



**NEW YORK CITY
BOARD OF CORRECTION¹**

The Death of
Layleen Xtravaganza Cubilette-Polanco
1991-2019

June 23, 2020

¹ Authored by Kate McMahon, Deputy General Counsel. Special thanks and acknowledgment to all Board staff and others who assisted or advised in this investigation and Report, including Monitoring Team members K. Blackman and Dilcio Acosta; Legal Associate Navdeep Bains; Prison Death Investigation consultant Kate Eves; Director of Policy and Communications Bennett Stein; General Counsel Michele Ovesey; Executive Assistant Tonya Glover; Executive Director Margaret Egan; Deputy Executive Director of Research Emily Turner; Research Associate Heather Burgess; and Prison Death Review Board members Jackie Sherman (Chair), Dr. Bobby Cohen, Dr. Steven Safyer, and Jennifer Jones Austin.

A. INTRODUCTION

On June 7, 2019, Layleen Xtravaganza Cubilette-Polanco died in a cell in the Restrictive Housing Unit (RHU), a form of punitive segregation (PSEG) (also known as solitary confinement) in the Rose M. Singer Center (RMSC) on Rikers Island. She was a 27-year-old Afro-Latinx transgender woman.

The Board of Correction (“Board” or “BOC”) has a duty² to investigate the death of any individual who dies while detained in a New York City jail. The Board’s investigation is distinct from those conducted by other City and State agencies.³ BOC investigations do not focus on criminal wrong-doing or individual fault. Rather, the Board’s investigations focus on the circumstances of deaths in custody, identifying where lessons can be learned to prevent future deaths. This Report presents the findings of the Board of Correction in connection with its investigation concerning Ms. Polanco’s death and makes recommendations to the Department of Correction, NYC Health + Hospitals/Correctional Health Services (CHS).

B. METHODOLOGY

BOC staff began investigating the circumstances leading up to Ms. Polanco’s death within days of being notified.⁴ The following is a detailed overview of all the materials reviewed that formed the basis for the summary of events laid out in Part C of this Report.

Interviews

BOC’s investigation included several visits to RMSC on Rikers Island where Ms. Polanco died, including in-person interviews of four DOC personnel who directly witnessed in some form the events of June 7. BOC also interviewed two of the three other women in custody in the segregation unit at the time Ms. Polanco’s medical emergency was discovered on June 7, as well as the Observation Aide (or Suicide Prevention Aide) on duty in the segregation unit in the morning and early afternoon of June 7, who also previously had lived in a dorm with Ms. Polanco.

For background, BOC interviewed Ms. Polanco’s friend Gisele Alicia Xtravaganza; the NYPD officer from the 17th precinct who arrested Ms. Polanco; Ms. Polanco’s public defender at the Legal Aid Society; a DOC correction officer who supervised Ms. Polanco during her two stays in the Transgender Housing Unit (THU) New Admissions area; a DOC captain who assisted in processing Ms. Polanco’s protective custody paperwork; and two individuals in custody who resided in a THU dorm with Ms. Polanco in April and May, 2019.

² Defined in §3-10(c)(2) of the New York City Board of Correction Health Care Minimum Standards (eff. May 15, 1991) as the Board’s role to “conduct an investigation of inmate deaths including the review of all medical records of the deceased.”

³ These other agencies include the New York City Department of Investigation (DOI), New York City Department of Correction’s Investigation Division, New York State Commission of Correction (SCOC), New York City Health & Hospitals (H+H), New York City Office of Chief Medical Examiner (OCME), and the Bronx District Attorney’s Office (“DA’s Office”). On June 5, 2020, DOI and the Bronx DA’s Office publicly disclosed that they had completed their investigations into Ms. Polanco’s death and found no criminality on the part of city personnel.

⁴ At its June 11, 2019 public Board meeting, the Board of Correction made a commitment to investigate the death of Ms. Polanco and report back to the public. On June 26, 2019 the Progressive Caucus and Women’s Caucus of the New York City Council sent a letter to the Board, DOC, and Mayor de Blasio, requesting a full investigation and public release of findings in a timely manner. On August 1, 2019, Public Advocate Jumaane Williams released a public request for information on Ms. Polanco’s death from City agencies, including the Board, in particular requesting information on how and why someone with a history of being medicated for epilepsy was placed in solitary confinement.

Recordings

BOC reviewed Genetec video footage of the RHU where Ms. Polanco died and select Genetec footage of one of the THU dorms where Ms. Polanco lived previously. BOC also reviewed recordings of telephone calls made by Ms. Polanco when she was in custody at Rikers and Elmhurst Hospital, as well as a recorded interview by DOC's Investigation Division of another transgender woman in custody who knew Ms. Polanco at Rikers and in the community.

Department of Correction Documents

BOC reviewed various DOC reports and records in the course of its factfinding. Records relied on include: information contained in DOC's Inmate Information System (IIS); classification and screening forms (regarding, e.g., involvement with NYC Administration for Children's Services (ACS), suicide risk, and risk of sexual victimization and abusiveness); transgender housing application paperwork; visit list and visit reports; clinic and housing area logbooks; infraction paperwork; staff incident reports; Ms. Polanco's floor card; Ms. Polanco's court accompanying card; voluntary statements by persons in custody; prisoner movement slips; Mental Health notification and referral forms; discharge planning forms; protective custody paperwork; select email correspondence; DOC Mental Health review form for punitive segregation housing; DOC investigation Division's Preliminary Investigative Report/Callout Report and Checklist for Ms. Polanco's death; DOC Health Affairs Report completed shortly after Ms. Polanco's death; Watch Tour data; and crime scene logs, photographs, and evidence chain-of-custody forms for June 7, 2019.

Court Records

In addition to DOC records, BOC reviewed a bail transmittal form; New York State arrest/conviction/warrant fingerprint response summary; New York State ID criminal repository report; the court securing order; and NYPD arrest paperwork and Medical Treatment of Prisoner form, all of which were in the possession of DOC and turned over to the Board for its investigation. BOC also reviewed the transcripts of Ms. Polanco's court proceedings.

