BOARD OF CORRECTION
CITY OF NEW YORK

First Report and Recommendations on 2026 Deaths in New York City Department of Correction Custody[1]

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Introduction

The New York City Board of Correction ("Board" or "BOC") investigates the circumstances of deaths in custody, pursuant to New York City Charter § 626(i)(2)[2] and § 3-10(c)(2) of Title 40 of the Rules of the City of New York.[3] These investigations do not focus on criminality or individual shortcomings. Rather, BOC aims to identify operational failures and procedural violations to make recommendations to the New York City Department of Correction ("DOC" or "Department") and New York City Health + Hospitals/Correctional Health Services ("CHS") to prevent future deaths.

The Department operates facilities on Rikers Island, an outposted therapeutic unit at Bellevue Hospital, and provides supervision and security at hospital prison wards located in Bellevue Hospital and Elmhurst Hospital. Additionally, DOC operates court holding pens in each of the five boroughs.

This report covers four deaths occurring between March and May 2026: Barry Cozart at the George R. Vierno Center ("GRVC"), John Price at Elmhurst Hospital, Rajpattie Ramkellawan at the Rose M. Singer Center ("RMSC"), and Umais Khan at the Eric M. Taylor Center ("EMTC").

Board staff began each investigation within 24 hours of receiving notification from DOC. Investigations include reviewing all relevant reports from DOC, CHS, the New York City Office of the Chief Medical Examiner ("OCME"), Emergency Medical Services ("EMS"), and hospital records. In addition, staff reviewed all available fixed

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[2] Except where the commissioner of investigation, the attorney general, or the district attorney for the county in which a death of an incarcerated individual held or confined under the jurisdiction of the department occurred investigates such death or prosecutes any alleged criminal offense related to such death and requests or directs the board not to investigate such death, the board shall investigate such death and prepare a report about such investigation. Such report shall include any recommendations about measures the department or correctional health services may implement to prevent the circumstances that contributed to the individual's death. Nothing in this subdivision shall be construed to limit the board's discretion to investigate a death of an incarcerated individual held or confined under the jurisdiction of the department, including any death the board attributes to a person's time in the custody of the department.

[3] The Board of Correction shall conduct an investigation of inmate deaths including the review of all medical records of the deceased.

surveillance footage and body-worn camera recordings. Staff also conducted interviews with both uniformed and non-uniformed personnel, as well as individuals in custody.

During each investigation, staff identified several lapses in adherence to policy, such as:

- Uniformed staff did not conduct meaningful tours of housing areas.
- Logbook entries noting consistent 30-minute tours were not accurate.
- Uniformed staff left their posts without authorization multiple times during assigned tours.
- Individuals in custody were observed congregating in unassigned cells due to unsecured doors.
- An observation aide engaged in unauthorized behavior in the presence of the floor post officer, instead of touring every ten minutes as required.
- Touring PIPES used to record tours were inoperable and offline.
- CHS staff were not notified by DOC that Mr. Price had been escorted to the clinic experiencing a medical issue requiring immediate attention, nor were they notified that Mr. Price's discomfort was escalating.
- Uniformed staff assigned to monitor medication disbursement failed to perform mouth inspections to verify individuals swallowed their medication.
- Video footage from one of the housing areas showed several individuals appearing to be in possession of drug paraphernalia.

Deaths in Custody

1. Barry Cozart

Age	39
Date of death	March 25, 2026
Admission date	November 15, 2025
Cause of death	Acute intoxication by the combined effects of methadone and gabapentin
Facility at time of death	GRVC
Bail amount	$30,000

Mr. Cozart entered DOC custody as a new admission on November 15, 2025. At the time of his initial intake assessment by DOC staff, he did not present any identified risk factors to support referral to further services or programming offered to individuals in custody.

During the medical screening, Mr. Cozart reported regular alcohol usage, stating that he drank four or more times a week, typically consuming five to six drinks per day. He also reported that he would experience tremors if he did not drink for three or more days. In addition, CHS learned through a urinalysis that Mr. Cozart recently used phencyclidine ("PCP"), methamphetamines, marijuana, and amphetamines. At the conclusion of Mr. Cozart's medical screening, CHS staff reviewed the results of his Clinical Institute Withdrawal Assessment ("CIWA").[4] Upon review, they determined he met the criteria for a STAT dose of Librium.

After completing the screening, Mr. Cozart was assigned to a new admission dormitory in EMTC. On January 3, 2026, DOC reported Mr. Cozart spit at staff through a cell window. Correctional staff served him an infraction for assaulting staff and transferred him to the Otis Bantum Correctional Center ("OBCC") three days later. On January 9, Mr. Cozart was found guilty on all charges following a hearing. On February 4, correctional staff transferred him to a cell housing area in GRVC, where he remained until he experienced a medical emergency.

On March 24, one day before Mr. Cozart's medical emergency, surveillance footage shows several individuals appearing to pass each other items resembling cigarettes.

[4] According to the National Institutes of Health, CIWA is a validated 10-item clinical scale used to objectively quantify the severity of alcohol of withdrawal syndrome and guide symptom-triggered treatment.

