



**Commission of
Correction**

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

In the Matter of the Death of

**Gilberto Garcia
an incarcerated individual of the
Anna M. Kross Center**

December 18, 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

7. [REDACTED]

8. [REDACTED]

9. [REDACTED]

10. [REDACTED]

11. On 11/8/19, Garcia was at court [REDACTED].

12. [REDACTED]

13. On 11/11/19 and 11/16/19, Garcia was not produced by DOC staff [REDACTED].

14. [REDACTED]

15. [REDACTED]

16. [REDACTED]

17. [REDACTED]

18. On 1/18/20, Garcia was not produced by DOC staff [REDACTED].

19. [REDACTED]

20. [REDACTED]

21. [REDACTED]

22. [REDACTED]

23. On 2/3/20, Garcia was not produced by DOC staff [REDACTED].

24. [REDACTED]

25. [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]
- 40. [REDACTED]
- 41. [REDACTED]
- 42. [REDACTED]
- 43. [REDACTED]

44. [REDACTED]

45. [REDACTED]

46. [REDACTED]

47. [REDACTED]

48. [REDACTED]

49. [REDACTED]

50. [REDACTED]

51. [REDACTED]

52. [REDACTED]

53. [REDACTED]

54. [REDACTED]

55. [REDACTED]

56. [REDACTED]

57. On 9/2/20, Garcia [REDACTED] following a fire in his cell. Garcia declined the examination. A review of the records by the Commission revealed that there was no reportable incident completed for this incident. This is a violation of 9 NYCRR §7022.2(a) which reads: *The following general categories of incidents shall be reported to the commission pursuant to the requirements of this Part (14) fires.*

58. [REDACTED]

59. [REDACTED]

60. [REDACTED]

61. On 9/11/20 at 9:48 a.m., Garcia requested to be seen by medical for complaints of having chest pain and mild dizziness. Garcia was instructed to inform the DOC officer in his housing area. The charge nurse was made aware of Garcia's complaints. At 8:17 p.m., there were several requests made by medical staff to DOC staff to bring Garcia to the clinic to be seen. Garcia had not been produced by DOC staff. The nurse was told by DOC staff that Garcia was in intake and was to be brought to the clinic, but he tried to "hold the floor" (refused to comply with direction) and was placed back in the cell. [REDACTED]

[REDACTED] The Captain was notified to bring Garcia to the main clinic. Garcia had not been produced. Operations was notified that Garcia had not been produced. [REDACTED]

62. [REDACTED]

63. [REDACTED]

64. [REDACTED]

65. [REDACTED]

66. [REDACTED]

67. [REDACTED]

68. [REDACTED] A review of records by the Commission revealed that there was no reportable incident for this. This is a violation of 9 NYCRR §7022.2(a).

69. On 10/26/20, Garcia was not produced by DOC staff [REDACTED]

70. [REDACTED]

71. On 11/3/2020, Garcia was not produced by DOC staff [REDACTED]

72. [REDACTED]

73. On 11/9/2020, 11/12/2020, 11/13/20, and 11/18/20, Garcia was not produced by DOC staff [REDACTED].

74. [REDACTED]

75. [REDACTED]

76. [REDACTED]

77. [REDACTED]

78. [REDACTED]

79. [REDACTED] On 1/4/21, Garcia was not produced by DOC staff [REDACTED].

80. [REDACTED]

81. [REDACTED]

82. [REDACTED]

83. On 1/19/21, Garcia was not produced by DOC staff [REDACTED] because Garcia was out to court.

84. [REDACTED]

85. On 1/26/21, Garcia was not produced by DOC staff [REDACTED]
[REDACTED]
[REDACTED] On 2/8/21, Garcia was not produced [REDACTED]

86. [REDACTED]
[REDACTED]

87. On 2/23/21, Garcia was not produced by DOC staff [REDACTED]
[REDACTED]

88. [REDACTED]
[REDACTED]

89. On 3/9/21, Garcia was not produced by DOC staff [REDACTED]
[REDACTED]

90. [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

91. [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

92. [REDACTED]
[REDACTED]

93. [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

94. [REDACTED]
[REDACTED]

95. [REDACTED]
[REDACTED]

96. [REDACTED]

97. On 6/2/21, a reportable incident was generated for Garcia. In the mailroom, the officer found mail which was intended for Garcia that tested positive for synthetic marijuana/K2.

98. [REDACTED]

99. [REDACTED]

100. [REDACTED]

101. [REDACTED]

102. On 8/31/21, a reportable incident was generated for Garcia. Per the reportable incident, a search of Garcia's cell revealed that moist paper was found inside a Bible which tested positive for Fentanyl.

