



**Commission of
Correction**

**Final Report of the
New York State Commission of Correction:**

**In the Matter of the Special Investigation into the Care and Treatment
Provided to**

**Tomas Cario,
an incarcerated individual of the
Anna M. Kross Center**

December 18, 2024

**To: Commissioner Lynelle Maginley-Diddie
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)(e), regarding the care and treatment provided to Tomas Cario, which occurred while an incarcerated individual in the custody of the NYC Department of Correction, the Commission has determined that the following final report be issued.

FINDINGS:

1. Tomas Cario was a 48-year-old male who died on 3/9/21 from a suicidal compression of the neck that resulted in an anoxic brain injury after suffering a cardiac arrest while in the custody of the New York City of the Department of Corrections (NYC DOC) at the Anna M. Kross Center (AMKC). Cario had forced his head through a cell door access slot which caused compression on his neck. 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 the holding cells post in the Mental Health Clinic at the time of the terminal event. Additionally, the Medical Review Board has found there were serious deficiencies in Cario's mental health care and psychiatric care from the providers at Correctional Health Services.

2. [REDACTED]

3. [REDACTED]

On 8/7/20, Cario was arrested for Attempted Assault of a Police Officer/Fireman/EMT, Attempted Assault 2nd Degree, Attempted Assault 3rd Degree, and Attempted Harassment 2nd Degree. On 8/12/20, Cario was arraigned on the charges of Assault 1st Degree, two counts of Assault 2nd Degree, Assault 3rd Degree, Criminal Obstruction of Breathing, Menacing 3rd Degree, and Harassment 2nd Degree and these charges were abated by his death.

4. On 8/14/20, Cario was received at NYC DOC. [REDACTED]

[REDACTED]

[REDACTED] Cario was unprovoked when he placed a staff member in a chokehold and repeatedly hit him in the face, seriously injuring the staff member's eye. On 8/12/20, Cario was arraigned. On 8/14/20, Cario was [REDACTED] to NYC DOC

[REDACTED]

[REDACTED] The Medical Review Board opines that Cario was still a danger to self and others and was in need of long term secure forensic hospitalization.

5.

[REDACTED]

6.

[REDACTED]

[REDACTED]

The Medical Review Board opines that Cario's extensive mental health history should have prompted placement into one of NYC DOC's mental health observation housing units and was not properly classified per requirements of 9 NYCRR §7013.8(c)(3) & (e)(4,5) which state the following:

(c) In arriving at a determination of each inmate's housing assignment, the chief administrative officer shall base his/her decision on the following information, if such information is available and accessible to the chief administrative officer: (3) history of medical/mental illness.

(e) In considering the information contained in subdivision (c) of this section, the chief administrative officer shall examine and verify the following: (4) information obtained from mental health treatment providers pursuant to Mental Hygiene Law, section 33.13(c)(9); (5) information contained in the detailed summaries of inmate medical and psychiatric records if disclosed by the facility medical director pursuant to section 7013.10 of this Part and sections 7064.7, 7064.8 and 7064.9 of this Chapter

7. [REDACTED]

8. [REDACTED]

9. [REDACTED]

10. [REDACTED]

11. On 8/18/20, Cario's was not produced by DOC staff [REDACTED]

12. [REDACTED]

13. [REDACTED]

14. [REDACTED]

15. On 8/22/20, Cario was not produced by DOC staff [REDACTED]

16. [REDACTED]

17. On 8/24/20 at 12:28 p.m., Cario was not produced by DOC staff [REDACTED]

18. [REDACTED]

19. On 8/25/20 at 4:06 p.m., Cario was not produced by DOC staff [REDACTED]

20. [REDACTED]

21. [REDACTED]

22. [REDACTED]

23. [REDACTED]

24. [REDACTED]

[REDACTED]

25. [REDACTED]

26. [REDACTED]

27. [REDACTED]

28. [REDACTED]

29. [REDACTED]

30. [REDACTED]

31. [REDACTED]

32. [REDACTED]

33. [REDACTED]

34. On 9/17/20, per DOC staff on the housing area, Cario refused to come to the clinic for his [REDACTED] appointment.

35. [REDACTED]

Review Board opines that the reported swallowing of an object would have been done with intention by Cario and should have prompted an immediate referral to psychiatry from the medical provider.

36. [REDACTED]

37. [REDACTED]

38. On 10/8/20 at 5:01 a.m., a medical emergency was called for Cario who appeared to be choking, coughing, and shaking. [REDACTED]

39. [REDACTED]

40.

[REDACTED]

41.

[REDACTED]

42.

[REDACTED]

43.

[REDACTED]

44.

[REDACTED]

45.

[REDACTED]

46.

[REDACTED]

[REDACTED]

47.

[REDACTED]

48.

[REDACTED]

49.

[REDACTED]

The Medical Review Board finds that there was improper diagnosis and management by the CHS psychiatric providers. Cairo was discontinued from the anti-psychotic therapy of Zyprexa after only one week and given a new diagnosis of Opioid Induced Depressive Disorder despite having a well-documented history of Schizophrenia.

50.

[REDACTED]

51.

[REDACTED]

52.