Medical and Autopsy Records

BOC examined Health + Hospitals ("H+H") medical records from Bellevue Hospital, Elmhurst Hospital, and CHS (including CHS electronic printouts reflecting pharmacy dispensing of medication to Ms. Polanco), all of which were obtained pursuant to a court-ordered subpoena ("Court Order"). Factual findings sourced solely from information from subpoenaed material were discussed between Prison Death Review Board members and CHS representatives; however, these findings do not appear in this report due to the confidentiality requirements of the Court Order.

In addition to these subpoenaed medical records, BOC reviewed the autopsy report completed by the Office of the Chief Medical Examiner on July 30, 2019.

Policies and Procedures

BOC also reviewed the following institutional DOC and CHS policies in connection with its investigation: DOC's RHU Directive 4499; Pre-Hearing Detention and Punitive Segregation Status Inmates Directive 4501R-D; Inmate Observation Aide Program Directive 4017R-A; Housing Area Logbooks Directive 4514R-C; Inmate Count Procedures Directive, 4517 R; RMSC – Command Level Order Punitive Segregation (Adults, and RHU), # 132-19; RMSC- Command Level Order Watch Tour System, #21-19R; and CHS's Evaluation for Exclusion from Punitive Segregation Policy # MH 38; Mental Health Rounding Policy # MH8; and Intake Evaluation Policy # Medical 1.

Limitations and Challenges

BOC encountered several notable obstacles during its investigation. As referenced above, the Board was compelled to commence a court proceeding to obtain Ms. Polanco's medical records from Health + Hospitals/CHS given their position that state privacy laws prohibit release of such records absent a court order. This procedural hurdle resulted in significant delay in obtaining and reviewing Ms. Polanco's medical information crucial to BOC's investigation.

Pursuant to the court-ordered subpoena, CHS provided the Board with pharmacy computer printouts reflecting Ms. Polanco's medication distribution. These records have a column indicating the dates and time of each prescribed dose, and a second column indicating the date and time the dose was dispensed. These records do not offer any guidance as to whether blank entries indicate that a particular dose was not offered to Ms. Polanco or whether she refused it. As a result, BOC was unable to meaningfully assess potential barriers to Ms. Polanco's medication compliance.

BOC was unable to interview CHS staff for this investigation, as H+H/CHS directed its staff not to speak with BOC investigators due to litigation concerns. Relatedly, H+H/CHS advised that it would not share any portions of H+H's internal post-mortem review with BOC, including recommendations resulting from such review.

Despite multiple visits to RMSC, BOC was unsuccessful in its attempts to interview Officer W., one of the housing area officers responsible for supervising Ms. Polanco in the RHU on June 7; however, Officer W.'s actions are recorded on Genetec video and, as discussed below, were carefully reviewed, as were the written incident statements Officer W. provided to DOC immediately after Ms. Polanco's death. BOC was likewise unable to interview one of the three other women confined with Ms. Polanco in the RHU on the day she died, as she declined to be interviewed. Nor was BOC able to speak with a sanitation worker (a person in custody) in the RHU who spoke with Ms. Polanco the morning of her death, as the sanitation worker was discharged from DOC custody before BOC could locate her. The Brooklyn Community Bail Fund was also contacted for an interview but declined to provide any comment.

While BOC carefully reviewed Genetec video footage of the RHU on June 7, Genetec has a number of limitations. Most significantly, Genetec footage does not include audio. Secondly, there are no cameras trained on the inside of cells in the RHU, and so the Board's investigation could not definitively determine (i) the precise time at which Ms. Polanco suffered her mortal seizure; (ii) what DOC and CHS staff observed each time they looked into her cell window on June 7 (beyond what DOC staff told BOC or DOC investigators about what they had observed); and (iii) what actions DOC staff and medical responders took once they entered Ms. Polanco's cell and discovered a medical emergency. For these reasons, review of Genetec footage can reveal only what happened directly outside of Ms. Polanco's cell before, during, and after her death, including the actions taken, or not taken, by DOC/CHS staff and the Observation Aide tasked with checking on her.

A thorough review of activity outside of Ms. Polanco's cell is further complicated by the fact that the surveillance cameras are motion-sensor activated, meaning they only record and save footage where there is movement within the camera's range. Therefore, BOC investigators were unable to determine whether gaps in footage were attributable to a lack of activity within the camera's range or to some other factor, such as camera malfunctioning. Additionally, Genetec video is erased after 90 days unless a hold is put on the footage; Board staff learned too late of Ms. Polanco's seizure episode on April 30 to review that relevant housing area footage.

Lastly, BOC reached out several times to counsel for Ms. Polanco's family for permission to speak with them; however, pursuant to counsel's instruction, the family declined BOC's request.

C. SUMMARY OF EVENTS

April 13 – 16: Arrest, Bellevue Hospital Stay, and Arraignment

On April 13, 2019, Ms. Polanco was arrested in Manhattan on two misdemeanor charges and brought to the 17th Precinct. As a result of her behavior at the precinct, officers escorted her to the emergency room at Bellevue Hospital. She remained at Bellevue for three days. Upon discharge on April 16, hospital staff prescribed her Keppra,⁵ which was recorded on the NYPD Medical Treatment of Prisoner Form (“TOP form”). A carbon copy of the TOP form was given to the court and to DOC, which later provided CHS with a photocopy.

Ms. Polanco was arraigned on April 16 in New York County Supreme Court and charged with six misdemeanors. She also had a bench warrant from a 2017 case. The Court set bail at \$501 on both cases and Ms. Polanco was transferred into DOC custody and brought to RMSC.

April 16 – May 5: Intake and Transgender Housing Unit Placement

In the days following her arrival at RMSC, Ms. Polanco went through various screening processes, including medical and mental health screenings. The Bronx DA’s Report notes that “[i]n connection with her intake ... [she] made DOC aware that she suffered from a seizure disorder.”⁶

Ms. Polanco applied for transgender housing, and on April 18 moved into one of the two Transgender Housing Unit (THU) dorms at RMSC.⁷ On April 30, Ms. Polanco suffered a seizure in the middle of the night in her dorm and was transported to the facility clinic.

