NEW YORK STATE COMMISSION OF CORRECTION

In the Matter of the Death of David Caban, an inmate of the the Anna M. Kross Center	: : : : :	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 David Caban who died on January 25, 2009 while an inmate in the custody of the NYC Department of Correction at the Anna M. Kross Center, the Commission has determined that the following final report be issued.

FINDINGS:

1. David Caban was a 38 year old Hispanic male who died on 1/25/09 while in the custody of the NYC Department of Correction (NYCDOC) at the Anna M. Kross Center (AMKC). Caban died from a sudden cardiac event while experiencing severe agitation due to acute psychosis. [redacted] Caban's inadequate psychiatric and medical care by Prison Health Services, Inc. (PHS), a business corporation holding itself out as a medical care provider, and inadequate supervision by the NYC Department of Correction were factors implicated in his death.

2. Caban was inappropriately discharged from treatment at the NYS Office of Mental Health's Bronx Psychiatric Center on 1/20/09 to be incarcerated on misdemeanor assault charges. Caban had been court-ordered to receive a CPL §730 Mental Health Examination and required continued hospitalization as he was a complex and refractory mental health clinical management case. The level of services available to him out-of-hospital at the NYC Department of Correction was not adequate for his needs. Had the court-ordered CPL §730 Mental Health Examination resulted in a Final Order, the criminal charges would have been vacated and Mr. Caban would have returned to the inpatient care of the NYS Office of Mental Health (OMH).

3. David Caban was born in Hoboken, NJ and raised in Manhattan, NY. Caban was the middle child of 4 brothers and 3 sisters. He was not married and had no children. He reported to have dropped out of school in the 11th grade. Caban often drifted between being homeless to living in community residence programs for the mentally ill.

4. Caban had no known prior criminal history. In May 2006, he assaulted a stranger in apparent response to his command hallucinations. In the instant offense, Caban was charged with Assault 3rd after he allegedly assaulted nursing staff and a

security officer on 12/29/08 at the Bronx Psychiatric Center's Transitional Living Residence.

5. [redacted]

6. [redacted]

7. [redacted]

8. [redacted]

9. [redacted]

10. [redacted]

11. [redacted]

[redacted]

12. [redacted]

13. [redacted]

14. [redacted]

15. [redacted]

16. [redacted]

17. [redacted]

18. [redacted]

[redacted]

19. On 1/20/09, Caban was taken by NYS Office of Mental Health (OMH) Safety Officers to the New York Police Department 49th Precinct for arrest processing. Caban was facing assault charges from one of the staff he attacked at the TLR on 12/29/08. David Caban was taken into police custody on 1/20/09 and screened by the FDNY EMS court section at 12:22 p.m. He was arraigned and remanded to the NYCDOC with an order for a CPL 730 Mental health Competency Exam to be done. Caban was received into custody by NYCDOC at the Bronx Court Detention Center at approximately 12:44 a.m. on 1/21/09. Due to his CPL 730 status, he was sent to AMKC - the C-71 Mental Health Observation Unit.

20. Caban arrived at AMKC reception at approximately 3:34 a.m. on 1/21/09. [redacted]

21. [redacted]

22. [redacted]

23. [redacted]

[redacted]

24. [redacted] A complex patient such as Caban should have required further consultation by NPP R.T. with Caban's primary psychiatrists prior to changing his established medication regimen.

25. Caban was housed in Modular 11 A, a mental health dormitory type housing on 1/22/09 by 1:05 p.m. On 1/23/09, he was moved over to Modular 12 B dormitory, bed #23. At approximately 2:30 a.m. on 1/23/09, Caban became highly agitated in the housing area. He was removed by correction officers and escorted down to the Hart's Island Medical Clinic (C-71's medical clinic). [redacted]

26. Dr. C.A., psychiatrist, failed to follow protocol for a patient with acute psychosis who required emergency medication therapy. [redacted] According to NYC Department of Health and Mental Hygiene, Correctional Health Services Policy on Psychiatric Emergencies, when IM medications are necessary to manage a patient's highly agitated behavior, the patient's vital signs need to be monitored every hour after administration until returned to the housing unit. Additionally, these patients should be highly considered for hospitalization. No vital signs were recorded on Caban nor was he considered for emergency hospitalization. Due to his failure to follow agency policy, Dr. C.A. was terminated by PHS,

Inc., and has been referred by his former employer to the Office of Professional Medical Conduct.

27. Caban remained in Mod 12 B dorm uneventfully through 1/24/09. On 1/25/09, Officer B.T. was assigned supervision of the dorm (B post) for the 11:00 p.m. to 7 a.m. tour. At approximately 2:30 a.m., Caban jumped up from his bunk and began running around the dormitory. Caban then charged at Officer B.T., pushing her desk back in the process. Officer B.T. yelled to the control room officer to get the captain, who was doing rounds on the 12 A dorm. An inmate suicide prevention aide got up from his post and attempted to hold Caban back and fell to the floor with him.

