



**Commission of  
Correction**

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

**In the Matter of the Death of**

**Dante Taylor (16A3177),  
an inmate of the  
Wende Correctional Facility**

**September 29, 2020**

**To: Honorable Anthony Annucci  
Acting Commissioner  
NYS Department of Corrections  
And Community Supervision  
The Harriman State Campus  
1220 Washington Avenue  
Albany, New York 12226**

**Allen Riley**  
*Chairman*

**Thomas J. Loughren**  
*Commissioner*



10.



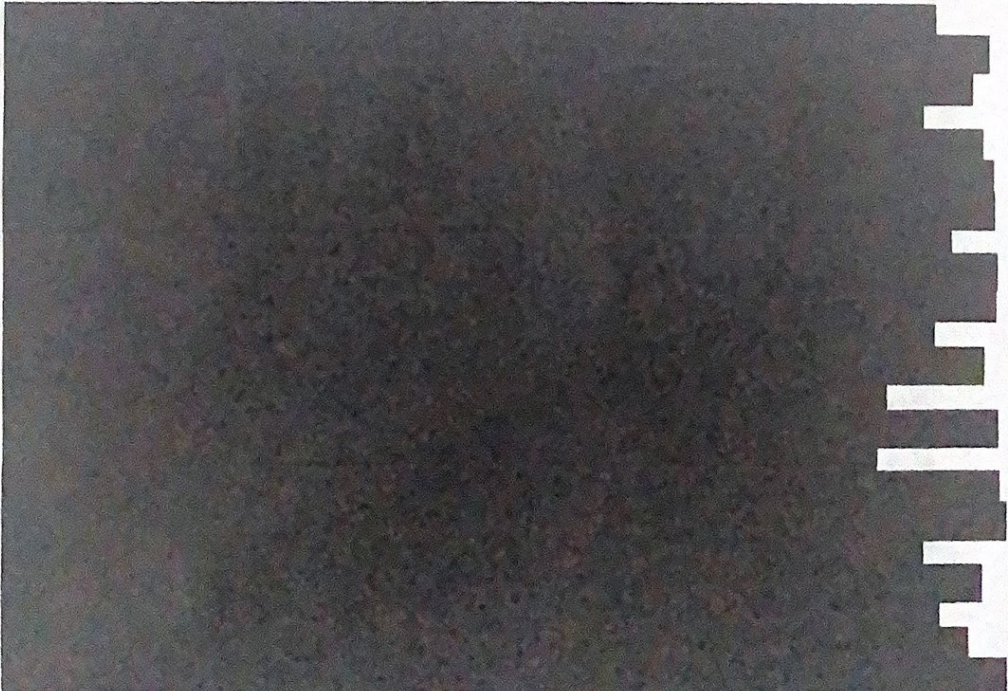
11.

The Medical Review Board finds that Taylor, a patient with an active mental health diagnosis, history of suicidal gestures, and taking prescribed psychotropic medication, was transferred to a new facility without his mental health records immediately available to the receiving facility.

12.

13.



25. 
26. Taylor had no medical encounters from 7/24/17 until 10/5/17. However, on 7/29/17, Taylor was not seen for sick call "per security" and there were no follow up notes on this entry.
27. On 8/4/17, Taylor was not seen for a medication evaluation due to being on keeplock. The Medical Review Board finds that there was a pattern of unspecified delays in Taylor's accessing mental health services due to being on keeplock, a status that warrants closer mental health attention.
28. 
29. On 9/1/17, the Hall Captain stated that Taylor refused his call out for his medication review. Taylor was rescheduled for 9/14/17.
30. 



[REDACTED]

The Medical Review Board finds that there was a pattern of medical, mental health, and security staff being aware of Taylor's substance abuse issues without any referral being made to an appropriate substance abuse program.

31.

[REDACTED]

32.

[REDACTED]

33.

On 10/5/17, a response was called to Taylor's cell at 12:16 p.m., because Taylor was disoriented and throwing water out of his cell. [REDACTED]

[REDACTED] During the removal of Taylor from his cell [REDACTED] Taylor was escorted off the unit to the infirmary and [REDACTED]

34.

[REDACTED]

35.

[REDACTED]



36.

37.