On May 2, following interpersonal conflict in her dorm, DOC transferred Ms. Polanco to the other THU dorm at RMSC. On May 4, she suffered another middle-of-the-night seizure and was again transported to the facility clinic.⁸

May 5 – May 15: Physical Incidents and Infraction

While visiting RMSC’s main clinic on May 6, Ms. Polanco had a physical altercation with someone from her former THU dorm. DOC charged her with a violation of its rules (an “infraction”) and held a disciplinary hearing on May 14. The Adjudication Captain sentenced Ms. Polanco to 20 days in punitive segregation (PSEG) (also known as solitary confinement), a form of discipline characterized by extended periods confined in a cell. An infraction hearing disposition does not specify when a sentence must be served, as that is determined by, among other things, the number of available PSEG cells at any given point in time.

On the same day as the disciplinary hearing, Ms. Polanco was involved in another fight with someone in her dorm whereupon an officer referred her to Mental Health Services (“Mental Health”), noting

⁵ Keppra is the brand name for levetiracetam, a prescription anti-convulsant medication taken by people with certain types of epilepsy.

⁶Page 7 of The Bronx District Attorney Report (“Bronx DA Report”), dated June 4, 2020, available at: <https://www.bronxda.nyc.gov/downloads/pdf/annual-reports/Polanco-Report.pdf>. As explained in footnote 5, the Bronx DA investigated the death of Ms. Polanco and found no criminality on the part of City personnel.

⁷ Pursuant to a new DOC policy effective October 2019, these units are now referred to as “Special Consideration Units.”

⁸ The Bronx DA’s report found that Ms. Polanco had suffered two seizures in DOC custody, her first on May 4 and another on May 10 (Bronx DA Report, p. 8). The BOC investigation found that she had her first seizure on April 30, but did not find evidence of a seizure on May 10.

that she was “showing radical changes in behavior.” She was subsequently seen by Mental Health. DOC then transferred her to THU New Admissions, an unofficial celled housing area in RMSC generally used to hold people temporarily before they enter a THU.

On May 15, in THU New Admissions, Ms. Polanco declined to come out of her cell for breakfast or services. When she eventually came out at medication time, she refused to take her medication and began rolling around on the floor in the dayroom, talking to herself, and growling. The officer assigned to that unit wrote her a referral to Mental Health (her second in two days), circling the following behavioral traits on the Department’s Referral of Inmates to Mental Health Services Form: “showing radical changes in behavior;” “expressing a desire to commit suicide and/or attempting suicide;” “frequent displays of shouting, crying and/or screaming;” “having hallucinations/delusions (seeing objects or hearing voices that do not exist);” “showing poor personal hygiene or appearance, doesn’t shave wash or change clothes, etc.,” “being alarmed (frightened) or in a state of panic;” and “any unusual action or behavior that should be brought to the attention of the Mental Health Staff.” In the notes section, the officer wrote “inmate randomly crying, shouting.” After lunch, Ms. Polanco charged at the officer with her fist out, striking the officer’s arm. Mental Health then initiated a formal transfer of Ms. Polanco to Elmhurst Hospital, indicating as the basis for the referral that she was highly assaultive and required a higher level of care.

May 15 – May 24: Elmhurst Hospital

Ms. Polanco remained at Elmhurst Hospital for nine days, from May 15 through May 24; eight of those days were in the Elmhurst Hospital Psychiatric Prison Ward (EHPW).

May 24 – May 30: Return to Rikers

Due to Ms. Polanco’s history of interpersonal conflict in the two THU dorms, DOC had difficulty identifying an appropriate place to house her upon her return to RMSC on May 24. On the evening of her return, the RMSC Tour Commander and several other facility personnel discussed over email various housing possibilities, including whether Ms. Polanco could be transferred to a male facility, placed in Protective Custody, or placed in PSEG to serve her 20-day sentence for the May 6 infraction.

Since 2015, the Department’s use of punitive segregation has been limited by BOC Minimum Standards. Specifically, Min. Std. § 1-17(b)(1) excludes certain populations of people from being placed in PSEG units (also known as solitary confinement), including people “with serious mental or serious physical disabilities or conditions.”⁹ Pursuant to Min. Std. § 1-17(b)(2), CHS has the authority to identify people for exclusion from PSEG and does so through its own internal procedures.

When DOC determines it wants to place a person in PSEG who has an “M” designation¹⁰ or who has been in custody less than five days, DOC submits a special form to CHS. In that event, a licensed CHS Mental Health Clinical Supervisor or psychiatric provider reviews that person’s medical chart and, generally within 72 hours, indicates on the DOC form whether the person should be excluded from PSEG because they have a serious mental illness (SMI),¹¹ a diagnosed intellectual disability, and/or

⁹ The Board’s Minimum Standards are codified in Title 40 of the Rules of the City of New York and are available at: <https://www1.nyc.gov/site/boc/jail-regulations/jail-regulations.page>.

¹⁰ An “M” designation is assigned to people in custody who have had three or more mental health encounters during their current incarceration.

¹¹ 18 NYC H+H/CHS, Serious Mental Illness, Policy No. MH 10 (Issued October 25, 2017, revised February 5, 2019): “SMI is defined in the New York City jail system as a mental illness falling into one of the following four diagnostic categories in the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (“DSM-5”), excluding those diagnoses resulting from a substance use or medical condition:

neurocognitive disorder (e.g., traumatic brain injury). If a person is determined to have mental health issues but does not meet the criteria for SMI, the person may be placed in a Restrictive Housing Unit (RHU), another form of disciplinary segregation meant to house individuals with other degrees of mental illness, a history of suicidal gestures/attempts, or those who are at risk of decompensation. Depending on the person's medical history, the CHS Mental Health service might also refer a person's medical record for a second review by CHS's Medical service to determine whether the person should be excluded from punitive segregation based on a serious physical condition.¹²

In the course of DOC's deliberations on May 24 about where to house Ms. Polanco upon her return from Elmhurst, the RMSC Tour Commander wrote: "Please be advised that as per our conversation regarding Transgender inmate [Layleen Polanco] her mental health chart "was reviewed by [a CHS Psychiatrist] who verbally stated that due to [her] medical history as it pertains to seizure disorder that he would not be able to authorized [sic] a cell housing placement for inmate [Polanco]." In a subsequent email, the Tour Commander stated: "We tried very hard to get Inmate [Polanco] cleared [for segregation] but [Mental Health] just won't clear her. We are in the process of generating [Protective Custody] paperwork for [her]."