[REDACTED]

[REDACTED]

53.

[REDACTED]

The Medical Review Board has found there was an overall lack of coordination by CHS in Cairo's mental health care. Within 30 days, Cairo had three different psychiatric diagnoses including Schizophrenia, Opioid Induced Depressive Disorder, and Adjustment Disorder with Mixed Anxiety and Depressed Mood from three different providers all who prescribed different therapies.

54.

[REDACTED]

55.

[REDACTED]

56.

[REDACTED]

57.

[REDACTED]

58.

[REDACTED]

59.

[REDACTED]

This was a previous medication order that the Medical Review Board found was discontinued for Cairo after only 7 days of therapy in October 2020. A medication that the Board opines was necessary to be consistently prescribed and taken in order to manage Cairo's established psychosis.

[REDACTED]

60.

[REDACTED]

61.

[REDACTED]

62.

[REDACTED]

63.

[REDACTED]

64.

[REDACTED]

65. [REDACTED]

66. [REDACTED]

67. [REDACTED]

68. [REDACTED]

69. [REDACTED]

70. [REDACTED]

71. [REDACTED]

72. [REDACTED]

73. [REDACTED]

74. [REDACTED]

[REDACTED]

75.

[REDACTED]

76.

[REDACTED]

77.

[REDACTED]

A review of Commission records revealed that there was no reportable incident related to this event which is in violation of 9 NYCRR §7022.2(b) which states: *Each facility shall report incidents to the commission pursuant to the requirements outlined in the commission's Reportable Incident Guidelines for County Correctional Facilities*

78.

[REDACTED]

79.

[REDACTED]

[REDACTED]

80.

[REDACTED]

81.

[REDACTED]

82. On 2/16/21, 2/18/21, 2/19/21, 2/20/21, 2/21/21, 2/22/21, 2/24/21, and 2/25/21, Cario was not produced by DOC staff [REDACTED]. DOC staff indicated that Cario refused the appointments on 2/20/21 and 2/24/21.

83.

[REDACTED]

84.

[REDACTED]

85.

[REDACTED]

86.

On 2/26/21, Cario was not produced by DOC staff [REDACTED]

87.

[REDACTED]

88.

On 2/27/21, 2/28/21, 3/1/21, and 3/2/21, Cario was not produced by DOC staff [REDACTED]

89.

[REDACTED]

- [REDACTED]
90. [REDACTED]
91. On 3/3/21, Cario was released from NYC DOC's custody while he was admitted to Elmhurst Hospital. [REDACTED]
92. A review of the Gentech camera per NYC DOC's closing report which was dated 3/3/20 (sic) indicated that :
- On 3/2/21 at 11:35 a.m., Cario was secured in holding pen #4 at Hart's Island Clinic.
 - At 12:14 p.m., Cario was given a lunch tray.
 - At 1:14 p.m., (Correction Officer) CO H.T. entered the area and conversed with Cario.
 - At 6:37 p.m., another incarcerated individual opened the food slot to give Cario a piece of candy. The incarcerated individual retrieved Cario's dinner tray. The incarcerated individual then gave Cario an open carton of an unknown liquid and walked away.
 - At 6:43 p.m., Cario drank from a container and became fidgety and uneasy.
 - At 6:53 p.m., Cario stuck his head through the food slot on the cell door.
 - At 6:57 p.m., Cario knelt down in front of the cuffing port with his legs extended out behind him.
 - At 7:02 p.m., the last movement of Cario's body was seen.
 - At 7:13 p.m., Cario was discovered stuck in the cuffing port by the officer. A medical response was called.
 - At 7:15 p.m., DOC staff were able to release Cario and there was a small amount of blood outside the cell. CPR was initiated and the AED was applied.
 - At 7:20 p.m., EMS was activated and arrived at 7:37 p.m.
 - At 7:58 p.m., a return of spontaneous circulation was achieved, and EMS departed the facility at 8:11 p.m. enroute to Elmhurst Hospital.
93. A review of the Hart's Island [REDACTED] A post logbook revealed:
- On 3/1/21 at 11:00 p.m., CO L., CO Z., and CO C. assumed the post.

At 12:00 p.m., operations were notified that there was no on-call psychiatric provider on post.

General supervisory tours were completed every 30 minutes until 7:00 a.m. CO Z. signed off post.

At 7:00 a.m., CO G. assumed the A post, CO F. and CO L. assumed the post.

At 8:00 a.m., Enhanced Supervision Incarcerated Individuals F. and M. had no Enhanced Supervision Officer (ESO) assigned to them.

At 1:10 p.m., the control room was notified of a three-hour mental health run for two individuals. No further entries were made.

At 3:00 p.m., CO G. assumed the A post, CO V. assumed the B post and CO R. assumed the ESO post. General supervision tours were made every 30 minutes until 11:00 p.m.

On 3/2/21 at 11:00 p.m., CO G. assumed the A post, CO S. assumed the B post and CO T. assumed the Security 1 post. Active supervision tours were completed every 30 minutes until 7:00 a.m.

At 7:00 a.m., CO G. assumed the A post, CO T. assumed the B post and CO H. assumed a post.

