NEW YORK STATE COMMISSION OF CORRECTION

In the Matter of the Death of David Mercado, an inmate of the Queens Court Division	: : : : :	FINAL REPORT OF THE NEW YORK STATE COMMISSION OF CORRECTION

TO: Commissioner Martin Horn
NYC Department of Correction
33 Beaver Street
New York, New York 10004

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 David Mercado who died on December 30, 2007 while an inmate in the custody of the NYC Department of Correction at the Queens Court Division, the Commission has determined that the following final report be issued.

FINDINGS:

1. David Mercado was a 17 year old Hispanic male who died on 12/30/07 from acute hypoxic ischemic encephalopathy due to suicidal hanging on 12/20/07 at the Robert N. Davoren Center (RNDC) while in the custody of the NYC Department of Correction (NYCDOC). Mercado was afforded inadequate mental health evaluation and treatment by Prison Health Services, Inc. (PHS, Inc.), a business corporation holding itself out as a medical care provider.

2. [redacted]

3. In the instant offense, Mercado was arrested on 12/18/07 and charged with Sexual Misconduct. He was arraigned in Queens County Court, held on $2500 cash bail/bond and remanded to the NYCDOC. The judge during arraignment submitted a request for a mental health evaluation documenting, "Defendant's attorney says the defendant is depressed and suicidal."

4. [redacted]

5. Following arraignment, Mercado was admitted to the NYCDOC at the Queens Court Division (QCD) where his Suicide Prevention Screening Form was completed on 12/19/07 at 12:49 a.m. by Officer K.R. There are multiple contradictions recorded on the Suicide Prevention Screening Guidelines completed at the QCD.

6. On the screening form, question #1, Officer K.R. marked both "yes" and "no" responses for "Police or transporting officer believes that the inmate may be a suicidal risk." All other responses are marked "no," scoring Mercado's risk as a zero, even though the judge and his attorney had identified him as a suicide risk.

7. The medical/mental health referral area is marked with both yes and no responses and the non-emergency mental health box is marked rather than emergency mental health.

8. Officer K.R. stated that she did not interpret the judge's securing order as the same as a suicide risk as defined in question #1 and thus it was "corrected" when the captain reviewed the sheet, as well as entry of the conflicting information in the referral area.

9. The supervising captain, Captain M. was notified and responded to the area. The captain reported that Mercado was "visibly depressed." In the section for Officer's comments/impressions, the captain wrote "Security Order Suicide Alert Watch." The captain enacted constant supervision on Mercado and reported that a suicide watch sheet was initiated. The captain also prepared a mental health referral marking Mercado as being depressed and under a court ordered suicide watch. The "Action" box of the guidelines was marked as "no" by Officer K.R. for both "supervisor notified" and "constant supervision instituted," even though both of these actions occurred.

10. The captain stated during interview that an assigned officer and the watch sheet would remain with Mercado at Queens Court Division and throughout his transport to RNDC. At RNDC, an assigned officer would remain with Mercado throughout his processing. The department was unable to produce the suicide watch sheet.

11. On 12/19/07, Mercado arrived at RNDC at approximately 4:00 a.m. and began his admission process at approximately 4:30 a.m. [redacted]

12. [redacted]

13. [redacted]

14. [redacted]

15. [redacted]

[redacted]

16. [redacted] According to Directive 4521, Suicide Prevention, the TNF form is forwarded to the tour commander and movement control. Mercado was not moved to a cell.

17. Mercado returned to the Receiving Room and at approximately 5:55 p.m. was escorted to Modular 1 South Housing Unit, a dormitory housing area. Officer T.R. stated that Mercado looked depressed when he arrived in the housing area and his partner was keeping an eye on him. Officer T.R. stated that he was unaware that Mercado had been discontinued from constant supervision or that he was to be transferred to a cell.

