

NEW YORK STATE COMMISSION OF CORRECTION

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In the Matter of the Death :  
of Aris Hiraldo, an inmate of :  
the George R. Vierno Center :  
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FINAL REPORT OF THE  
NEW YORK STATE COMMISSION  
OF CORRECTION

TO: Commissioner Dora Schriro  
NYC Department of Correction  
75-20 Astoria Blvd, Ste. 100  
East Elmhurst, NY 11370

## 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 Aris Hiraldo who died on February 3, 2011 while an inmate in the custody of the NYC Department of Correction at the George R. Vierno Center, the Commission has determined that the following final report be issued.

FINDINGS:

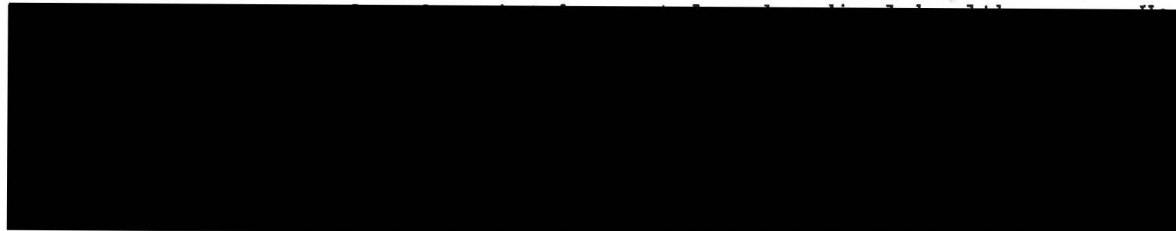
1. Aris Hiraldo was a 24 year old Hispanic male who died on 2/3/11 at 11:22 a.m. from a suicidal hanging while in the custody of the NYC Department of Correction (NYCDOC) at the George R. Vierno Center (GRVC). At 10:25 a.m., Hiraldo was found hanging in his cell by two correction officers after they observed and removed a sheet from his cell window. While incarcerated in the NYCDOC, Hiraldo was under the medical and mental health care of Corizon, Inc., a business corporation holding itself out as a medical care provider.

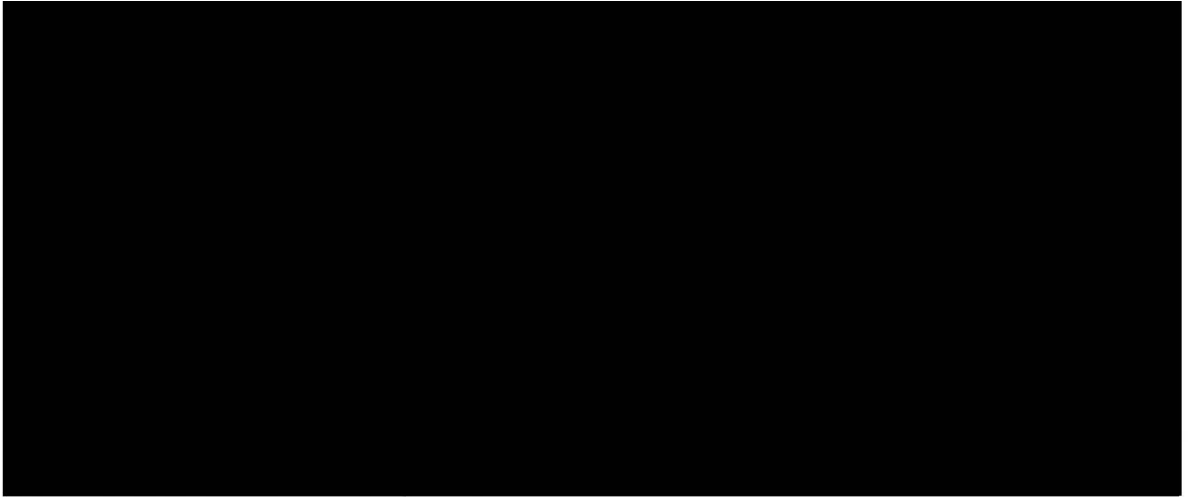
2.



