Deputy Superintendent of Health Services were to have Health Services Administrative Staff develop a Quality Improvement Project/Corrective Action Plan related to improve in the following areas: complete physical assessments and repeat abnormal vital signs during medical encounters.

ACTIONS REQUIRED:

TO THE DEPUTY COMMISSIONER OF THE NYS DEPARTMENT OF CORRECTIONS AND COMMUNITY SUPERVISION, DIVISION OF HEALTH SERVICES:

The Deputy Commissioner shall convene a comprehensive quality assurance review on the health care provided to Love related to his Hypertension and abnormal electrocardiogram.

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

In a response dated 8/1/24 to the Commission's preliminary report, Deputy Commissioner for Health Services indicated that the requested review was completed.

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-0105
September 25, 2024

cc: Dr. Carol Moores, Deputy Commissioner Chief Medical Officer
James Donahue, Associate Commissioner of Mental Health
Superintendent Christopher Collins, Great Meadow CF