Early the next morning, on May 25, DOC's Operations Security Intelligence Unit (OSIU) denied, via email, a protective custody placement for Ms. Polanco, citing a lack of evidence or documentation to validate any threat to her safety. While the Department continued to deliberate over where to house her, DOC sent her back to THU New Admissions where she was housed alone in the unit for five days.

Even though on May 24 a CHS psychiatrist had refused to "clear" Ms. Polanco for PSEG/RHU placement on account of her seizure history, on May 29, another Mental Health clinician reviewed her medical chart and authorized her placement into the RHU, pending "medical clearance." The next morning, on May 30, a CHS medical doctor notified DOC that Ms. Polanco had "been cleared." As noted in the press, CHS records of the May 30 "clearance" reflected Ms. Polanco's seizure disorder, but found as "[p]er chart review, her condition has been stable. She has no acute contraindication to the RHU."¹³

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- Schizophrenia Spectrum and Other Psychotic Disorders
 - Bipolar and Related Disorders
 - Depressive Disorders
 - PTSD

Individuals who do not meet the above diagnostic criteria but experience significant functional impairment or clinical distress as a result of a DSM-5 diagnosis not resulting from substance use or a medical condition are also designated as SMI."

¹² On July 23, 2019, CHS confirmed to the Board that following Ms. Polanco's death, RMSC medical staff were no longer evaluating people for exclusion from PSEG/RHU, as CHS did not believe BOC's Minimum Standards required medical clearance — a view at odds with BOC's own interpretation of Min. Std. § 1-17. CHS's assertion triggered a series of discussions between CHS and the Board, including negotiation of expanded exclusionary language in BOC's proposed restrictive housing rules. At a special meeting of the Board on October 31, 2019, the Board voted to propose rules pursuant to the City Administrative Procedure Act (CAPA)); public hearings on the proposed rules took place December 2 and December 16, 2019. CHS and the Board also discussed new protocols for CHS to effectuate mental health and medical exclusions that would minimize CHS staff ethical concerns and susceptibility to undue pressure from DOC and which are briefly outlined in BOC's Statement of Basis and Purpose regarding the proposed rules (pp. 18-19), available at: <https://www1.nyc.gov/assets/boc/downloads/pdf/Jail-Regulations/Rulemaking/2017-Restrictive-Housing/2019.10.29%20-%20Rule%20and%20Certifications.pdf>. These conversations are ongoing.

¹³ See Reuven Blau and Rosa Goldensohn, "Medical Condition Should Have Kept Polanco From Solitary, Experts Say," *The City*, (August 2019), <https://thecity.nyc/2019/08/medical-issue-shouldve-kept-polanco-from-solitary-experts.html>

Accordingly, on May 30, Ms. Polanco was transferred from THU New Admissions into the RHU to serve her 20-day disciplinary sentence for the May 6 infraction.

May 30 – June 7: Restrictive Housing Unit

As described above, the RHU is a form of punitive segregation to which people in DOC custody are sentenced after being found guilty at a disciplinary hearing of having committed serious infractions, including violence. At RMSC—as opposed to in the men’s facilities—individuals in RHU and traditional PSEG are held in the same housing area, designated the “Special Central Punitive Segregation Unit for Women” (hereinafter, “Unit” or “Segregation Unit”). The unit is staffed by three Correction Officers—one in the “A-station” observation room, and two on “the floor” (i.e. inside the housing area). DOC’s RHU policy states that every RHU is supposed to have one steady Captain and two RHU-trained and steady officers assigned at all times, though it does not specify which two of the three officers must be steady (i.e. the floor officers conducting the rounds or the A-station officer).¹⁴

The front of the Unit consists of a raised observation room surrounded by plexiglass (“A-station” or “bubble”). About 21 individual cells line the other three sides of the Unit, with a dayroom in the middle. There is also an upper tier of cells overlooking the dayroom, which is not utilized. Most of the cell doors have narrow windows about five inches wide and 20 inches high, though seven doors on the first tier are modified with larger cell windows (more than double the size) for better viewing of people placed on suicide watch. Every cell door has a lockable meal slot that can be opened so that officers can deliver or retrieve things from people’s cells when they are locked inside; the slot is also used by officers as a “cuffing port” through which they handcuff people in custody before they exit their cells.

When locked out of their cells, women are permitted to commingle in the dayroom and at recreation. Unlike the segregation units in the men’s facilities, at RMSC there is no meaningful distinction between the programs offered to women in the RHU and women in traditional PSEG. All the women confined in the Unit are offered the same number of hours outside their cells and the same services, including mental health programming. According to Department policy, women in the Unit are out of their cells up to seven hours a day, either at recreation, art therapy, group therapy, clinic, showers, court, or in the dayroom where they can sometimes watch television. Group recreation takes place in a pen outdoors, while art therapy and group therapy are offered at three metal tables bolted to the floor in the dayroom. When women are seated at these tables for art and group therapy or to watch TV, they are handcuffed to the table by one wrist attached to a chain.

According to DOC policy, Pre-Hearing Detention and Punitive Segregation Status Inmates Directive 4501R-D (“PSEG Directive”), housing area officers must make visual observations of people inside their cells (this is referred to as a “round”) every 15 minutes.¹⁵ In addition, the Inmate Observation Aide Program Directive mandates Inmate Observation Aides (sometimes referred to as “Suicide Prevention Aides”) be assigned to segregation housing areas at all times, and that they “conduct a minimum of 6 vigilant patrols of their assigned areas per hour at irregular intervals.”¹⁶ These Observation Aides are people in custody who are trained and employed by the jails to conduct visual observations of people in their cells, recognize signs of decompensation, and prevent suicide.

¹⁴ DOC Directive No. 4499 re “Restricted Housing Unit Program” (eff. March 10, 2014), section VII(H), p. 3.

¹⁵ DOC Directive 4501R-D re “Pre-Hearing Detention and Punitive Segregation Status Inmates,” (eff. January 23, 2016), section IV(D)(8), p. 28.

¹⁶ DOC Directive No. 4017R-B re Inmate Observation Aide Program (eff. September 17, 2019), section II(C) and section III(E)(1)(a), pp. 1, 4; these provisions also appeared in the previous version of this Directive (No. 4017R-A) in effect in June 2019. The Observation Aide program is mandated by BOC Minimum Standard§ 2-02(d)).