3. On 12/7/10, Hiraldo was admitted to the custody of NYCDOC at the Queens Criminal Court. He was arraigned on an Assault 2<sup>nd</sup> charge with bail set at \$10,000 cash or bond. He was additionally charged with a violation of parole. On 12/7/10 at 7:56 p.m., Officer W. completed a Suicide Prevention Screening Form giving Hiraldo a score of one. This was for an affirmative answer to the question: "Inmate has a history of drug or alcohol abuse." The officer listed comments of "alcohol" and "appears OK."

4. On 12/8/10, Hiraldo was transferred to the Vernon C. Bain Center (VCBC)

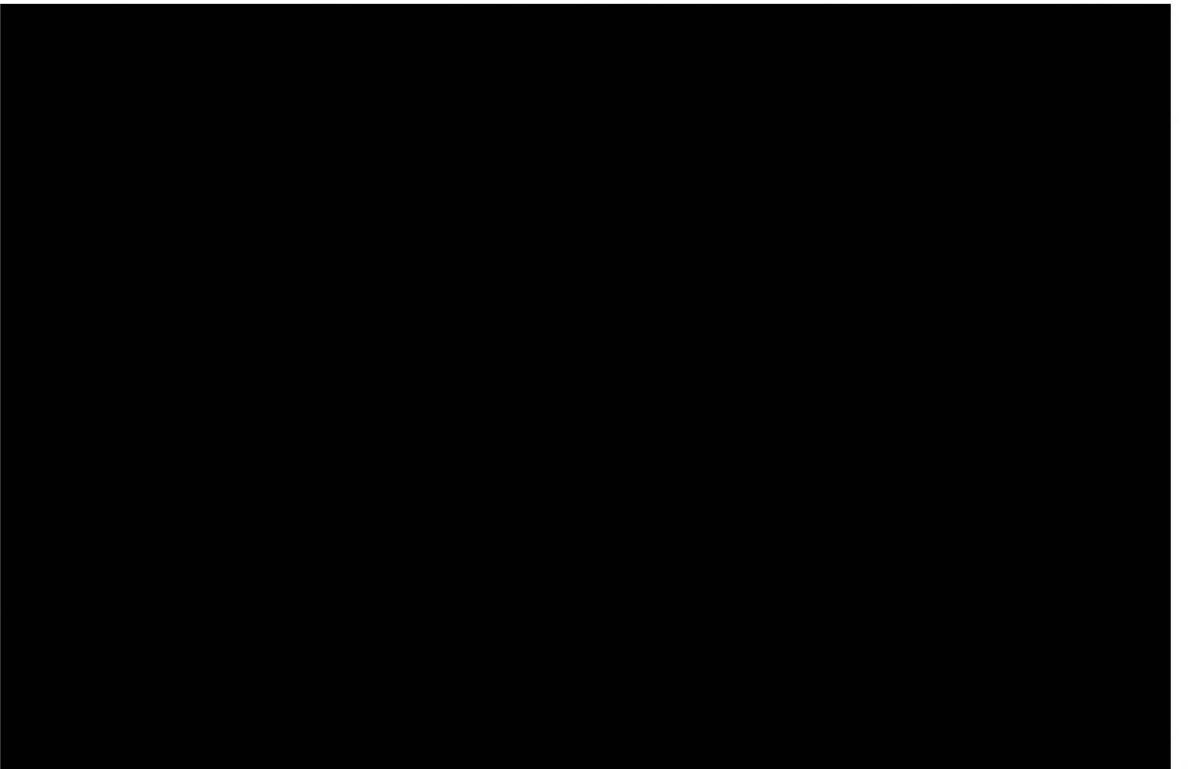




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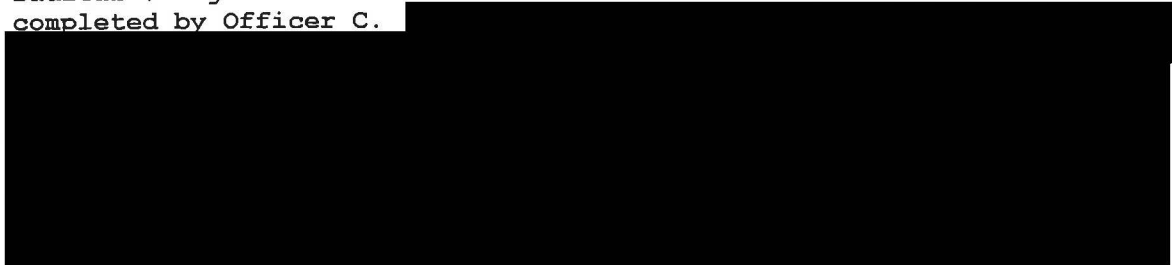