From 8:00 pm through 8:15 pm, footage captured Mr. Cozart passing and retrieving unknown items from individuals confined to their cells and actively moving around both levels of the tier, appearing to be under the influence. At one point, Mr. Cozart moved very slowly and lethargically, before suddenly running up the stairs. While on the top tier, he collapsed in front of a closet and slid to the floor, where he rested in the presence of the floor post officer[5] who was engaging with an individual nearby. The floor post officer subsequently returned to post without checking on Mr. Cozart. Approximately one minute later, Mr. Cozart returned to his feet, then collapsed again. Within minutes, he stood up, walked to the lower tier, and tried to access an unassigned cell multiple times but could not because it was locked.

Mr. Cozart entered his cell for the final time at approximately 8:57 pm, shortly before the 9:00 pm lock-in.[6] At approximately 9:13 pm, surveillance footage captured Mr. Cozart standing at his cell window. One minute later, the floor post officer opened his cell and engaged in a brief conversation with him before closing the door and continuing the lock-in process.

During the overnight tour, the observation aide on duty failed to conduct a tour every 10 minutes as required in Directive #4017R-D.[7] Instead, the aide was seen assisting individuals in opening their cell doors, allowing them to exit their cells during lock-in hours. Although the floor post officer generally conducted tours with the captain, there were periods of inconsistent supervision.[8] From 11:12 pm to 11:45 pm, the floor post officer was off post, leaving the area unstaffed and unsupervised.

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[5] The floor post officer, often referred to as the "B" post officer, is responsible for supervising, interacting, and ensuring the safety of incarcerated individuals directly on the housing area floor.

[6] DOC Directive #4009R-C, titled "Lock-In/Lock-Out," sets forth a mandatory schedule noting that individuals shall be locked-in every night, for no longer than eight hours within a twenty-four-hour period, specifically, from 9pm to 5am.

[7] DOC's Directive #4017R-D, titled "Observation Aide Program" classifies an Observation Aide as a specialized support incarcerated individual who is trained in suicide detection and intervention. They're primarily employed to monitor people at risk of suicidal behavior in mental health areas, restrictive housing, protective custody, new admission, and intake areas.

[8] Teletype Order No. HQ-02438-0, dated Oct. 20, 2023, mandates correction officers conduct unscheduled 30-minute rounds of their assigned housing units for the visual inspection of all individuals in all areas.

Video footage shows the officer spending that time inside the "A" control post.[9] A few hours later, from 2:12 am to 2:35 am, the floor post officer again went into the "A" control post, leaving the unit unstaffed and supervised.

At 12:08 am, the floor post officer and a captain toured the unit, both using their flashlights to look inside cells, including Mr. Cozart's. After briefly observing Mr. Cozart, they continued their rounds. During the overnight tour, the floor post officer recorded entries in the floor post logbook, noting that the touring PIPE was inoperable, cell doors could easily be manipulated, and individuals were instructed to remain in their cells. Despite these instructions, several individuals were observed outside their cells and moving around the tier.

Throughout the night, the floor officer conducted multiple tours. During each tour, the officer used their flashlight to inspect cells through the windows. The area captain also toured and used a flashlight for observation. The floor officer stated in a report that while touring overnight, they observed Mr. Cozart standing in his cell.

At 3:24 am, the floor officer again exited the post for the "A" control post and returned to the unit at 4:31 am with the food wagon. At 5:00 am, another officer arrived and relieved the floor post officer of their duties. The new floor officer signed onto the post at 5:57 am. After the floor officer assumed the post, they recorded a logbook entry confirming everyone in the unit was alive and well, without conducting a tour of the area.

The newly arrived floor officer conducted their first tour at 6:04 am. During the tour, the officer connected the tour PIPE[10] to the wall reader to register a tour despite

[9] The control post, also referred to as the bubble or the "A" station, serves as the housing area's secured control room, which is occupied by the "A" post officer and inaccessible to people in custody.

[10] According to Operations Order 11/17, "Watch Tour System," (effective July 11, 2027), the watch tour system is operated through the use of a handheld device known as a "PIPE," which transmits data to Touch Memory Buttons ("TMBs") mounted in housing areas. Each time a correction officer places the PIPE on a TMB, the device records the date and time of activation. Officers are required to immediately report any apparent malfunction of either the PIPE or TMB to the area supervisor and document the issue in the housing area logbook.

prior entries in the floor post logbook noting the tour PIPE was inoperable. The officer conducted a partial tour because they never walked the lower level.

30 minutes after the initial tour, the floor officer conducted another tour but did not check on Mr. Cozart. The floor officer exited the unit at 8:05 am and returned at 8:18 am, leaving the housing area unstaffed and unsupervised for approximately 13 minutes. The floor officer was continually off post, leaving the unit unstaffed and unsupervised from 8:19 am to 8:35 am, 8:46 am to 9:41 am, and again from 9:46 am to 9:53 am. At that time, they returned to their post with a clear bag containing toilet paper. With the assistance of one individual in the unit, the floor officer went cell to cell, distributing bathroom tissues. The individual threw one roll of tissue inside Mr. Cozart's cell. Afterwards, the floor officer partially entered the cell, then exited and continued distributing bathroom tissues throughout the unit.

At 10:30 am, 30 minutes after tossing the roll of tissue into Mr. Cozart's cell, the area captain and floor post officer conducted another tour of the housing area. Both briefly looked into Mr. Cozart's cell window. At 10:56 am, the mail room officer entered the control room with the mailbag.