June 7

On Friday, June 7, 2019, there were a total of six women, including Ms. Polanco, in the Segregation Unit at RMSC, spread out across cells on the lower tier. Ms. Polanco was in cell #6, located more than halfway down the left wall of the Unit; her cell door contained a 20-inch by-5-inch window (as opposed to seven cells in the Unit with larger cell door windows for people on suicide watch). Inside the 12-foot-by-7-foot cell, there was a small window to the outside, a ceiling light, a bed, two plastic storage bins stacked to function like a table, and a metal mirror, toilet, and sink.

June 7 was Ms. Polanco's ninth day in the Segregation Unit. At 5:15 a.m., she received breakfast through her meal slot. From 6:50 a.m. to 7:34 a.m., she took a shower and, at 7:53 a.m., a CHS staff person distributed medication through Ms. Polanco's meal slot.

Officer W. and Officer G. were the housing area officers assigned to the 7 a.m. to 3 p.m. tour that day; Officer W. was steady on the Unit—meaning she was regularly assigned there—while Officer G. did not have a steady assignment and estimated that she was assigned there approximately every other week for one day. The officers and captains in the Unit that afternoon whom BOC interviewed reported that they were never informed that Ms. Polanco had a seizure disorder, and nothing in the DOC housing area records that BOC reviewed referenced Ms. Polanco's propensity for seizures.

According to the housing area logbook, the Observation Aide arrived around 8:00 a.m. At 8:20 a.m., Ms. Polanco went to recreation for an hour, during which one of the other women in the Unit was discharged and escorted out of the unit, reducing the total count to five people. The Observation Aide cleaned out the vacated cell from around 9:00 a.m. until 9:20 a.m. According to Genetec, the Observation Aide did not return to the Unit until 9:51 a.m.

A sanitation worker (i.e., a sentenced person in DOC custody) entered the Unit at 9:30 a.m. and had what appeared to be an animated interaction with Ms. Polanco through her cell window at 9:49 a.m. During this interaction, the Observation Aide and two housing area officers were on the other side of the floor near the A-station.

At 10:48 a.m., an officer escorted Ms. Polanco to the West Corridor Clinic so she could discuss her hormone therapy with CHS personnel.¹⁷ She returned from the Clinic at 11:20 a.m. As she was being escorted back to her cell, the other four women housed in the Unit and the Observation Aide were in the dayroom at the metal tables finishing up art projects as part of an art therapy program offered by CHS. According to Genetec, Ms. Polanco's demeanor appeared normal and healthy at the time she re-entered her cell.

Within ten minutes of Ms. Polanco's return to her cell, Officer W. and Officer G. locked the four other women in the dayroom back in their cells to prepare for lunch. Around 11:38 a.m., Officer W. retrieved Ms. Polanco's water cup from her meal slot, filled it up at the water station on the other side of the dayroom, and deposited it back in her meal slot; Officer W. then left the housing area. At that point, the Observation Aide prepared six lunch trays in the pantry off the dayroom and, along with Officer G., wheeled the food cart through the Unit placing lunch trays through the meal slot of each cell. The Observation Aide and Officer G. served Ms. Polanco first at 11:44 a.m., and then served the other four women on the Unit over the course of the next two minutes; one lunch tray was left over. Officer G. then left the housing area. At this time, the Observation Aide walked around from cell to cell engaging with the women. At around 11:47 a.m., Ms. Polanco appeared to request a second helping of food. At the same time, the woman in the cell closest to Ms. Polanco's refused her lunch tray. The Observation Aide, after conferring with the woman in the cell closest to Ms. Polanco's,

¹⁷ Bronx DA Report, p. 2.

retrieved the full food tray from that woman's meal slot and deposited it into Ms. Polanco's meal slot at 11:49 a.m.

At 12:01 p.m., the Observation Aide collected two empty trays and the green water cup from Ms. Polanco's meal slot. The Aide refilled Ms. Polanco's water cup and deposited it back in her meal slot at 12:02 p.m. This is the last point in time the BOC investigation can definitively state Ms. Polanco was still alive.

At 12:06 p.m., the Observation Aide walked past Ms. Polanco's cell and looked briefly inside the cell door window; at 12:08 p.m., she checked the inside of Ms. Polanco's meal slot; and at 12:20 p.m. she closed the gate to the meal slot. At 12:25 p.m., Officer W. went on a lunch break and another officer relieved her.

Around 12:29 p.m., the Observation Aide conducted rounds and walked past Ms. Polanco's cell, and the relief officer recorded in the logbook that there was a verified count of five women in the unit "all in alive or breathing bodies." At 12:41 p.m., the relief officer walked past Ms. Polanco's cell and briefly looked in the window. The Observation Aide rounded past Ms. Polanco's cell for the last time at 12:50 p.m., at which time she paused for 12 seconds to study the inside of Ms. Polanco's cell; this stands in contrast to most of the Observation Aide's rounds earlier that morning and afternoon, when she looked inside Ms. Polanco's cell window for 1 second. At 12:51 p.m., the relief officer accompanied a captain on an unannounced PREA tour¹⁸ and they glanced quickly into Ms. Polanco's cell as they walked past.

No one walked near Ms. Polanco's cell in the 35-minute stretch between 12:51 p.m. and 1:26 p.m., as evidenced by a lack of Genetec footage indicating motion in front of her cell during that time period. Officer W. returned from her lunch break and the relief officer left. It appears that during this time, the Observation Aide also left the Unit for the day, though her departure was not recorded in any of the area logbooks.

At 1:26 p.m., two Mental Health clinicians appeared on the Unit. The first clinician went straight to Ms. Polanco's cell, knocked on her door, and, getting no response, proceeded to knock on the cell door for another two minutes, leaning on the glass at times to peer inside as she knocked. She left word search puzzles in the meal slot.¹⁹

At 1:28 p.m., Officer B.—the A-Station officer who was temporarily on the floor because Officer G. had stepped off her post for personal reasons — joined the first clinician outside of Ms. Polanco's cell and took out her keys to open the meal slot, tapping on the cell window and also peering inside with her face pressed up against the window. The second clinician — a licensed clinical social worker who was on the unit to conduct mental health rounds and provide group therapy — then walked over, and all three stood outside of Ms. Polanco's cell, talking to each other and taking turns looking in the cell before dispersing in different directions at 1:29 p.m. Officer B. recorded in the A-station logbook that an active supervision tour of the area was completed at 1:30 p.m. and there was "nothing unusual to report."