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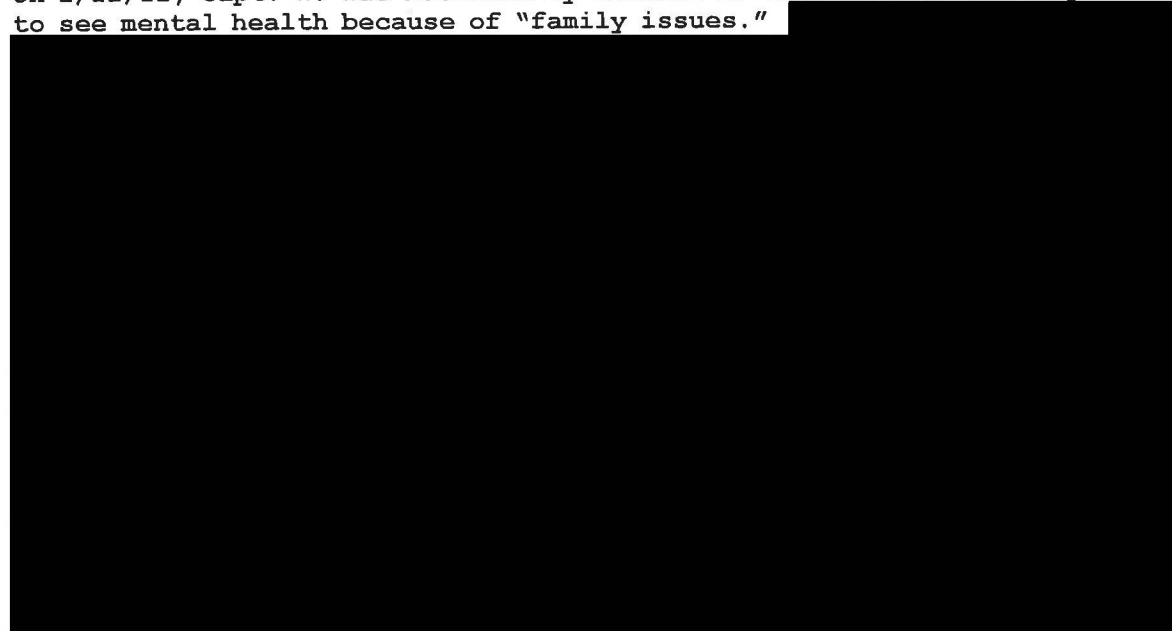


7. On 12/15/10, Hiraldo was transferred from VCBC to GRVC and on 12/16/10, he was placed in GRVC General Population cell housing. On 12/27/10 at 3:00 p.m., Hiraldo was observed by security staff going from cell to cell when he was ordered to return to his cell for lock-in for the count. He ignored the officer who ordered him back to his cell. Hiraldo received a disciplinary ticket for his actions and was placed in GRVC, Bldg. 13 in punitive segregated cell #17 as a disciplinary sanction for not following a direct order. Hiraldo was given 22 days of punitive housing placement in GRVC.

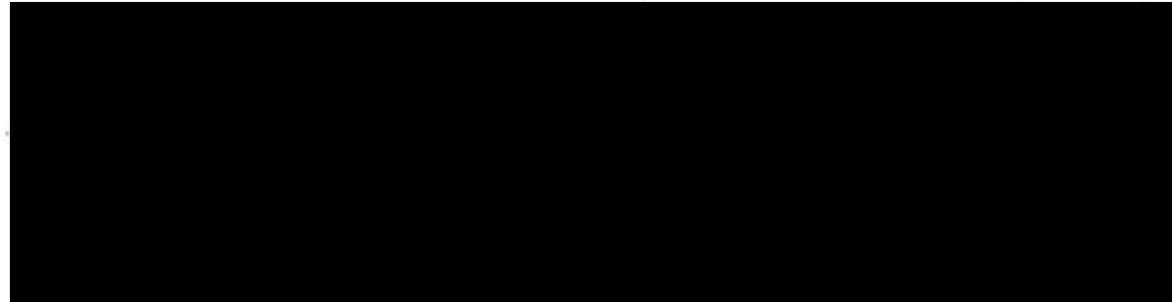
8. On 1/7/11, Capt. L. was notified by Officer C. that Hiraldo was complaining he was unable to sleep, was depressed, and had demonstrated a radical change in his behavior. A mental health referral for Hiraldo was completed by Officer C.