At 11:02 am, the floor officer walked to Mr. Cozart's cell to advise him that he had received a package. The floor officer appeared to knock on the cell door and open it to call out to Mr. Cozart, but Mr. Cozart did not respond. The floor officer did not enter the cell. Two nearby individuals entered the cell and quickly exited. After the individuals exited the cell, the floor officer closed the cell door, exited the housing area, and appeared to communicate with the mailroom officer while standing outside the "A" control room. That brief exchange prompted the mailroom officer to enter the housing area and check on Mr. Cozart.

The mailroom officer reported that, upon reaching Mr. Cozart's cell, they tapped Mr. Cozart's leg and arm, which caused him to turn over. Foam and blood discharged from his mouth. At that moment – 11:05 am – the mailroom officer instructed the floor officer to call in a medical emergency and began performing chest compressions. The area captain arrived after hearing the call for medical assistance over the radio. Body-worn camera footage captured the captain assessing Mr. Cozart

and instructing the floor officer to turn him onto his side to perform rescue breaths.[11] The floor officer stated that Mr. Cozart "has blood coming from his mouth," which prompted the mailroom to retrieve a face mask and reposition Mr. Cozart's head for rescue breaths, but reported being unable to perform the first aid technique due to an obstruction in the airway. The two officers continued alternating performing chest compressions and administered one application of Narcan while awaiting CHS medical staff's arrival.

Medical staff arrived at 11:10 am. Records confirm that, upon arrival, uniformed staff were performing CPR. CHS response staff took over resuscitation efforts. Reports note that Mr. Cozart did not have a pulse. He was described as stiff and cold, bleeding from his nose, with fixed and dilated pupils. The heart monitor reflected a "flatline." The response team administered three additional doses of Narcan, utilized the Automated External Defibrillator ("AED") machine, provided oxygen, and continued CPR via a Lund University Cardiopulmonary Assist System device ("LUCAS").

While the response team attempted to resuscitate Mr. Cozart, body-worn camera activated by the mailroom officer recorded a person in Custody shouting that Mr. Cozart had "been like that for hours." Body-worn camera footage also captured a person in custody attempting to operate the LUCAS device, moving the gurney closer to Mr. Cozart's cell, and stating that Mr. Cozart needed to be shocked.

An Urgicare doctor declared Mr. Cozart deceased at 11:33 am.

Board staff interviewed people in custody who were present at the time of Mr. Cozart's passing. One individual stated that earlier that morning, the floor officer supervised him as he distributed rolls of bathroom tissue throughout the unit. He recalled that Mr. Cozart was sleeping when he reached his cell. He did not want to wake him, so he tossed the roll of tissue on his bed. He overheard the floor officer

[11] Healthline defines rescue breaths as a type of first aid that is given to people who have stopped breathing. During rescue breathing, you blow air into a person's mouth to supply them with vital oxygen.

attempt to speak to him. When Mr. Cozart did not respond, the officer closed his cell and they moved on.

Several individuals stated Mr. Cozart was known to use drugs. However, they did not specify the type of substances he would use. They further stated that drug use is widespread within the housing area and claimed that individuals using drugs could sometimes be identified by discoloration of their fingertips – described as black, orange, or burned – allegedly resulting from burning paper or tissues to lit cigarettes.

DOC's Special Investigation Unit officers inspected Mr. Cozart's cell following the incident. Officers observed paraphernalia affixed to the ventilation area, as well as two pills, Aripiprazole and Hydrochlorothiazide. They retrieved one metal object from underneath his bed. OCME investigators reported that, upon their arrival at the unit, Mr. Cozart exhibited signs of obvious rigor, foam in his mouth and nostrils, and his eyes were bloodshot. OCME determined that Mr. Cozart died due to acute intoxication by the combined effects of methadone and gabapentin. Mr. Cozart was not prescribed either of these medications by CHS.

Based on a preliminary review of the incident, DOC's Special Investigation staff determined there was enough evidence to support that the area captain and floor post officer were inefficient at performing their duties and therefore recommended both be suspended from duty for one month without pay.

2. John Price

Age	49
Date of death	March 28, 2026
Admission date	December 18, 2024
Cause of death	Influenza B pneumonia with superimposed methicillin-resistant staphylococcus infection (contributory: hypertensive and atherosclerotic cardiovascular and cerebrovascular disease)
Facility at time of death	EMTC
Bail amount	Remand

Mr. Price was admitted into DOC custody on December 18, 2024. Mr. Price informed correctional staff that he felt "fine." Due to court documentation requesting that he undergo a medical and mental health examination, uniformed staff flagged the request for CHS. During the medical screening, Mr. Price tested positive for cocaine. He informed the clinician he had an extensive medical history that included hypertension, congestive heart failure, and coronary artery disease, including a triple coronary artery bypass graft procedure in 2022. He also reported experiencing shortness of breath and heart palpitations.