A minute after walking away, the first clinician returned to Ms. Polanco's cell and resumed leaning on the glass to look inside. Officer G., who had returned to the Unit, walked over and looked inside Ms. Polanco's cell window, tapping on the glass. Genetec shows the Mental Health staff person in

¹⁸ Under BOC Minimum Standard § 5-04(k), "intermediate-level or higher level supervisors (such as Captains)" must "conduct and document unannounced rounds to identify and deter staff sexual abuse and staff harassment."

¹⁹ These blank word search puzzles were still in her meal slot later that afternoon when DOC investigators took photographs of the inside of her cell and the area outside.

discussion with Officer G., with the first clinician gesturing to suggest Ms. Polanco may have had something on her head or in her ears. Officer G. later explained to BOC investigators that Ms. Polanco appeared to be sleeping face down under a blanket with her hair wrapped in a cloth, and that it was not unusual for people to be sleeping with headphones. At 1:32 p.m., the first clinician walked away from Ms. Polanco's cell but Officer G. remained by the cell door looking inside for another 15 seconds before walking off to another cell.

The first clinician left the Unit at 1:33 p.m., at which time Officer G. returned briefly to knock on Ms. Polanco's cell and then walked away after three seconds. Consistent with the A-station logbook entry made by Officer B. at 1:30 p.m., Officer G. made an entry in the housing area logbook stating that a general supervision tour was completed at 1:30 p.m. and there was "nothing unusual to report."

At 1:40 p.m., Officer W., who had returned from lunch, walked over to Ms. Polanco's cell and looked inside the window for about 45 seconds. The second clinician joined Officer W. at 1:41 p.m. and also looked inside Ms. Polanco's cell, after which Officer G. came over and looked inside the cell once more. On Genetec, the two officers and the second clinician appeared to have a conversation for another minute next to the cell door, while Officer G. continued to peer into the cell periodically before all three walked away without making affirmative contact with Ms. Polanco.

At 1:46 p.m., while group therapy was taking place in the dayroom, Officer G. approached Ms. Polanco's cell again, glancing inside and then walking away. According to Genetec, no one (officers or the Observation Aide who had apparently left the unit) looked in Ms. Polanco's cell to check on her for the next 41 minutes. Although the logbooks report an active supervision tour with "nothing unusual to report" at 2:00 p.m., Genetec does not show anyone checking on Ms. Polanco until 2:27 p.m., at which time Officer W. conducted rounds by peering into Ms. Polanco's cell before walking away. A logbook entry for 2:30 p.m. notes an active supervision tour with "nothing unusual to report," and an entry at 2:35 p.m. states: "routine tour of area - all appears normal."

Group therapy ended around 2:37 p.m., at which time the second clinician left the Unit. Officer G. reported to BOC that in her last conversation with Ms. Polanco, hours earlier, Ms. Polanco had asked to be brought to the dayroom when it was time to watch television. At 2:41 p.m., while the TV was on in the dayroom, Officer G. peered inside Ms. Polanco's cell window again for about three seconds before walking away. Two minutes later, at 2:43 p.m., Officer W. walked over to Ms. Polanco's cell and stood there for almost two minutes, knocking repeatedly on the door and looking through the window. At one point, Officer W. took her keys out, though she did not use them to open the cell door. Instead, she opened the gate to Ms. Polanco's meal slot. After a minute, Officer G. joined Officer W. at the cell door, carrying handcuffs; Officer G. also knocked on the door again and looked in the window.

At 2:45 p.m., Officer W. used her keys to open Ms. Polanco's cell door for the first time since Ms. Polanco had returned from the clinic at 11:20 a.m. Without entering her cell, the Officers stood at the threshold for two minutes, from 2:45 p.m. to 2:47 p.m., talking and laughing to each other, calling out to Ms. Polanco before closing her cell door again. At that moment, a Mentor Captain²⁰ arrived in the Unit and immediately directed the officers to reopen the door and physically check on Ms. Polanco. Officer W. entered the cell, reemerging nine seconds later. The Captain and Officer W. immediately walked over to the officer station to retrieve a radio and call for a medical emergency; the Captain also returned with a bag with a defibrillator. The housing area officers reentered Ms. Polanco's cell and turned her body over, reportedly discovering that her face was purple and blue. The officers began chest compressions and the Captain and one of the officers employed the defibrillator. In response to a radio call of a medical emergency, two other Captains arrived and assisted until 2:55 p.m. when Medical staff arrived and took over. FDNY EMS arrived at 3:25 p.m. and worked inside the

²⁰ Mentor Captains travel to various units and seek out inexperienced officers to mentor them.

cell with various medical equipment for 15 minutes. An UrgiCare doctor pronounced Ms. Polanco dead at approximately 3:45 p.m.

Autopsy and Cause of Death

On July 30, 2019, the press reported that the Office of the Chief Medical Examiner had ruled the death “Natural,” and determined the cause death to be “Sudden Unexpected Death in Epilepsy due to or as a consequence of mutation in CACNA1H gene.”²¹

D. KEY FINDINGS

***Note:** The Board made additional findings based on the subpoenaed medical records it reviewed, which BOC is not able to publicly disclose in this Report as per the terms of the court-ordered subpoena for Ms. Polanco’s H+H/CHS records. The Prison Death Review Board presented these findings separately to CHS.*