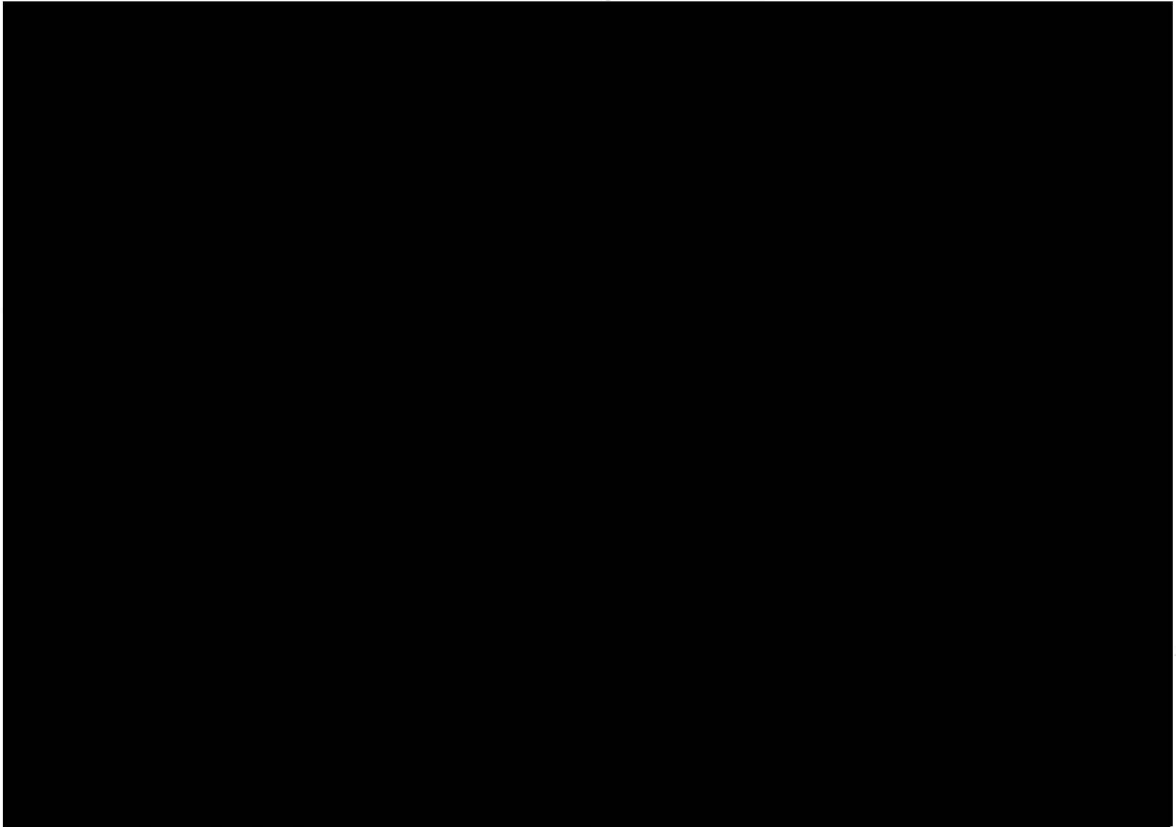
9. On 1/11/11, Capt. W. was notified by Officer L. that Hiraldo had requested to see mental health because of "family issues."