After the screening, the clinician diagnosed Mr. Price with coronary artery disease, congestive heart failure, callosity, hypertension, obesity, hypokalemia, and xerosis. He was prescribed ammonium lactate lotion, amlodipine, potassium, spironolactone, hydralazine, clopidogrel, metoprolol succinate, and furosemide. The clinician listed Mr. Price as a "carry" patient and provided him with medication to self-administer in his housing area.[12]

During the mental health assessment, Mr. Price reported he occasionally consumed alcohol, typically drinking one to two drinks per month, and acknowledged past

[12] According to CHS's Medical Policies (Med #26), designated individuals with chronic medical conditions are allowed to carry and self-administer their prescribed medication in order to enhance access to treatment and self-management. Carry medication is dispensed by pharmacy staff through the medication window or secured area in the housing area and includes up to a seven-day supply.

cocaine use. The assessment did not reveal any history of suicidal thoughts, suicide attempts, or preparatory behaviors. Based on the clinical evaluation, Mr. Price did not meet the criteria for a major psychiatric disorder. However, the clinician diagnosed him with mild alcohol use disorder and cocaine use disorder. It was determined that no further mental health evaluations were necessary, and he was cleared to be housed in general population.

From December 8, 2024 through March 25, 2026, DOC housed Mr. Price in general population at three facilities: EMTC, West Facility, and the North Infirmary Command ("NIC").

On March 27, 2026, two individuals in Mr. Price's unit had an altercation in the dayroom, which led DOC staff to deploy chemical agents. Mr. Price was in the living area outside the dayroom when the altercation occurred.

Later that evening, correctional staff escorted Mr. Price to the clinic after he complained of nasal congestion and shortness of breath. CHS records note that a provider checked his vitals and administered an EKG test. After being seen in the clinic, CHS staff prescribed him guaifenesin and pseudoephedrine to relieve his chest congestion and cleared him to be returned to his housing area.

Surveillance footage shows Mr. Price moving slowly throughout the housing area at approximately 10:00 am on March 28. He showed signs of medical compromise, including fatigue and shortness of breath. He stopped to rest every few steps, sitting on unassigned beds. When he returned to his feet, he held onto his bed frame and the railing of a vacant bed to maintain his balance. Eventually, individuals noticed Mr. Price was in distress and began bringing him food.

At 12:49 pm, after lying on his bed for about 10 minutes, Mr. Price got up and approached the floor officer seated at the floor post desk. After reaching the floor post, he placed both hands on the desk, appearing to use it for support, then briefly spoke to the floor officer, who then spoke with the "A" post officer. Subsequently, the floor officer escorted him to the EMTC clinic. Upon arrival at the clinic, Mr. Price was secured in a clinic pen with other individuals awaiting medical evaluation.

Mr. Price arrived at the clinic at approximately 12:59 pm, just as the medical team was preparing to respond to another housing unit where an individual collapsed and was reportedly experiencing a seizure. The individuals in the clinic at that time, including Mr. Price, were secured in a pen while the medical team departed to respond to the emergency. According to the DOC clinic logbook, at the time he arrived at the clinic to be seen, the officer wrote that "no medical provider was on post," which caused a delay in treatment. Per CHS, nurses were available in the adjacent clinic, having responded to a medical emergency in that location, but DOC did not alert them to the need for additional medical support.

Medical staff returned to the clinic at 1:17 pm with the individual who reportedly suffered a seizure and moved him into a private room. While medical staff attended to the individual in the private room, uniformed staff allowed Mr. Price to exit the clinic pen several times to use the bathroom and fetch water. Each time he exited the pen, he appeared weak and showed signs of being lethargic. On one instance, he leaned on a trash can to avoid falling to the floor. At 1:47 pm, staff escorted the individual who reportedly experienced a seizure out of the clinic.

Medical staff started seeing other patients after the individual in distress departed the clinic. Mr. Price was seen by a medical provider at 4:33 pm, three hours and 34 minutes after he was produced at the clinic. The exam took place in a treatment room and lasted for 31 minutes. CHS records note that Mr. Price was seen for complaints related to shortness of breath and chest pain. Following the exam, at 5:03 pm, the examiner activated an EMS run. Mr. Price sat on a bench outside the treatment room while awaiting EMS until they arrived at 5:16 pm. They departed for Elmhurst Hospital with Mr. Price at 5:42 pm.

EMS arrived at the hospital at 6:00 pm. Reports note that, upon arrival, Mr. Price experienced significant respiratory distress as his breathing was abnormally rapid and shallow, his pressure was low, and he was not producing an adequate supply of oxygen. Hospital staff placed him on continuous cardiac, blood pressure, and pulse oximetry monitoring. In addition, laboratory studies were obtained, and imaging was ordered. Laboratory testing revealed Mr. Price's white blood cells were higher than

normal. He had a bacterial infection and low oxygen levels, and he began to enter renal failure, otherwise known as kidney failure.

As lab testing and chest imaging revealed Mr. Price was experiencing worsening respiratory distress, hospital staff transitioned him from a continuous positive airway pressure ("CPAP") to a bilevel positive airway pressure ("BIPAP"). In several instances, Mr. Price removed the BIPAP and catheter without notifying the medical team and got out of bed. Each time, staff redirected him back to bed and reconnected intravenous tubes.

Mr. Price's health continued to decline rapidly. Subsequently, he was admitted into the Medical Intensive Care Unit ("MICU") to manage low oxygen levels, lung malfunctioning, bacterial infection, and buildup of inflammation in the lungs. After transferring into the MICU, staff placed him on mechanical ventilation, vasopressor support, continuous cardiac monitoring, and ongoing intravenous antibiotic therapy.