103. On 9/19/21 and 9/28/21, Garcia was not produced by DOC staff [REDACTED]

104. [REDACTED]

105. [REDACTED]

106. [REDACTED]

107. [REDACTED] A review of Garcia's records by the Medical Review Board did not indicate that Garcia was ever appropriately provided with the requested psychiatric referral. Additionally the Board opined that although suicide was not Garcia's known manner of death, his encounter with mental health on 12/6/21 was significant and required further follow up.
108. On 12/7/21, Garcia was not produced by DOC staff [REDACTED].
109. [REDACTED]. On 12/11/21, three times on 12/12/21, 12/14/21, and 12/26/21, Garcia was not produced by DOC staff [REDACTED].
110. On 1/3/22, Garcia was not produced by DOC staff [REDACTED].
[REDACTED]
111. On 3/3/22, Garcia was not produced by DOC staff [REDACTED].
[REDACTED]
112. On 4/22/22, Garcia was not produced by DOC staff [REDACTED].
113. On 7/7/22, a reportable incident was generated for Garcia after a search of the housing unit located 10.2 grams of Marijuana under Garcia's bunk.
114. On 7/29/22 and 8/3/22, Garcia was not produced by DOC staff [REDACTED].
[REDACTED] A review of the records revealed that Garcia had not been produced for his mental health callouts for five months. The Medical Review Board finds that the repeated failures to produce Garcia for mental health appointments by DOC staff are unacceptable. Additionally, the reason that Garcia was on "enhanced restraint" status indicating a higher security level is needed does not justify denying Garcia's access to mental health care. If the escorting or movement of an individual to an area for a mental health appointment cannot be accomplished due to security risks, then alternative methods in order for the individual to access care must be provided.

115. [REDACTED]

116. [REDACTED]

117. [REDACTED]

118. [REDACTED]

119. [REDACTED]

120. On 8/24/22, Garcia was not produced [REDACTED] as he was “holding up the floor”. Garcia was out of his cell threatening and being aggressive. Garcia reported that he was going to start a fire. The DOC staff were able to de-escalate the situation.

121. [REDACTED]

122. [REDACTED]

123. On 8/26/22, Garcia was not produced by DOC staff [REDACTED]

124. [REDACTED]

125. [REDACTED]

126. [REDACTED]

127. [REDACTED]

128. [REDACTED]

129. [REDACTED]

130. On 8/30/22, Garcia was not produced by DOC staff [REDACTED]

131. On 8/30/22, 8/31/22, 9/2/22, 9/3/22, 9/6/22, 9/12/22, and 9/13/22, Garcia was not produced by DOC staff [REDACTED]. On 9/9/22, Garcia was not produced by DOC staff [REDACTED] and the officer reported that Garcia was in hand restraints. The Medical Review Board finds that NYC DOC failed to produce Garcia eight times for a medical appointment. The Medical Review Board finds that the repeated pattern of failing to produce individuals for scheduled appointments is an unacceptable practice and is tantamount to denying incarcerated individuals access to health care.

132. [REDACTED]

133. [REDACTED]

134. [REDACTED]

On 10/31/22 at 11:50 a.m., CO S.R. noted that maintenance was on post.

On 10/31/22 at 11:56 a.m., a captain toured the area.

On 10/31/22 at 12:00 p.m., CO S.R. noted that a standing count was completed with a count of 27.

On 10/31/22, at 12:20 p.m., a medical emergency was called.

138. The NYC DOC closing report noted that CO S.R. and Captain G. were charged with multiple department violations. CO S.R. did not make adequate supervisory tours and did not assure living breathing bodies. Captain G. did not make adequate supervisory tours and failed to look in all the cells.

139.

[REDACTED]

ACTIONS REQUIRED:

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

1. The Commissioner shall conduct an investigation as to why there was no reportable incident submitted related to Garcia on 9/2/20 and 10/25/20. in comportment with 9 NYCRR §7022.2(a).
2. The Commissioner shall conduct an investigation as to why the correction officer assigned to the housing area was unable to enter a cell to render emergency care and necessitating an incarcerated individual to have to assist with resuscitation measures
3. The Commissioner shall conduct an investigation into the failure to maintain adequate staffing.
4. The Commissioner shall conduct an investigation as to why Garcia was not produced for his CIWA evaluations, his mental health callouts, and his radiology appointments. The Commissioner must immediately initiate efforts to cease the practice of not producing an individual for any all scheduled medical and mental health appointments absent a facility-wide emergency.

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

In a response dated 12/3/24 to the Commission's preliminary report, NYC DOC indicate that the requested investigations were completed with corrective and administrative actions taken. The corrective action(s) taken be subject to further review by the Commission as 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 to determine why Garcia's stat mental health referral was not completed for 5 days.
2. Correctional Health Services shall conduct a quality assurance review to determine why Garcia's x-ray was not completed for 60 days.
3. Correctional Health Services shall conduct a quality assurance review to determine why Garcia's mental health referral was not completed for 90 days.
4. Correctional Health Services shall conduct a quality assurance review to determine why Garcia was not assessed for suicide risk and or self-harm at his 12/6/21 clinical encounter.
5. Correctional Health Services shall conduct a quality assurance review to determine why the referral to psychiatry at the 12/6/21 clinical encounter was not completed.

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

In a response dated 11/14/24 to the Commission's preliminary report, Correctional Health Services indicated that the requested reviews were completed. Corrective actions taken will be subject to further verification by the Commission at a later scheduled evaluation.

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
2022-M-0121
December 18, 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
Chief Medical Officer
Correctional Health Services
Executive Director
NYC Board of Correction