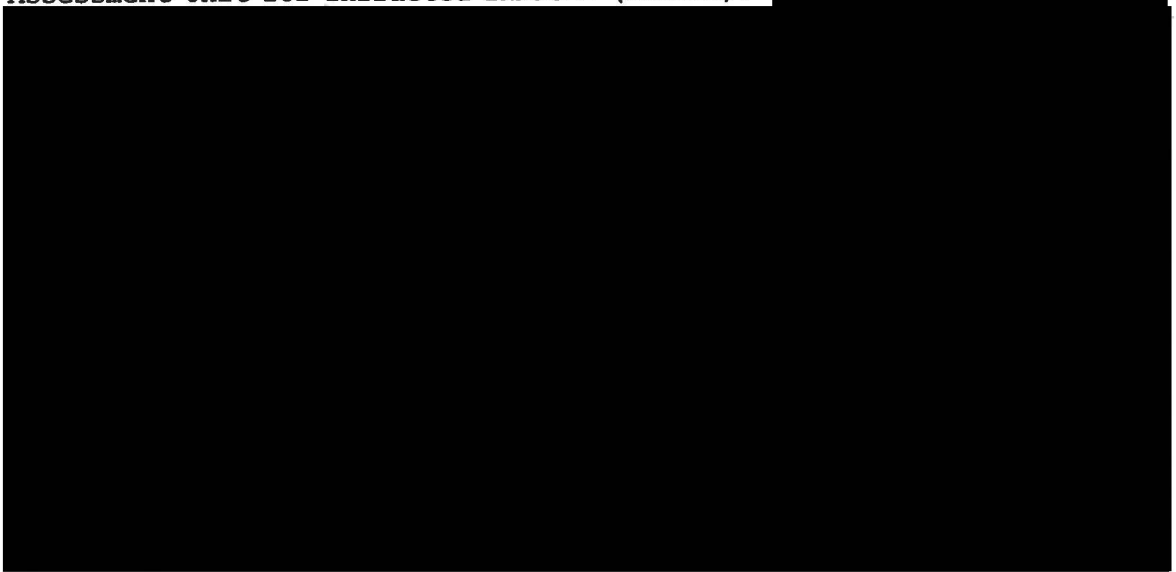
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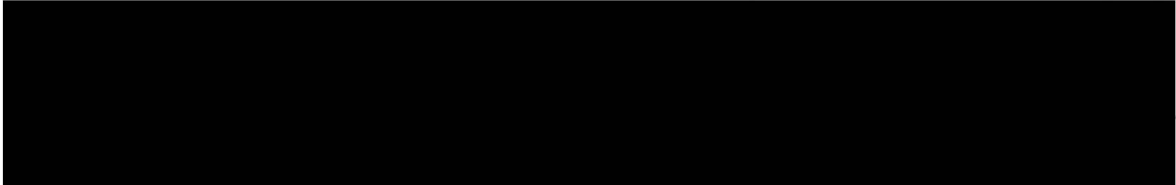
11.



12. On 1/19/11, Hiraldo was placed in GRVC Bldg. 11, B unit, the Mental health Assessment Unit for Infracted Inmates (MHAUII).



13.



[REDACTED]

14.

[REDACTED]

15.

[REDACTED]

16.

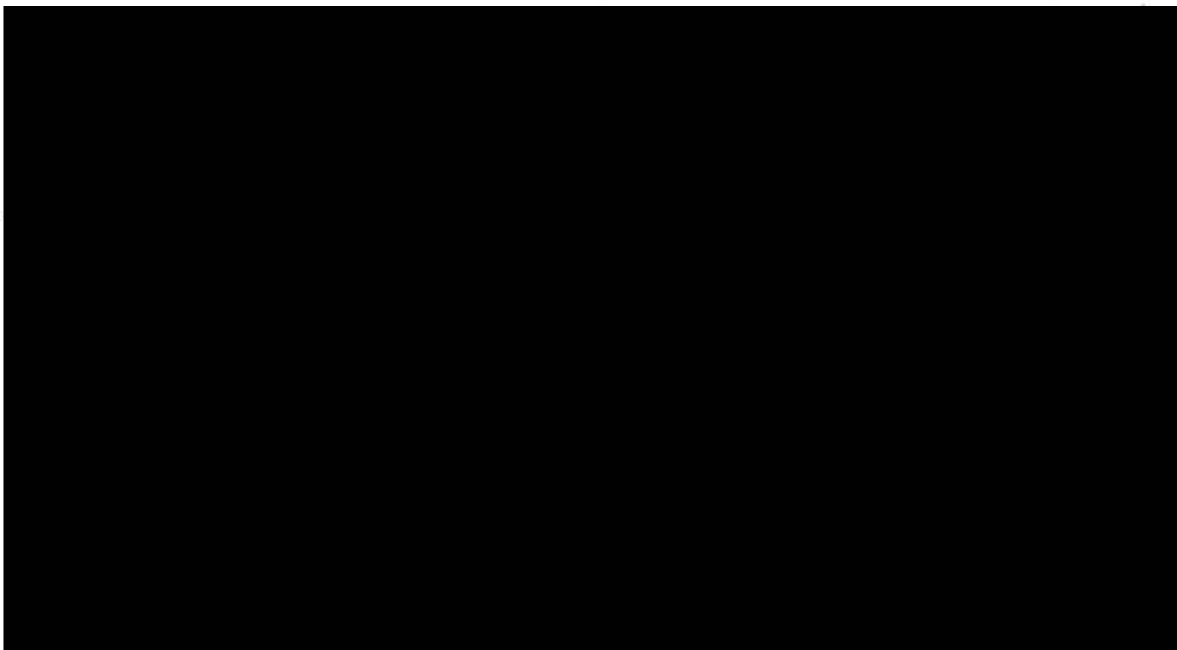
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17.