On March 29, 2026, hospital staff found Mr. Price unresponsive and pulseless in the MICU. Medical responders attempted CPR. Initially, it seemed successful as it restored Mr. Price's heartbeat. However, he experienced a second cardiac arrest. Despite continued resuscitative efforts, Mr. Price was ultimately pronounced deceased at 5:37 am.

Board staff reported to EMTC to interview individuals housed with Mr. Price. During the interviews, several alleged Mr. Price began experiencing breathing difficulties following exposure to chemical agents. An Urgicare consultation note entered on March 29 noted that Mr. Price was exposed to chemical agents on Friday night (March 27). People in custody also alleged that he complained about shortness of breath and difficulty sleeping. Additionally, individuals advised that on more than one occasion, Mr. Price stated he felt as though he had "water in his lungs."

DOC investigators did not report finding anything unusual that would be considered contraband on Mr. Price's person or in the emergency room at Elmhurst Hospital. Investigators referenced notes from a hospital doctor, stating that Mr. Price did not appear to be under the influence of any substance at the time of admission. Hospital

staff believed his death was related to underlying medical conditions such as heart disease, pre-diabetes, and pneumonia.

A medical examiner performed an autopsy of Mr. Price on March 30, finding Mr. Price was atraumatic, with significant heart disease and pneumonia. OCME determined Mr. Price's cause of death was influenza B pneumonia with superimposed methicillin-resistant staphylococcus infection, contributed by hypertensive and atherosclerotic cardiovascular and cerebrovascular disease.

No DOC staff were suspended following Mr. Price's death.

3. Rajpattie Ramkellawan

Age	41
Date of Death	May 18, 2026
Admission Date	March 19, 2026
Cause of Death	Pending
Facility at time of Death	RMSC
Bail Amount	Remand

Ms. Ramkellawan entered DOC custody on March 19, 2026. At intake, staff observed her being incoherent and disoriented. During the medical screening, Ms. Ramkellawan denied using alcohol or drugs for over a year. Based on a records review from a previous incarceration, CHS learned that at a prior admission in 2025, Ms. Ramkellawan reported a history of using heroin, crack/cocaine, fentanyl, and on one instance, accidentally overdosing. Urinalysis tested positive for cocaine, fentanyl, and buprenorphine. Subsequently, the provider generated a Key Extended Entry Program ("KEEP") referral. KEEP is an opioid treatment program that provides methadone, buprenorphine, and other substance-use support services to individuals with an opioid use disorder.

During the mental health assessment, the examining clinician noted that Ms. Ramkellawan was not experiencing any mental health or emotional problems such as suicidal ideation, auditory and visual hallucinations. However, because of her extensive history of receiving psychiatric treatment during previous incarcerations, the clinician recommended placement in general population housing with mental health follow-up. In addition to the housing recommendations, the clinician

reaffirmed previous diagnoses, including bipolar 1 disorder with manic episodes, benign hypertension, and moderate to severe opioid use disorder. During the medical intake at around 10:00 pm on March 19, a CHS provider placed orders for immediate doses of methadone, Benadryl, Abilify, and Hydrochlorothiazide, which were then provided to Mr. Price.

On March 20, Ms. Ramkellawan was assigned to a new admission dormitory. Later that night, she was provided with the above-mentioned medications. In the days that followed, Ms. Ramkellawan missed scheduled appointments for nursing, dental, and psychiatry medication reevaluation. CHS records note that the missed appointments were attributed to court appearances, refusals, rescheduling by CHS, and non-production to the clinic by DOC.

On March 23, three days after transferring into the housing area, KEEP counselors met with Ms. Ramkellawan to assess her eligibility for the KEEP program. During the assessment, she denied misusing opioids and knowingly taking fentanyl. CHS records noted that at the time of the assessment, she was not interested in a medication-assisted treatment program.

On March 26, during a follow-up mental health assessment, a CHS clinician noted that Ms. Ramkellawan appeared mildly anxious, disheveled, and unkempt. Additionally, Ms. Ramkellawan did not appear to be an immediate danger to herself or others, and she was amenable to taking medication. Ultimately, the clinician reaffirmed that she was appropriate for general population housing with ongoing mental health monitoring and evaluations.

On March 30, Ms. Ramkellawan was transferred to a mental observation dormitory, where she remained for the duration of her incarceration. CHS staff met with her frequently following the move to assess her condition. CHS initially reported that her behavior, mental health awareness, and medication compliance improved. On May 12, CHS enrolled her in the KEEP program. On May 13, during a follow-up mental health visit, a clinician noted she seemed slightly disheveled and fatigued. Ms. Ramkellawan attributed her behavior to lack of sleep, anxiety, and mild depression, triggered by incarceration and the possibility of a negative legal outcome.

On May 17, four days after Ms. Ramkellawan's last clinician's assessment, surveillance footage captures Ms. Ramkellawan crushing pills received from other individuals in the unit and taking them. That day at 5:00 pm, the CHS pharmacy technician and medication escort officer entered the unit's "A" station to facilitate medication distribution. During medication distribution, the floor officer was observed alternating between medication services at the "A" station window and supervision of the housing area living quarters. Board staff did not observe the medication officer instruct the individuals receiving medication to open their mouths to confirm they ingested their prescribed medication nor did they as policy indicates.[13][14] Video footage shows individuals sharing their medication with others after receiving it, including Ms. Ramkellawan. Video footage also captures Ms. Ramkellawan crushing, snorting, and sharing medication with others.