- CHS staff did not follow-up on collateral medical information at Intake —namely, the NYPD Medical Treatment of Prisoner form (“TOP form”) — that would have alerted them to the fact that Ms. Polanco had been at Bellevue Hospital immediately before coming to Rikers and allowed them to retrieve those records.
- CHS’s current process for identifying people for Medical and/or Mental Health exclusion from PSEG/RHU is insufficient, inconsistent, and potentially susceptible to undue pressure from DOC.
- CHS’s rounding practices in the RHU on June 7, 2019 were inadequate to ensure Ms. Polanco’s health and safety in that Unit.
- DOC’s determination not to house a transgender woman in general population housing areas for cisgender women in May 2019 resulted in increased pressure to place Ms. Polanco in the RHU — a Unit unsuitable to manage both her medical and mental health needs.
- DOC staff in the RHU on June 7 failed to round every 15 minutes as required by DOC policy governing procedures in punitive segregation, leaving Ms. Polanco unobserved by DOC staff for stretches of 57 minutes, 47 minutes, and 41 minutes during the period between when she was last confirmed alive and when the medical emergency was declared. Based on interviews conducted, BOC investigators found that many DOC staff in the Unit are confused as to what DOC policy requires in terms of rounding frequency, particularly since several other DOC policies suggest that rounding in cell housing areas is required only every 30 minutes.
- DOC failed to properly oversee and manage the Observation Aide Program at RMSC on June 7, 2019. DOC policy requires Observation Aides to be posted in PSEG and RHU units at all times, conducting visual observations at least six times an hour. Nevertheless, the Observation Aide in the RHU on the afternoon of June 7 left sometime after 12:50 p.m. and

²¹ See Matt Tracy, “Medical Examiner Finds Epilepsy Caused Polanco’s Death,” *Gay City News*, (July 30, 2019), <https://www.gaycitynews.com/medical-examiner-finds-epilepsy-caused-polancos-death/>. See also Christina Carrega, “‘No criminality’ found in the death of transgender inmate on Rikers Island: Prosecutor,” *ABC News*, (June 5, 2020), <https://abcnews.go.com/US/criminality-found-death-transgender-inmate-rikers-island-prosecutor/story?id=71095463>.

was not replaced. While she was on the Unit, she performed meal distribution and sanitation work in violation of DOC policy.

- Ms. Polanco was unobserved by anyone—DOC staff, CHS staff, or the Observation Aide — for periods of 35 minutes and 41 minutes during the critical hours after she was last observed alive. Notably, the 41-minute stretch during which no one observed Ms. Polanco occurred after the extended period when the clinicians and housing area officers had gathered outside her cell.
- The Department’s training requirements and Directives (PSEG Directive 4501R-D and RHU Directive 4499) are insufficient to ensure that housing area officers in PSEG units are adequately trained to conduct quality visual observations and confirm signs of life.
- The Department failed to maintain accurate and complete housing area logbooks in RMSC’s Segregation Unit on June 7, 2019.
- Housing area officers’ lack of notice about Ms. Polanco’s serious medical condition (epilepsy) compromised her safety.
- After Ms. Polanco’s death, DOC staff involved in the medical response were not appropriately connected to follow-up services, either through DOC ministerial services or DOC’s Correction Assistance Response for Employees program (CARE).
- Institutional record-sharing failures endangered Ms. Polanco’s safety in custody, in particular, problems with the legibility and distribution of the NYPD Medical Treatment of Prisoner (TOP Form) and the court’s failure to note Ms. Polanco’s medical issues on any of the court paperwork that accompanied her to Rikers.

E. RECOMMENDATIONS

To CHS

1. CHS should institute controls to ensure that collateral medical information accompanying a person into custody — such as information contained in NYPD Medical Treatment of Prisoner form and court notations — is thoroughly reviewed by Medical and Mental Health staff at Intake. This should include adding a question to the electronic intake screening form requiring CHS staff to indicate whether they have reviewed any accompanying/collateral medical information.
2. CHS should institute controls to ensure that a new patient’s current medications — including all recent prescriptions captured in the community fill database — are continued in custody, and that all such medications are bridged immediately at Intake, as required by CHS’s Intake Evaluation Policy (Policy#: MED 1). If there is a clinical determination that continuing a community medication is not appropriate, the reasons for that decision and any consultations with community providers or the patient should be recorded.
3. CHS must immediately act on SCOC’s December 17, 2019 Final Report on the Death of Wayne Henderson, which directed CHS to “commence a comprehensive review and revision of the medication delivery and reconciliation process for inmates within NYC DOC. Proper health records must also contain a record of medications prescribed by the physician and administered.”

4. CHS should develop a process for flagging and tracking patients with serious medical conditions who have low rates of medication compliance. This process should include a written analysis of the reasons why a patient has low compliance (e.g. patient refusal) and any operational barriers to compliance, (e.g. CHS staff could not locate the patient), and should also include an individualized medication compliance plan to address such issues.
5. As described in the Statement of Basis of Purpose to the Board's proposed rules on restrictive housing,²² CHS should develop and implement a clinical instrument to identify people with serious medical conditions (i.e. asthma, seizure, diabetes, heart disease, lung disease, liver disease, kidney disease, organ transplants, treatment with anticoagulants, and involuntary hospitalizations) at intake and in subsequent clinical encounters who are at elevated risk for negative outcomes if placed in cell housing areas. People so identified should be on a list accessible to DOC and should be categorically excluded from segregated units. Once this instrument is developed, CHS should regularly review it and make adjustments where clinically advisable.
6. CHS should institute greater controls to ensure that all clinicians conducting Treatment Plan Reviews review a patient's complete mental health and medical records before rendering an SMI designation for purposes of housing placements.
7. CHS should articulate an action plan to ensure that its staff are properly trained to effectuate exclusions from segregated units based on serious mental illness (SMI) and serious medical conditions.
8. CHS should institute written protocols for overriding previous exclusion determinations made by clinicians at an earlier date.
9. CHS should articulate an action plan to ensure all staff working in segregated units are properly trained on rounding protocols, particularly as they relate to conducting rounds of individuals who are in bed. CHS should take steps to ensure that prior to rounding in a segregated unit, Mental Health staff review the patient's full medical history, and Medical staff review the patient's full mental health history.

²² As stated in the Board's Statement of Basis and Purpose, (pp. 18-19): "Proposed rule § 6-07 emphasizes a separate exclusion for people with serious medical conditions from PSEG I and II . . . To implement this exclusion going forward, CHS, in consultation with the Board, has agreed to identify certain medical conditions and corresponding markers of acuity and advancement of disease for which separation could present a higher level of risk. Such conditions include, but are not limited to, asthma, seizure, diabetes, heart disease, lung disease, liver disease, kidney disease, organ transplants, treatment with anticoagulants, and involuntary hospitalizations. The Board will approve this list of conditions and markers, and all future modifications to it . . . [T]he Board and CHS have agreed on a new process for identifying people who are excluded from certain types of restrictive housing based on medical or mental health factors. Going forward, CHS will create a list at intake of individuals identified as meeting one or more medical or mental health exclusionary criteria. This list can also be updated after clinical encounters if and when someone develops an exclusionary condition while in custody. Every time the Department determines to place someone into a restrictive housing unit that carries medical or mental health exclusions, DOC will need to check against the list before placing that individual into the restrictive unit. This new process will obviate the need for the 'Mental Health Review for Punitive Segregation' form and all post-infraction involvement by CHS which could be perceived as "clearance" and, hence, minimize CHS' actual or perceived involvement with punishment."

