NEW YORK STATE COMMISSION OF CORRECTION

In the Matter of the Death	:	FINAL REPORT OF THE
	:	NEW YORK STATE COMMISSION
of Oswald Livermore, an inmate	:	OF CORRECTION
of the Manhattan Detention Center:		
	:	

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 Oswald Livermore who died on May 11, 2007 while an inmate in the custody of the NYC Department of Correction at the Manhattan Detention Center, the Commission has determined that the following final report be delivered.

FINDINGS:

1. Oswald Livermore died from unrecognized and untreated acute alcohol withdrawal with delirium tremens on 5/11/07 while in the custody of the NYC Department of Correction (NYCDOC) at the Manhattan Detention Center (MDC). Livermore's death may have been prevented had he received timely medical diagnosis and treatment.

2. Livermore was born 1/1/56 in New York. He lived in New York, NY and did not reportedly have any children. His occupation and education level were unknown but he had served in the military at some point. [redacted]

3. [redacted]

4. At MDC, Livermore was under the medical care of Prison Health Services, Inc. (PHS, Inc.), a business corporation holding itself out as a medical care provider. [redacted]

5. Livermore was processed through Manhattan Criminal Court and delivered to NYCDOC at MDC on 5/9/07 at approximately 10:20 p.m. [redacted] PA J.M. failed to follow NYC Department of Health and Mental Hygiene's Management for Alcohol Withdrawal which states: *"For patients who report alcohol dependence, daily drinking, or those the clinician suspects may be undergoing alcohol withdrawal, an Alcohol Withdrawal Sheet should be generated."*

"Patients will be evaluated as being either minor or major alcohol abstinence syndrome. Every patient with alcohol withdrawal issues is to be placed in an infirmary setting."

[redacted]

6. Livermore remained in 7 West 90 throughout the day on 5/10/07 without incident. At approximately 10:00 p.m., he was referred to mental health by a correction officer due to displaying unusual and erratic behavior. [redacted]

7. [redacted]

8. Livermore was in a holding area awaiting an escort back to his housing area when he began displaying more erratic behavior. He was observed by Captain S.L. to be anxious, crying, and sweating, saying people were out to get him. She had asked him what day it was and Livermore could not give the correct date. Captain S.L. requested Livermore be returned immediately to the clinic for an evaluation.

9. [redacted]

10. [redacted]

11. Livermore returned to 7 West at approximately 1;10 a.m. Officer J.H. locked Livermore into cell #9 as he appeared okay at that time. Approximately five minutes later, Livermore began hitting and kicking his cell walls and door. He was yelling out that he couldn't stay in the cell and that he couldn't live in there. Officer J.H. went to Livermore's cell and instructed him to relay and that he would be contacting medical for him. Officer J.H. went back to notify his captain that he was having a problem with an inmate on the unit and that he was contacting the medical clinic.

12. Officer J.H. returned to Livermore's cell where Livermore was still kicking and banging on the door. Officer J.H. told Livermore that he was going to let him out of his cell and have him sit in a chair to wait for medical to come get him. Livermore exited the cell, ran down the staircase and then fell down the last few stairs landing in the day space. Officer J.H. got Livermore to sit down at the top of the lower stairwell. Livermore was acting more incoherent saying that the police were coming to get him and that they wanted to operate on his penis. Officer J.H., along with an inmate

suicide prevention aide (SPA), kept a hand on each shoulder so Livermore would remain still and await an escort to go to the clinic.

13. Area supervisor Captain S.S. arrived on the unit and observed Livermore sitting on the top step of the lower stairwell with Officer J.H. and the SPA each keeping a hand on his shoulders. She observed Livermore to be sweating profusely and saying incoherent statements such as "the police are after me, I want my mother, I don't want an operation." Captain S.S. called to have the probe team (response team) come and assist with escorting him and called the clinic to have them respond to the unit as well.

14. At approximately 1:30 a.m., Captain S.L. responded as the supervisor of the probe team, along with Officers A.G. and J.V. Upon arrival, they found Livermore still acting erratic. Captain S.L. talked to Livermore and asked him if he would calm down and stand up and they would escort him to the clinic. Livermore agreed, however, when he got to his feet, he suddenly ran to the back of the housing unit yelling "they're out to get me."

15. Captain S.L. ordered Officers A.G. and J.V. to secure Livermore. Officers A.G. and J.V. each took control of one of Livermore's arms and attempted to get Livermore to calm down. Livermore continued to resist and tried to pull away from the officers. Captain S.L. then ordered Livermore be taken to the ground and secured. Livermore was ordered to lie face down on the ground to which he complied. Captain S.L. then attempted to apply a pair of flexible handcuffs, however, Livermore continued to resist. As Captain S.L. finally secured Livermore's wrists in the handcuffs, he relaxed and was no longer resistant.

16. [redacted]

17. [redacted]

[redacted]

18. [redacted]

RECOMMENDATIONS:

TO THE COMMISSIONER OF THE NYC DEPARTMENT OF CORRECTION:

The Department should conduct a joint review with PHS, Inc. of the mental health referral process to see if improvements can be made as to how critical observations of the referring staff are communicated.

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 professional conduct of the PA who failed to follow policy for patients with histories of alcohol abuse. Administrative action should be taken if found to be in violation of operating policy.

2. The Division should conduct an inquiry into the professional conduct of the PA [redacted]

3. The division should conduct a joint review with NYCDOC of the mental health referral process to see if improvements can be made as to how critical observations of the referring staff are communicated.

4. 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.

5. 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
of Strategic Planning and Programs
Eric Berliner, Executive Director
of Health Services
Florence A. Hutner, General Counsel
Mark Cranston, Deputy Chief of Staff
Louise Cohen, Deputy Commissioner
Correctional Health Services, NYC
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