That evening, an individual called 311 to file a complaint about the hot temperature in the dormitory. According to the logbook, the temperature in the morning ranged from 71.7 to 71.8 degrees Fahrenheit.

Ms. Ramkellawan appeared to sleep through the night. The following morning, on May 18, maintenance staff rectified the temperature issue. According to DOC records, the entire 800-bed was without air conditioning due to a water leak in the first-floor mechanical room that caused the HVAC system to shut off. The water leak caused the steam to activate the fire alarm system, prompting the HVAC to shut off. The leak was subsequently isolated, and the fire alarm was reset. The air conditioning was restored and working to reduce the temperature in the building.

During the night, the floor post officer did not make consistent meaningful tours as required in the absence of a suicide prevention aide.[15] Additionally, the floor officer

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[13] Post Description Index Number 015, Facility Medication Escort (effective Nov. 16, 2022), states staff are responsible for "controlling the medication to ensure that [a person in custody] ingests the medication."

[14] Operation Order No. 11/08, Post Descriptions (effective Nov. 19, 2008) notes, "floor post officers are responsible for monitoring and controlling inmate activity in cells, dayrooms, bathrooms, and showers."

[15] Per Directive # 4017R-D, Observation Aide Program, in the event an observation aide is absent or cannot perform the prescribed duties, the correction officer assigned to the "A" post shall make

walked off post several times. At 10:00 am on May 18, a CHS pharmacy technician and medication escort officer returned to the unit to dispense medication. Unlike the previous evening, the medication officer stood inside the unit near the "A" station, observing individuals as they received their medication.

Ms. Ramkellawan was in bed while medication was being dispensed. According to DOC records, the floor officer instructed individuals to wake Ms. Ramkellawan for medication. Body-worn camera video captures individuals attempting to wake her by tapping, shaking, and lifting her, while the floor officer called her name. Footage also recorded people saying, "something isn't right, she is foaming at the mouth." The floor officer responded and observed an unknown substance discharging from Ms. Ramkellawan's mouth, prompting the officer to tap her shoulder and ask if she needed help. After not getting a response, the floor officer performed a sternum rub and administered Narcan, while the escort officer activated a medical emergency via radio. The officers then administered a second dose of Narcan, checked her pulse, and began chest compressions. Uniformed staff continued life-saving efforts until medical staff arrived at 10:10 am.

CHS records note Ms. Ramkellawan was unresponsive, pulseless, and apneic, with fixed, dilated pupils. Her cornea was cloudy, her extremities were cyanotic, and she was cold to the touch. CHS response staff attached their cardiac monitor and defibrillator and requested assistance from EMS and the Urgicare doctor. They continued CPR, applied a finger stick, and attempted intravenous medication, but were unsuccessful due to poor venous access. Response staff also provided ventilation. Furthermore, they administered two additional doses of Narcan and used the LUCAS device for mechanical chest compressions. Upon arrival, Urgicare administered dextrose, a sugar solution via intraosseous access, and initiated Advanced Cardiac Life Support ("ACLS"). The Urgicare doctor confirmed a pulse before Ms. Ramkellawan was transported to the clinic.

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immediate notification to the housing area supervisor. The area supervisor shall instruct the security (floor) post officer to commence making 15-minute tours of inspection and logbook entries.

At 10:59 am, DOC surveillance footage captures medical staff entering a treatment room in the clinic with Ms. Ramkellawan, while EMS paramedics were already inside. According to CHS records, EMS attempted peripheral intravenous medication and transferred Ms. Ramkellawan onto their gurney, at which point she became pulseless with asystole. Paramedics restarted CPR and ACLS and administered four doses of epinephrine through an intraosseous site. Additionally, staff provided sodium bicarbonate. Unfortunately, all attempts to revive Ms. Ramkellawan were unsuccessful, prompting the Urgicare doctor to pronounce her deceased at 11:13 am.

On May 18, BOC staff interviewed individuals housed with Ms. Ramkellawan. They all stated that she recently started taking methadone. They recalled she was acting unusually and appearing unwell the night before her passing. While in bed, she would suddenly start screaming. They report that she was helped to her bed because she seemed unable to care for herself. The overnight observation aide stated that she observed Ms. Ramkellawan in bed, nodding off while sitting up.

Individuals further reported that Ms. Ramkellawan often sought pills from others, which she would crush and snort. The night before her death, surveillance video captured her crushing and snorting medication given to her by another individual in the unit.

Following Ms. Ramkellawan's death, DOC investigators searched her assigned bed and property, which yielded no contraband findings. Their preliminary review identified deficiencies in DOC staff's response; however, reports note further investigative actions are necessary to determine applicable discipline.

OCME investigators' preliminary review was inconclusive.

4. Umais Khan

Age	40
Date of Death	May 19, 2026
Admission Date	May 7, 2026
Cause of Death	Pending
Facility at time of Death	EMTC
Bail Amount	Remand

Mr. Khan, age 40, was arrested on May 5, 2026. Two days after his arrest, he entered DOC custody. During intake screening, he informed officers that he used cocaine in the community on a weekly basis. He also advised staff he was experiencing withdrawal and would like help overcoming his drug addiction.