28. Captain M.K. was conducting rounds on Mod 12 A dorm when she heard a commotion coming from the B dorm. Captain M.K. responded and brought the 12 A dorm officer, J.R., with her. Captain M.K. and Officer J.R. found Caban highly agitated and fighting to get away from the inmate holding him. Caban did not respond to verbal orders from Officer J.R. to stop fighting so Captain M.K. ordered him to be secured in handcuffs.

29. Caban continued to struggle with Officer J.R. while he attempted to handcuff him. Caban continued to swing his arms, kicked at Captain M.K., and even grabbed at Officer B.T.'s keys. Captain M.K. requested the probe team to respond and Officer J.R. alerted them by pressing his personal body alarm. Finally, Officer J.R. was able to get Caban secured in a pair of handcuffs.

30. Probe team members arrived and escorted Caban down to the Hart's Island Medical Clinic. Caban was able to get to his feet and ambulate. Caban was not communicative with any of the officers and just made unintelligible grunting sounds. Caban was brought down to the clinic and placed in a holding cell area at approximately 2:46 a.m. A video recording of the Hart's Island Holding Pen confirms the chronology of events with Caban. Officer A.G. was assigned to Hart's Island A post. Officer A.G. advised the probe team captain against un-cuffing Caban due to his agitated behavior two nights earlier. Officer A.G. summoned Psychiatrist, Dr. T.B.

31. [redacted]

[redacted]

32. Dr. T.B. failed to initiate proper monitoring of a patient who was highly agitated and in mechanical restraints. The current NYC Department of Health and Mental Hygiene policy #MH21, Physical Restraint for Psychiatric Treatment Purpose, does not adequately address clinical responsibility for monitoring patients in therapeutic restraint. Additionally, the actions of the psychiatrist, nursing staff, and corrections staff, in addition to the provisions of policy #MH21, do not comport with the NYC Board of Correction Minimum Standards for Mental Health §2-06 Restraint and Seclusion (C) Procedures (2, 4(i)(ii)(iii) which state:

> *2. Physical restraint or seclusion may be used only upon the direct written order of a psychiatrist which includes the reasons for taking such action.*
>
> *4. An inmate put in restraints or seclusion shall be kept under constant observation and need for continued restrictive measures shall be assessed by nursing or mental health staff.*
>
> *(i) use of restraints shall be assessed every fifteen minutes and seclusion shall be reviewed every thirty minutes;*
> *(ii) written findings of such reviews shall be noted on the inmate's medical chart;*
> *(iii) vital signs (temperature, pulse, blood pressure and respiration) shall be recorded every hour.*

34. On the video recording of the holding cell area from 2:57 a.m. to 3:09 a.m., Caban is observed sitting up, on the floor, rocking back and forth, and kicking his feet out. At approximately 3:11 a.m., he is observed lying down on his back in the corner of the cell. At 3:18 a.m., he is observed to be moving his foot. By 3:22 a.m., he is no longer moving and appears to be unresponsive.

35. NYCDOC staff failed to initiate proper supervision of Caban. By 3:11 a.m., Caban was observed to be lying on his side in a fetal position in the holding cell. Caban was supervised by Officer A.B. and Officer M.R. No additional supervision orders were given for Caban. Per 9 NYCRR §7003.3(h) when a prisoner's condition warrants it, additional supervision shall be ordered. A prisoner in a highly agitated state due to acute mental illness who is in mechanical restraint clearly requires constant supervision.

36. NYCDOC staff failed to properly notify medical of a change in a prisoner's condition. At approximately 3:24 a.m., Captain M.K. entered the holding cell to take photos of Caban for the Use of

Force Report. Officer M.R. and Captain M.K. entered the holding pen and ordered Caban to sit up. Caban did not respond to the verbal commands. Captain M.K. "nudged" Caban with her foot and did not get any response. Officer M.R. stated he reached down and felt a carotid pulse on Caban. He then lifted Caban's shirt and stated he saw his chest rise and fall with breathing. Captain M.K. took four photographs of Caban's torso areas and then left the pen. Neither Captain M.K. nor Officer M.R. notified medical staff that Caban now appeared to be unresponsive.

37. At approximately 3:26 a.m., Officer D.H. reported to the Hart's Island Clinic as he was assigned to escort Caban to the hospital. Officers D.H. and M.R. entered the holding cell. Caban still lay on the floor, on his back, unresponsive. Officer M.R. once again stated he checked Caban's pulse and respirations. Officer D.H. decided he would wait to apply full restraints to Caban for transport until confirmed with the supervisor. NYCDOC staff again failed to notify medical staff that Caban now appeared to be unresponsive.