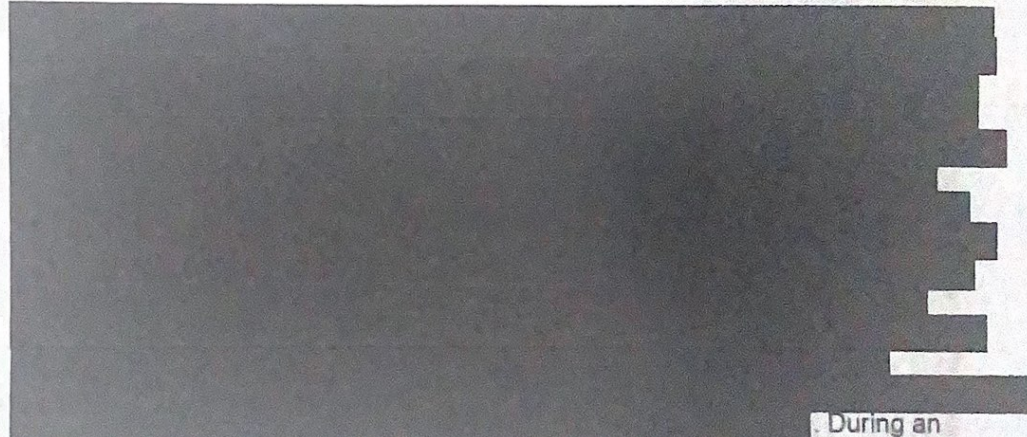
The Medical Review Board finds that the mental health staff failed to identify the need for Taylor to have his Comprehensive Suicide Risk Assessment updated following incidents which included the death of his grandfather, recent serious rule violations, and making threats of suicide as is indicated per Corrections Based Operations Manual Policy #1.0 Comprehensive Suicide Risk Assessment Process.

38. Taylor was logged into the A Block at 10:50 a.m. The log entry indicated that Taylor was on kepplock pending a ticket. There were no further entries specific to Taylor until 9:50 p.m. During an interview with Commission staff, CO J.F. reported that she was familiar with Taylor who was on the block she was touring. On 10/6/17 during the 3:00 p.m. to 11:00 p.m. shift, CO J.F. stated that Taylor was quiet and never gave her any problems. CO J.F. stated that nothing unusual was going on during the shift. CO J.F. stated that she was alerted to a problem with Taylor by other inmates yelling for her. CO J.F. called for assistance but stated that she did not respond to Taylor's cell due to "having the keys". CO T.W. stated during an interview with Commission staff that he, CO D.J., and CO J.H. responded to the cell. The officers consistently reported that Taylor was screaming, hitting himself on the cell bars and floor, and was not responding to any verbal commands. CO D.J. stated to Commission staff during an interview that "there was no way a sober person would be doing that". CO J.H. stated to Commission staff during an interview that he recalled seeing redness on Taylor's face prior to going into



the cell. Officers D.J., T.W. and J.H. entered the cell after being given direction by Sgt. T.L. CO D.J. stated that Sgt. T.L. "picked" people to go into the cell. CO J.H. stated during an interview with Commission staff that Sgt. T.L. instructed which officers went into the cell. The officers consistently reported to Commission staff that they had to struggle with Taylor and that Taylor ripped through the first set of "Flexi-Cuff" they applied to him. The three COs who entered the cell consistently reported during interviews with Commission staff that they carried Taylor in cuffs and shackles out of the cell, down the galley, down the stairs and placed him on a gurney. They all consistently reported that two officers looped their arms in Taylor's arms and one officer held his legs. None of the officers recalled if Taylor hit anything while they were moving him. CO M.M. reported to Commission staff during an interview that he responded to the area with the gurney. CO M.M. stated that he "thought he was there when they brought him down the stairs". CO M.M. could not recall any details about how Taylor was brought down, who brought him down, or any involved staff that were present.

39.



. During an interview with Commission staff, RN [REDACTED] stated that she responded to the block when the emergency was called. RN [REDACTED] stated, "they did not let us down to the company and the officers were standing around the cell". RN [REDACTED] stated that she did not recall details regarding what officers were present or how Taylor was removed from the cell and carried down the stairs. In a written statement by Sgt. T.L., it was documented that he responded to the area with the officers to find Taylor striking his head, face, and body on the cell floor and lockers. Taylor refused to be calmed by verbal commands. Sgt T.L. documented that he instructed the officers to enter the cell and that they had to use necessary force to control Taylor. Sgt. T.L. documented that he and the three officers carried Taylor to the gurney and "uninvolved staff" took over from there. The report by Sgt. T.L. ended by stating that Taylor was seen by medical staff and had self-inflicted injuries to his right eye, face, a swollen lip and a small cut. Taylor was "also assessed as being under the influence of K2." The Medical Review Board finds the reports of Sgt T.L. and statements by officers involved were inaccurate as they are not qualified to determine if an inmate's behavior is drug related or injuries were self-inflicted unless directly observed.

40. Included in the facility records were 15 photos of Taylor. The photos were dated 10/6/17 and documented as being taken at "approximately 11:10 p.m.". Taylor is observed in the photos standing in boxer shorts unrestrained. The Medical Review Board finds the reports of Taylor's behavior inconsistent with what appears to be compliance with



removing his clothing and having photos taken at the same time that it was documented, at 11:10 p.m., that he was being given medication for being uncooperative and combative.

41. The "Emergency Telemedicine" form was type written and the author is not known. [REDACTED]  
[REDACTED] During an interview with Commission staff, CO M.M. stated that Taylor did not talk about what happened during the transport.

42. At approximately 11:30 p.m., a cell frisk was conducted on Taylor's cell. Two rolled cigarettes with a green leafy substance inside them were found. They were turned over to a facility "Certified NARK II Tester" and they tested positive for K2.