Medical staff conducted their assessment of Mr. Khan on May 8. During the assessment, he disclosed to the examiner that he consumed five to six alcoholic beverages and smoked six cigarettes a day before being arrested. He also disclosed using heroin, fentanyl, crack/cocaine, marijuana, and ecstasy. Urinalysis results returned positive for cocaine.

Additionally, Mr. Khan reported that he was epileptic and experienced his first seizure at 13. He further advised that three weeks before entering custody on April 29, he had a seizure. He stated that the seizures are induced by his regular drug and alcohol use. He also shared that he had asthma. Furthermore, he disclosed mental health concerns such as a previous suicide attempt, depressed mood, hopelessness, and worthlessness. However, he denied current suicidal ideation. Subsequently, the medical provider submitted a STAT referral for him to receive a mental health evaluation.

Mental health staff evaluated Mr. Khan shortly after he completed the medical screening. The clinician reported that he did not appear to be internally occupied, in acute psychological distress, or violent. He presented himself as fully oriented with adequate judgement and no perceptual distortions. During a review of his Psychiatric Services and Clinical Knowledge Enhancement ("PSYCKES") paperwork, the clinician noted it included several inpatient hospitalizations related to alcohol abuse and one treatment of opioid overdose. Based on his positive urinalysis for cocaine, confirmed hospital admission for alcohol abuse, cigarette use, and opioid overdose, the clinician determined he met the criteria for several diagnoses that

included alcohol related disorder, other psychoactive substance-related disorders, tobacco-related disorder, cocaine related disorder, and opioid induced depressive disorder. He was also diagnosed with a seizure disorder. In response, CHS prescribed an inhaler, anti-seizure medication, and detox medication, which he had received in the community. CHS recommended placement in general population housing, with scheduled mental health follow-up appointments.

On May 8, Mr. Khan was transferred to a general population dormitory. On May 12, CHS enrolled him in the KEEP program. KEEP staff performed a clinical assessment, established a treatment plan, and counseled him on medication and overdose prevention.

On May 13, Mr. Khan called CHS's health triage line, requesting to be added to the call-down list to be seen for eczema all over his body. The following day, DOC transferred Mr. Khan to another general population dormitory in EMTC. Mr. Khan was seen by a mental health prescriber after he transferred into the new unit as part of his treatment plan. During the visit, he informed the prescriber that he felt depressed and requested medication to counter the symptoms. The clinician recorded his concerns and noted that he exhibited mild psychiatric symptoms, which prompted them to prescribe new medications including an antidepressant and melatonin for insomnia.

CHS scheduled Mr. Khan for a clinical appointment after he called the health triage line to complain about eczema spreading over his body. Between May 14 and May 18, CHS placed him on the clinic call down list three times, but each time records indicate DOC did not produce him to the clinic.

Mr. Khan remained in his new housing unit without incident until May 19. Board staff reviewed footage from Mr. Khan's housing area beginning at 8:58 pm on May 18.

Throughout the evening on May 18, Mr. Khan ate, played cards, and socialized with various individuals in the unit. During this same time, the "B" post officer failed to conduct consistent 30-minute rounds. Instead, video footage captures the officer standing in the rear of the unit engaging with individuals.

At 11:20 pm, Mr. Khan went to bed. At 1:38 am on May 19, he woke up and walked to the bathroom. At 1:41 am, he returned to his bed, covered himself with a blanket, and went back to sleep. At 3:09 am, he appeared to slightly move his foot.

At 4:30 am, correctional staff delivered breakfast to the unit. The floor post officer unlocked the dayroom door to allow individuals to assist with food preparation and distribution of the breakfast trays. At 4:59 am, an observation aide placed a breakfast tray on Mr. Khan's institutional bin. Mr. Khan remained asleep and did not respond to receive his meal. Throughout the morning, tours were inconsistent. Video footage captured the floor officer walking off post for the “A” station twice, leaving the floor without direct supervision from 7:33 am to 7:55 am and 9:05 am to 9:26 am. While the officer was off post, Mr. Khan, who appeared to be asleep, was observed moving several times between 8:52 am and 8:55 am.

At 10:54 am, an individual in the unit attempted to wake Mr. Khan after noticing his food tray had gone untouched. The individual stated that he pulled back the cover over Mr. Khan’s body and noticed his nose was running. That prompted him to alert the floor post officer, who responded to Mr. Khan’s bed along with other individuals in the unit. They shook Mr. Khan, hoping to get a response. Once they stopped, the floor officer observed bodily fluid discharging from his mouth.

With the assistance of individuals, the floor officer turned him on to his side to keep his airway clear and prevent choking. At that moment, the floor officer noticed that he was not breathing, and his lips were blue-ish or gray. Subsequently, at 10:55 am, the floor officer activated a medical emergency and began chest compressions. Additionally, the floor officer handed an individual in the unit Narcan and instructed him to administer Narcan while they continued chest compressions. Another individual attempted rescue breaths in between chest compressions performed by the floor officer. Uniformed staff continued resuscitation efforts until the CHS response team arrived.