38. [redacted]

39. As Lt. D.M. was coming into the clinic, Officer A.G. entered the holding cell to help get Caban ready to be transported. Officer A.G. observed Caban lying on his back, eyes open, mouth open and did not appear to be breathing. Lt. D.M. then entered the cell to assess Caban. Officer A.G. did not immediately remove the handcuffs from Caban as he was not instructed to and did not have a key readily available. This is an inadequate security procedure for prisoners who have been ordered into restraint. Correction staff responsible for supervising prisoners in restraints must be immediately available and have the ability and authority to apply and remove the restraints at any moment.

40. [redacted]

41. [redacted]

[redacted]

42. [redacted]

RECOMMENDATIONS:

TO THE COMMISSIONER OF THE NYC DEPARTMENT OF CORRECTION:

1. The Department should conduct a policy and procedure review with the NYC Department of Health and Mental Hygiene to establish revised policy and procedures for the purpose of inmate therapeutic restraint. Specific items should include defining responsible authority for ordering restraint, proper supervision requirements, and responsible authority for removing restraints.

2. The Department should conduct a policy and procedure review for inmate supervision while in restraint. Specific items should include who is authorized to order restraint, officer's supervision requirements, documentation requirements, ability to remove restraints, and assuring proper equipment has been issued.

3. The Department should conduct a review of the captain and officers) who observed that Caban was unresponsive in the Hart's Island Clinic holding cell area and failed to properly notify medical staff of his condition. Disciplinary measures should be initiated if found to be in violation of department policy and procedure.

4. The Department should conduct a review of the officer(s) who were responsible for the supervision of the Hart's Island Clinic area who failed to recognize that they did not have a living, breathing prisoner inside the holding cell area. Disciplinary measures should be initiated if found to be in violation of department policy and procedure.

5. The Department should conduct a review of the supervisor (captain) of the Hart's Island Clinic post who failed to order additional supervision, in accordance with 9 NYCRR §7003.3(h) on an inmate who was in a highly agitated state, placed in restraints, and was at risk for self injury. Additionally, a comprehensive review of policy and procedure for inmate supervision in the Hart's Island Clinic should be conducted.

6. The Department should conduct a joint review with the NYC Department of Health and Mental Hygiene on the hospitalization referral process for court ordered CPL 730 mental health competency exams. Focus should be on why an inmate, [redacted] was not considered for immediate placement at the NYCDOC psychiatric prison ward at Bellevue Hospital.

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

1. The Division should conduct a policy and procedure review with the NYC Department of Correction to establish revised policy and procedures for the purpose of inmate therapeutic restraint. Specific items should include defining responsible authority for ordering restraint, proper supervision requirements, and responsible authority for removing restraints.

2. The Division should conduct a thorough review and revision of policy #MH21, Physical Restraint for Psychiatric Treatment Purpose. Specific items should include responsible authority for ordering restraint, appropriate clinical indications, length of time restraints may be applied, and responsibility for medical assessment prior to, during, and after the application of the restraints.

3. The Division should conduct a quality improvement review with the Psychiatric Nurse Practitioner who conducted the intake exam for Caban on 1/22/09. A focus should be on why a long standing and confirmed medication regimen was not continued for a highly complex psychiatric patient. Additionally, it should be reviewed why further consultation with Caban's primary psychiatrist was not pursued given his extensive history of difficulties in management.

4. The Division should conduct a joint review with the NYC Department of Correction on the hospitalization referral process for court ordered CPL 730 Mental health Competency exams. Focus should be on why an inmate [redacted] was not considered for immediate placement at the NYCDOC psychiatric prison ward at Bellevue Hospital.

TO THE NYS DEPARTMENT OF HEALTH, OFFICE OR PROFESSIONAL MEDICAL CONDUCT (OPMC):

Investigate the conduct of the psychiatrist, C.A., who on 1/23/09 exhibited gross negligence, gross incompetence and failure to make a medical record in that he failed to conduct a proper assessment of Caban prior to administering emergency anti-psychotic medication, failed to properly monitor the patient for medication efficacy, and failed to document an appropriate treatment plan.

TO THE NYS OFFICE OF MENTAL HEALTH, BUREAU OF FORENSIC SERVICES:

Conduct an internal review of Caban's care while a patient at the Bronx Psychiatric Center. [redacted]

WITNESS, HONORABLE PHYLLIS HARRISON-ROSS, M.D., Commissioner, NYS Commission of Correction, 80 Wolf Road, 4th Floor, in the City of Albany, New York 12205 this 18th day of December, 2009.

Phyllis Harrison-Ross, M.D.

Phyllis Harrison-Ross, M.D.
Commissioner

PHR:mj
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8/09

cc: Carolyn Thomas, Chief of Department
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