18. At approximately 6:20 p.m., Assistant Deputy Warden M.M. was touring the Modular 1 housing area, along with Officer H. who was assigned Modular 1 South Meal Relief, when they observed Mercado who appeared to be depressed. When Officers B.D. and T.R. returned to their posts, ADW M.M. instructed them to generate a Referral of Inmate to Mental Health Form #4018R and contact their area supervisor. Captain L.H. was notified and instructed Officer T.R. to have Mercado seen by mental health. NYCDOC has been unable to produce this mental health referral form. According to interviews, the form was marked as "depressed" with no supervisor assessment and recommendation. Also, Captain L.H. failed to make any entries in the Control Room Mental Health log book and failed to follow up on the status of the mental health referral. This is a violation of NYCDOC Directive 4018, Referral of Inmates to Mental Health Services, which states in part:

> Upon receiving notification that an inmate may be in need of Mental Health Services, the area supervisor shall ascertain the urgency of the situation and take appropriate action.
>
> The supervisor's assessment of the referral and the disposition of handling same can be carried out by giving oral instruction to the reporting officer or by promptly responding to the area concerned. The assessment should include interviewing the subject (if feasible), the officer, and any other appropriate parties. In any event, the supervisor shall complete the lower part of the form #4018R.
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> After submitting the form, the supervisor shall make the appropriate entries in the Mental Health Referral Logbook.

19. [redacted]

[redacted]

20. [redacted] This is a violation of NYCDOC Operations Order, Escort and Delivery of Inmates to Mental Health Services Staff, which states in part that: "all correctional facilities effect the timely and complete escort and delivery of inmates to mental health services upon request of mental health services staff." The Commission was informed that escort officers are frequently not available when they are requested.

21. Officer R.G. stated that he handed the mental health referral to P.J., Unit Chief, and that P.J. informed Officer R.G. that Mercado would be seen the next day. Mercado was returned to his housing area.

22. Officer R.G. failed to make any log entries in the mental health clinic log of Mercado's arrival and departure from the mental health clinic.

23. Officer T.R. stated that Mercado returned to his housing area 20 minutes after he had left for the Mental Health Clinic. When questioned by Officer T.R. about his return, he stated that he was going to see the psychiatrist in the morning. Mercado then proceeded to his bunk and appeared to fall asleep.

24. On 12/20/07, Officer V.C. and Officer C.B. were assigned to the Modular South 1 "A" and "C" posts respectively on the 11:00 p.m.-7:30 a.m. tour. Inmate interviews reported that Mercado was pacing during the night, wrapping a sheet around his arm. They claimed that Mercado went back to his bunk when he noticed the observation aide watching him. The Commission was unable to substantiate this information.

25. In addition to officers, inmate observation aides are posted twenty-four hours, seven days a week, in designated areas of the RNDC, including Modular South 1, to monitor those inmates believed to be at high risk for suicide or to help identify behaviors not previously recognized by staff.

26. Officer V.C. and Officer C.B. assigned to the Modular South 1 "A" and "C" posts respectively on the 11:00 p.m.-7:30 a.m. tour allowed the midnight Observation Aide to leave without a relief being present or without notifying their supervisor. This is a direct violation of NYCDOC Directive 4017R, Inmate Observation Aide Program, that states in part:

> "The Inmate Observation Aide Program shall be maintained twenty-four hours, seven days a week, in each designated area of the facility.
>
> Observation Aides shall be assigned to all special housing areas where the entire population has been placed under observation. These areas include: New Admission housing areas.
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> The Housing area "A" Post Officer shall:
> --Ensure that the Observation Aides who are scheduled to work are on the post and performing the prescribed duties.

--Notify the Housing Area Captain of any Observation Aide who cannot perform the prescribed duties.
--Make appropriate entries in the Housing Area Logbook.

The Correction Officer assigned to the security post shall:
-Ensure that the Observation Aide(s) is performing the prescribed duties."

27. On 12/20/07, Officer K.F. was assigned to the Modular 1 "C" post for the 7:00 a.m.-3:30 p.m. tour. Officer K.F. stated that at approximately 7:30 a.m. she conducted a tour of inspection and the institutional count and was logging her entries in the log book when Mercado got up and went into the bathroom. Soon thereafter, she observed inmate C.B. get up and go into the bathroom. A short while later, inmate C.B. came out of the bathroom and informed Officer K.F. that there was an inmate in the bathroom trying to hang himself. Officer K.F. rushed into the bathroom and observed Mercado hanging from a sheet tied to the ceiling vent in the last stall of the bathroom. She then notified the "A" post officer, Officer C.B., and returned to the bathroom. Using her 911 cut down tool, Officer K.F. cut Mercado down and started chest compressions until medical staff arrived.