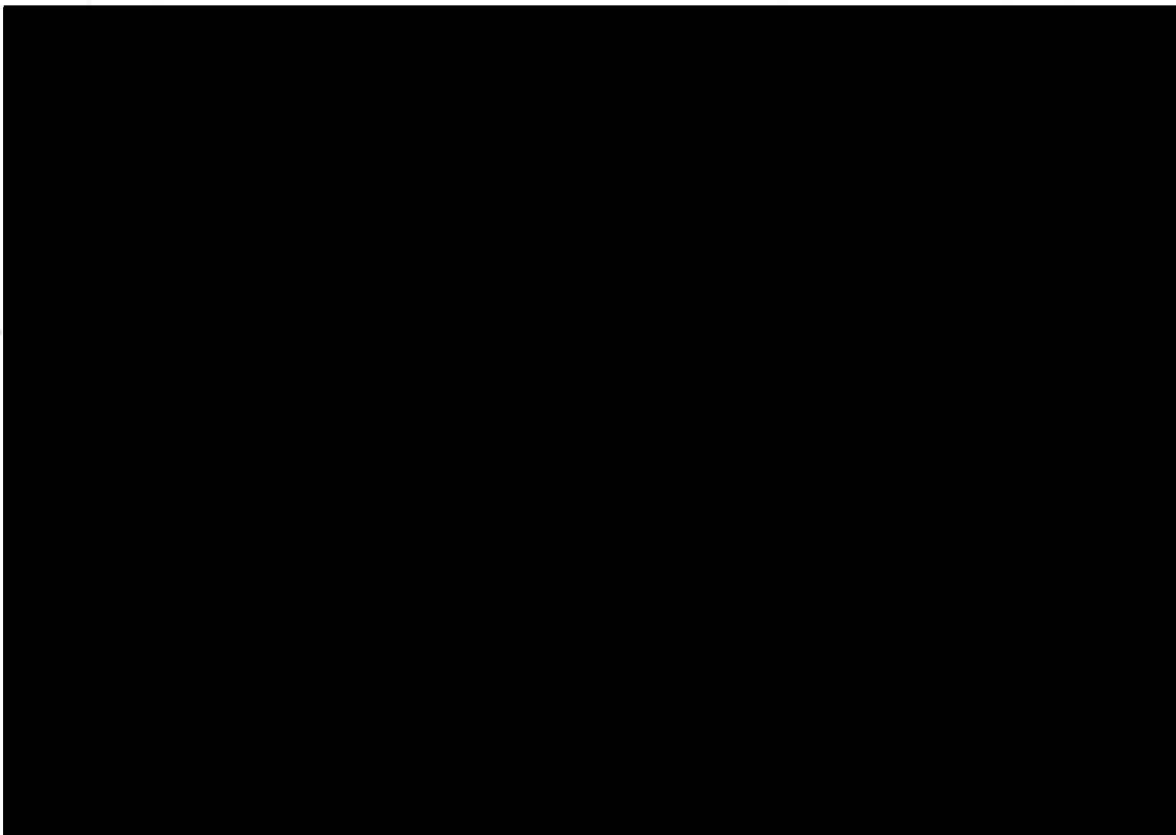
[REDACTED]

18.