TO DOC

1. DOC should articulate an action plan for managing interpersonal conflict in Special Consideration Units (formerly known as Transgender Housing Units (THUs)) to mitigate the need to transfer people out of a housing area, including the implementation of a population-specific conflict mediation program.²³
2. DOC should articulate an action plan for rehousing people transferred out of Special Consideration Units due to interpersonal conflict, including placement of transwomen in General Population units with cis-women.
3. DOC should issue an RMSC Command Level Order outlining the placement criteria and time limitations in new admission units, particularly units like SCU/THU New Admissions where people are housed alone for extended periods of time before and after entering a Special Consideration Unit. These units should be officially labeled in DOC records to reflect their population and function, to ensure transparency, and to enable oversight.
4. DOC should articulate an action plan to ensure that collateral medical information that accompanies someone into custody — such as any court or NYPD document reflecting a medical issue, including the Medical Treatment of Prisoner form — is relayed immediately to CHS, in a legible format. This plan should include elevating such information to a captain designated for that purpose as soon as the information is received or discovered.
5. To the extent that the practice of isolation continues in the NYC jails, individuals should only be held in cells with observation windows significantly larger than 5” x 20” (the current dimensions of most PSEG/RHU cells at RMSC).
6. Section IV(D)(5) of Directive 4501R-D (“PSEG Directive”) should be revised to resolve any ambiguity suggesting that the frequency of officer rounds is dependent on the presence of an Observation Aide, which it is not.
7. DOC should revise RMSC Command Level Order 21-19R (re: Watch Tour System) to specify that General Supervision Tours in PSEG areas must happen in 15-minute intervals, and also correct its Watch Tour documentation to flag when more than 15 minutes has lapsed between tours (in contrast to RMSC’s current practice of flagging Watch Tour data in red only if more than 30 minutes have lapsed between tours).
8. DOC should revise PSEG Directive (4501R-D) and RHU Directive (4499) to specifically require that officers look for and confirm signs of life during their regular rounds. These Directives should

²³ The Board notes that in July 2019, after Ms. Polanco died, Elizabeth Munskey joined DOC as its first Director of LGBTQ+ Initiatives, and that since then DOC has made strides in providing services, programming, and support for transgender people in custody. In February 2020, DOC reported to the NYC Task Force on Issues Faced by TGNCBI People in Custody that Ms. Munskey tours all facilities twice a month and RMSC (including the SCU) every Wednesday and holds one-on-one meetings with anyone who wishes to speak with her. DOC also has implemented bi-weekly trans-masculine and trans-feminine discussion groups with the intention of further developing these groups in collaboration with community partners.

expressly incorporate the “signs of life” language from DOC’s Inmate Count Procedures Directive (4517 R).

9. DOC should articulate an action plan to ensure that all housing area officers in PSEG units are steady in these posts and trained on PSEG/RHU-rounding procedures, including frequency and quality of rounds as well as supervision of people with serious medical conditions.
10. DOC should transition out of the practice of keeping paper logbooks and develop an electronic log system. The electronic system should capture information triggered at the individual cell-level. Until such a system is implemented, Tour Commanders should articulate an action plan to regularly audit PSEG logbooks against Genetec footage and Watch Tour data at unpredictable times to ensure that rounds are taking place as required and to detect incorrect entries.
11. The RMSC Tour Commander should ensure that the RHU maintains an RHU Behavioral Logbook, as required in DOC’s RHU Directive.
12. DOC should articulate an action plan to guarantee greater controls over the Observation Aide Program, including (i) protecting against the misuse of Observation Aides to perform other housing area duties; (ii) ensuring that all Observation Aide activities are properly documented, including their arrival and departure from the unit; (iii) ensuring that Observation Aides are posted in PSEG units at all times as required by DOC’s Observation Aide Program Directive (4017R-A). DOC should also resolve conflicting language in Section IV(D)(5) of the PSEG Directive suggesting that PSEG units can sometimes be without an Observation Aide.

TO DOC AND CHS, JOINTLY

1. Without revealing specific diagnoses or private medical information, CHS and DOC should develop a protocol to inform all housing area officers (whether or not assigned to segregation posts) when someone in their charge has a medical condition such as epilepsy that may require additional supervision or where a medical emergency is a foreseeable possibility. Such protocols may include a generalized code, color, or notation on an individual’s floor card, or else a process for requesting patient consent to make housing officers aware of certain conditions through the use of a bracelet or other identification. CHS and DOC should articulate an action plan to ensure that both agencies’ staff are trained in this new protocol, including additional supervision of those with serious medical conditions. CHS and DOC should articulate a joint plan to address lapses in medication administration and tracking due to patients being transferred to new housing placements.
2. DOC and CHS should coordinate a plan to ensure that CHS exclusionary determinations are made independently of DOC pressure, including a reporting system for CHS staff to inform management when undue pressure is being exerted by DOC personnel, and a system of accountability for DOC personnel who attempt to interfere with CHS’s evaluation processes.
3. DOC and CHS should articulate a joint action plan to ensure (i) that any staff involved in the immediate medical response of a serious incident be given the opportunity to have the remainder of their shift covered; and (ii) that all staff are directed to support services and provided an opportunity for follow-up services.

4. DOC and CHS should coordinate a grief response team for engagement in housing areas following serious incidents.

F. CONCLUSION

The Board takes seriously its obligation to thoroughly examine deaths in custody to identify systemic failures where they exist and make recommendations concerning DOC and CHS policies and practices. It is our hope that DOC, CHS, and the public can learn from our review of Ms. Polanco's death, and that the agencies will implement our recommendations to address systemic issues and prevent future deaths.