28. [redacted]

29. On 12/21/07, Mercado was released on his own recognizance from the NYC Department of Correction, remaining at Elmhurst Hospital where he expired on December 30, 2007.

30. Following Mercado's suicide, his co-defendant A.C. provided Captain K. with a statement as to his insight into Mercado's actions. He stated that Mercado was very depressed after being arrested. He reported that he was able to talk to Mercado in the medical clinic while undergoing the Admission Process and Mercado expressed that he was very sorry for getting him (A.C.) arrested. A.C. stated that in September he and Mercado had a sexual encounter with a female that they thought was seventeen years old but who actually was fourteen years old. Inmate A.C. stated that Mercado said he wanted to kill himself, and then everyone would know that A.C. was innocent. When questioned as to why he did not notify anyone, he sated, "I thought he was joking so I didn't tell anyone."

The State Commission of Correction's Medical Review Board has reviewed a number of suicide deaths under circumstances wherein the deceased told someone that he or she may attempt or commit suicide. This information is not reported to jail officials in many cases.

It has been determined that inmates in temporary mental health crises may act impulsively in a suicidal manner even though they are not necessarily determined to commit suicide. Intervention allows time for the crisis to pass.

RECOMMENDATIONS:

TO THE COMMISSIONER OF THE NYC DEPARTMENT OF CORRECTION:

1. Administrative action should be taken against the officers who failed to follow NYCDOC Directive 4017R, Inmate Observation Aide Program and allowed the inmate observation aide to leave the housing area early on 12/20/07 without proper relief or notification of their supervisor.

2. Administrative action should be taken against the officer who failed to follow NYCDOC Operations Order, Escort and Delivery of Inmates to Mental Health Services Staff and sent Mercado to the Mental Health Clinic unescorted on 12/19/07.

3. Administrative action should be taken against the captain who on 12/19/07 failed to follow NYCDOC Directive 4018, Referral of Inmates to Mental Health Services.

4. The two hour block of annual Suicide Prevention Refresher Training should include a review of proper completion of the Suicide Prevention Screening Form. This is of particular importance for officers working in booking areas who conduct the majority of screening.

5. An inquiry should be conducted into why Mercado was not transferred to a cell [redacted]

6. An inquiry should be conducted into the records that NYCDOC was unable to locate and produce; specifically the Mental Health Referral Form generated at the Modular 1 housing area on 12/19/07 and the Suicide Watch Sheet generated at the Queens Court Division on 12/19/07.

7. The Commissioner should post information informing inmates and visitors to alert jail officials with reported suicidal ideation or other associated actions. This information should be posted in inmate rule books, jail lobbies, visiting rooms, inmate housing areas, booking areas, interview rooms, and any other area of your facility where inmates or visitors are permitted.

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

1. The Division should conduct an inquiry into the inadequate mental health evaluation and treatment provided to David Mercado by Prison Health Services, Inc. during his incarceration at RNDC.

2. The Division should conduct a review of the mental health staffing levels for RNDC to assure that adequate coverage is available to manage all routine and emergency mental health care.

3. As recommended by the Board in previous cases, the Deputy Commissioner should require that PHS, Inc.'s mental health staff be trained in the Local Forensic Crisis Service Model - Suicide Prevention and Crisis Intervention Program.

4. The Deputy Commissioner, in consultation with the Commissioner of Health, should ask the New York City Corporation Counsel's Office to inquire into

the status of PHS, Inc. to lawfully hold itself out as a medical care provider in New York State.

WITNESS, HONORABLE DANIEL L. STEWART, Commissioner, NYS Commission of Correction, 80 Wolf Road, 4th Floor, in the City of Albany, New York 12205 this 19th day of December, 2008.

Daniel L. Stewart
Commissioner

DLS:mj
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9/08

cc: Carolyn Thomas, Chief of Department
Roger Parris, Deputy Commissioner
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