43. [REDACTED]

44. [REDACTED]

45. [REDACTED]



46. [REDACTED]
47. [REDACTED]
48. At 10:20 a.m., RN [REDACTED] was alerted by CO R.B. that Taylor was found hanging by a twisted bedsheet knotted several times and affixed to a safety railing on the wall. [REDACTED]
49. [REDACTED]
50. [REDACTED]
51. Following Taylor's death, the Office of Special Investigations conducted an investigation into the allegation made by inmates that on the evening of 10/6/17, Taylor was assaulted inside his cell by numerous officers. The investigation included interviews with inmates, staff members, review of statements and other documents. The report substantiated that Taylor died [REDACTED]. The report also substantiated that Taylor was assaulted by numerous officers on 10/6/17, after they responded to a medical emergency. The report indicated that as per the report of the Erie County Medical Examiner, [REDACTED]. The injuries were not consistent with the staffs' reported description of the use of force but were consistent with the reported staff assault. Additionally, the report substantiated that official documents associated with the incident on 10/6/17 were falsified by officers. The results of the investigation were reported to the Bureau of Labor Relations on 3/15/18.



The case was also referred to the U.S. Attorney's Office for the Western District of New York for review. The Medical Review Board finds that the report of the Office of Special Investigations substantiated the allegations of Taylor being assaulted on 10/6/17, resulting in numerous injuries and reports and statements of staff members involved being inconsistent or falsified.

#### ACTIONS REQUIRED:

##### TO THE COMMISSIONER OF THE DEPARTMENT OF CORRECTIONS AND COMMUNITY SUPERVISION:

1. The Commissioner shall conduct an investigation into the failure of transporting Taylor for mental health appointments while on keeplock and while in the Special Housing Unit resulting in delays of mental health care. The results of the investigation shall be provided to the Board when completed and shall include recommendations for preventing delays in the future.
2. The Commissioner shall follow up on the substantiated findings of the assault on Taylor and the falsifying of documents related to the use of force with Taylor on 10/6/17. Administrative action should be taken if found in violation of department directives.
3. The Commissioner shall consider the use of body cameras in situations where cell extraction and use of force are anticipated for a thorough and timely review of the incidents.

##### TO THE NEW YORK STATE OFFICE OF MENTAL HEALTH DIVISION OF FORENSIC SERVICES

1. The Division shall conduct an investigation into the reason Taylor was not referred to an appropriate substance abuse program following a positive history of substance abuse, admission and voicing desire to cease drug use in the facility and medical care needed following episodes of drug use. The results of the investigation shall be provided to the Board when completed.

*In a response to the Commission's preliminary report dated 8/27/20, the Office of Mental Health indicated that substance abuse treatment is under the purview of DOCCS and that DOCCS staff were aware of Taylor's substance use. The Medical Review Board remains opined that proper coordination between services is necessary for optimal patient outcomes, especially when a substance use issue is identified as having a clinical impact on a patient.*

2. The Division shall review the policies and procedures regarding the transfer of mental health records with inmates to assure that the records for patients are immediately available to the receiving facility.

*In a response to the Commission's preliminary report dated 8/27/20, the Office of Mental Health indicated that the review was completed and that patient records are now sent, tracked and followed up via an electronic database.*

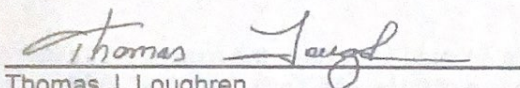
3. The Forensic Division shall conduct an investigation into why a comprehensive suicide risk assessment was not completed on Taylor on 10/6/17 per CBO Policy #1.0, prior to



his release from the Residential Crisis Treatment Program, following the death of his grandfather, his recent drug use, his being returned to keeplock, and his recent suicidal thoughts. The results of the investigation shall be provided to the Board when completed.

*In a response to the Commission's preliminary report dated 8/27/20, the Office of Mental Health indicated that the issue was identified by the Corrections Based Operations Risk Management Special Investigation Report. The Medical Review Board acknowledges that this issue was identified and addressed, however remains opines that these were significant risk factors that Mr. Taylor presented with.*

WITNESS, HONORABLE THOMAS J. LOUGHREN, 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 on this 29<sup>th</sup> day of September, 2020.



Thomas J. Loughren  
Commissioner & Chair  
Medical Review Board

TJL:ET:jdb  
2017-M-0118  
9/2020

cc: Dr. John Morley, Deputy Commissioner Chief Medical Officer  
Joan Smith, Assistant Commissioner for Health Services  
Bryan Hilton, Assistant Commissioner for Mental Health  
Superintendent Stewart Eckert, Wende CF  
Dr. Li-Wen Lee, Acting Associate Commissioner  
Division of Forensic Services, NYS Office of Mental Health  
Dr. Danielle Dill, Acting Executive Director,  
Central New York Psychiatric Center  
William Vertoske, Associate Director of CBO, CNYPC  
Meaghan Bernstein, Director of CBO Risk Management, CNYPC