At 2:45 p.m., the control room was notified of a three-hour mental health run for two individuals.

Active supervision tours were documented every 30 minutes.

At 3:00 p.m., CO G. assumed the A post. There were no other officers noted in the logbook. There was no documentation in the logbook to indicate the number of persons housed in the clinic holding area at that time. Active supervision was documented at 3:30 p.m., 4:00 p.m., and 4:30 p.m.

At 4:50 p.m., Assistant Deputy Warden (ADW) H. toured the unit.

At 5:00 p.m., operations were notified that they were still awaiting a "psych doctor" and operations stated that a "psych doctor" should be on their way. Active supervision tour.

At 5:20 p.m., a captain toured the unit.

At 5:30 p.m., one individual was escorted out to intake for discharge. Active supervision tour completed.

At 5:45 p.m., one individual was sent to Bellevue.

Active supervision was documented at 6:00 p.m., 6:30 p.m., and 7:00 p.m.

At 7:01 p.m., CO G. noted that there was no B post officer and that the captain was notified.

At 7:20 p.m., a medication emergency was called for Cario.

The logbook indicated that Cario was placed in the cell "PT" and was seen by "█".

94. A review of the Hart's Island Clinic logbook revealed:

On 3/1/21 at 7:00 a.m., CO C. assumed the A post. There were no officers listed for B post or the "Sec 1" post. Active supervision was documented every 30 minutes until 3:00 p.m.

At 3:00 p.m., CO L. assumed the A post and CO K. assumed the Security 1 post. There was no documentation of a B post officer. The B post officer is responsible for conducting visual inspections and active supervisory tours of the area. Active supervision was completed every 30 minutes until 10:30 p.m.

On 3/2/21 at 7:00 a.m., CO C. assumed the A post and CO S. assumed the Security post.

95. A review of the 9MOD C post logbook revealed:

On 3/2/21 at 10:09 a.m., CO A. noted that Cario was experiencing erratic behaviors and Hart's Island was notified. Cario was sent to Hart's Island.

96. A review of the 9Mod A post logbook revealed:

On 3/2/21 at 2:00 a.m., Cario was at the bubble window requesting his medication. Cario was advised that it was 2:00 a.m. and that medications were given on the 7:00 a.m. to 3:00 p.m. tour.

At 3:00 a.m., a mental health referral was generated for Cario.

At 8:43 a.m., Cario was out to the pharmacy window.

At 10:20 a.m., Cario was out to Hart's Island.

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

The Medical Review Board also finds that the facility failed to ensure that proper population counts were conducted as there was no documentation indicating the number of incarcerated individuals in the clinic holding area. This a violation of 9 NYCRR §7003.5(a) and (b) 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.

(b) 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.

Additionally, the Medical Review Board finds that due to the abandonment of the B post officer, the facility failed to comport with the requirements of 9 NYCRR §7003.2 (c) which states:

Active supervision shall mean the immediate availability to prisoners of facility staff responsible for the care and custody of such prisoners which shall include:

(1) uninterrupted ability to communicate orally with and respond to each prisoner unaided by any electronic or other artificial amplifying device; and

(2) the conducting of supervisory visits at 30-minute intervals;

(3) the ability of staff to immediately respond to emergency situations; and

(4) in any facility housing area in which more than 20 inmates are housed, the continuous occupation of a security post within such housing area.

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 and supervised in comportment with 9 NYCRR §7003.3(a) and 9 NYCRR §7003.2(c) and why population counts were not properly completed in accordance with 9 NYCRR §7003.5 (a) and (b). Administrative action should be taken if staff are found to be in violation of department directives.
2. The Commissioner shall conduct an investigation as to why there was no reportable incident submitted for Cario on 12/28/20 in comportment with 9 NYCRR §7022.2(b).
3. The Commissioner shall review Cario's classification in compliance with 9 NYCRR §7013.8(c)(3) & (e)(4,5) as to why he was not referred to mental observation housing after admission into NYC DOC.

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

In a response dated 12/2/24 to the Commission's preliminary report NYC DOC indicated that the requested investigations were completed with corrective actions taken. The Commission will further review the corrective actions taken at a later scheduled evaluation.

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

1. Correctional Health Services shall conduct a quality assurance review regarding why Cario was not considered for mental health observation housing upon his admission given his extensive mental health history and recent hospital discharge.
2. Correctional Health Services shall conduct a quality assurance review to determine why Cario was not started on Zyprexa upon his admission to NYC DOC despite it being part of his hospital discharge orders.
3. Correctional Health Services shall conduct a quality assurance review regarding why Cario had his diagnosis of Schizophrenia changed and his antipsychotic therapy stopped after one week despite having a known history of psychosis.
4. Correctional Health Services shall conduct a quality assurance review of Cario's psychiatric care noting the multiple changes in diagnoses and therapies within 30 days by multiple psychiatric providers.

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

In a response dated 11/14/24 to the Commission's preliminary report, Correctional Health Services indicated that that requested reviews were completed with corrective actions taken.

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 18th day of December 2024.



Yolanda Canty
Commissioner
Commission of Correction

YC:DC:vc
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