[REDACTED]



19.



Presently the pharmacy technicians' practice in New York State is not regulated by license or certification by the NYS Department of Education.

20.



- [REDACTED]
21. On 2/3/11 at approximately 10:25 a.m., Officers J.J. and E.F. were en route to another cell when they observed that the window of Hiraldo's cell door was covered with a sheet. Both officers ordered Hiraldo to uncover his door window to which he did not respond. Officer J.J. opened the door slot and removed the sheet. Both officers stated that they observed Hiraldo standing upright against the back cell wall suspended. Hiraldo was unresponsive. Officer J.J. called to Officer O.J., escort officer, to have Officer T.U., the control officer, open Hiraldo's cell. Officer O.J. did instruct Officer T.U. to complete such. When the cell door was opened, Officers J.J. and E.F. stated they entered the cell. Officer E.F. held up Hiraldo's body and Officer J.J. cut the nylon-type drawstring from the water sprinkler and from Hiraldo's neck. This drawstring matched the material used for inmates' sweat pants. Officer O.J. arrived and cut the ligature from Hiraldo's neck. Officer J.J. stated he immediately began chest compressions on Hiraldo. Officer E.F. obtained and applied the AED. The AED ordered CPR which was continued by Officers E.F. and J.J. Capt. S.D. arrived on the scene and ordered the officers to let PA N.P. in the cell where he assumed CPR.
- [REDACTED]

[REDACTED] A suicide note was later found in Hiraldo's cell to notify his mother and girlfriend in the event of his demise.

22. According to NYCDOC documentation completed by T.M., Forensic Investigator, following Hiraldo's suicide, it was discovered that his nylon sweat pants drawstring was attached to the overhead fire sprinkler water pipe instead of the actual sprinkler head itself. The sprinkler head itself is designed to be difficult to attach anything to it and will break off if more than 40 pounds of weight is applied to it. The end of the water pipe the sprinkler is attached to usually has a metal plate (a.k.a. escutcheon plate) covering it to make it flush against the cell wall. This escutcheon plate covers the water supply pipe to make its access almost impossible. However in this case, the escutcheon plate was tampered with exposing the water pipe. Hiraldo tied the ligature to the small exposed water pipe, not the sprinkler itself. It was reported to the Commission that NYCDOC has replaced the escutcheon plates in GRVC to a new version.

RECOMMENDATIONS:

TO THE DEPUTY COMMISSIONER, DIVISION OF HEALTH CARE ACCESS AND IMPROVEMENT, NYC DEPARTMENT OF HEALTH AND MENTAL HYGIENE AND THE DIRECTOR OF THE NYS HEALTH AND HOSPITAL CORPORATION:

1. The Deputy Commissioner should inquire into Corizon Health's fitness to conduct prescription medication administration and directly observed therapy with needed psychotropic medications at Rikers Island. Specifically, the Division should inquire into the current medication delivery/administration credentialing and qualification system used by Corizon Health, Inc. focusing attention on the use of pharmacy technicians



in directly observed therapy and other medication administration, generally recognized a nursing care function.

2. The Deputy Commissioner should direct NYC Department of Health and Mental Hygiene mental health clinicians employed at the Vernon C. Bain Center to review inmates' admission/screening documentation, specifically in the areas of mental health and social history prior to the completion of a mental health referral.

WITNESS, HONORABLE PHYLLIS HARRISON-ROSS, M.D., Commissioner, NYS Commission of Correction, Alfred E. Smith State Office Building, 80 South Swan Street, 12<sup>th</sup> Floor, in the City of Albany, New York 12210 this 17<sup>th</sup> day of April, 2012.

  
Phyllis Harrison-Ross, M.D.  
Commissioner

PH-R:mj  
11-M-12  
12/11

cc: Eric Berliner, Executive Director  
of Health Services  
Thomas Bergdall, General Counsel  
Sara Taylor, Chief of Staff  
Amanda Parsons, Deputy Commissioner  
Correctional Health Services, NYC  
Department of Health & Mental Hygiene  
George Axelrod, Deputy Executive Director,  
NYC Department of Health & Mental Hygiene  
Homer Venters, Assistant Commissioner