Medical staff entered the area at 11:01 am, six minutes after the officer activated the medical emergency. The response team arrived with a cardiac monitor, a LUCAS device, and an Ambu bag that supplies oxygen. Per CHS reports, upon arrival, Mr.

Khan was supine on the bed, unresponsive, not breathing, with pupils fixed and dilated, discolored lips, a rigid jaw, and cool to the touch.

CHS continued resuscitation efforts, which included utilizing a cardiac monitor, a LUCAS device, an Ambu bag, and administering four additional doses of Narcan. CHS records indicate medical staff attempted to provide medication intravenously through Mr. Khan's left arm. However, body-worn camera footage captures them stating the line was unsuccessful.

The Urgicare doctor entered the unit at 11:18 am and began assessing Mr. Khan, confirming he was pulseless and had flatlined. CHS response staff were instructed to discontinue resuscitation efforts. Urgicare declared Mr. Khan deceased at 11:21 am.

Board staff interviewed individuals housed with Mr. Khan on May 19. Of the individuals interviewed, three were observation aides. The observation aides stated they knew Mr. Khan well. They met him during his previous incarceration (January 2026 through April 2026) when they were assigned to the same housing area. Upon returning to custody, in May 2026, he advised that he was receiving methadone through the KEEP program. They remembered hearing him complaining about the side effects of medication, which usually occurred after eating. They reported that he tried to get to the clinic multiple times, but he was “never picked up by DOC.” Medical records show CHS scheduled Mr. Khan to be seen in the clinic on May 14 and May 15 after he contacted them through the Health Triage Line, but missed those appointments due to non-production.

Before Mr. Khan’s medical emergency, correctional staff conducted a search in his housing area on May 12, 2026. The search did not recover contraband. Following Mr. Khan’s death, correctional staff searched his bed and personal belongings and did not recover contraband.

A medical examiner performed an autopsy on the morning of May 20, 2026. A quick toxicology test revealed positive results for opiates and methadone. The autopsy report and official cause of death is still pending.

DOC's investigators determined that the floor officer assigned to Mr. Khan's housing area on the morning of his medical emergency was inefficient in performing his duties and therefore issued a ten-day suspension without pay.

Key Findings

Deficient supervision and failure to conduct meaningful tours

BOC staff discovered that in each of the four deaths, correctional staff failed to conduct supervisory tours and welfare checks in accordance with DOC Teletype HQ-02438-0, which requires correctional staff to conduct 30-minute unscheduled rounds in general population areas and every 15 minutes in a mental observation housing unit when there is no observation aide on shift.

Based on a review of surveillance video, correctional staff appeared to rely on brief visual observations through cell windows or from the floor post desk at the front of the dormitories, rather than walking around the area to adequately assess the condition of individuals in custody. Housing areas were also frequently left unstaffed or unsupervised for extended periods, which violate DOC Rules and Regulations #7.05.070, prohibiting correctional staff from leaving their post without approval from their supervisor or without being properly relieved.

Inaccurate logbook entries

According to Directive 4514R-C, "Housing Area Logbook," logbook entries must be made without undue delay, recorded legibly, accurately, consistently, and in chronological order. However, BOC uncovered several instances across all four investigations when logbook entries did not fully align with independent review of the available video footage.

Observation aide engaged in behavior inconsistent with DOC rules

According to Directive 4017R-D, "Observation Aide Program," observation aides are required to conduct vigilant patrols of housing areas at irregular intervals not to exceed 10 minutes between tours. The directive further outlines that individuals may be removed from the program for improper performance of duty, sleeping on

duty, improper conduct, violating rules, or encouraging an individual to attempt suicide or engage in suicidal gestures.

Observation aides failed to conduct required tours and, in some instances, participated in unauthorized activities such as sharing prescribed medication. They were also observed not wearing identification vests required under Security Memorandum No. 01/26, effective February 3, 2026. At the time of Mr. Cozart's death, however, the required vests had not yet been distributed to his housing area, as they were being utilized in another housing area as part of a pilot program.

The overnight observation aide in Mr. Cozart's unit was observed on camera assisting individuals to manipulate their cells to allow them to exit their cells after the institutional lock-in. Further, the observation aide did not make any tours of the unit.

In the case of Ms. Ramkellawan, video footage shows the observation aide, who was readily identified by the required vest, sharing medication with other individuals in the housing unit. The floor post officer was simultaneously monitoring the dayroom, the dormitory, medication distribution, and food distribution at the time, allowing individuals to engage in this activity without notice.

<u>Medication escort officer failed to perform mouth inspections following medication disbursement</u>

According to the post description for the facility medication escort, the duties of the medication escort include supervising people in custody during medication administration by positioning themselves to personally observe ingestion, ensuring that medications are swallowed, and preventing hoarding or unauthorized use.

Video footage reviewed by the Board uncovered that correctional staff failed to adhere to the policy while distributing medication in Ms. Ramkellawan's housing area the evening before her death. The CHS pharmacy technician dispensed medication from the "A" station while the medication escort remained inside the "A" station. Additionally, after entering the unit, the medication officer failed to verify that individuals ingested their medication.

PIPES used to record tours were inoperable and offline

The tour PIPE (equipment used to record floor post officer tours) was inoperable when used by the floor post officer in Mr. Cozart's housing area the day of his death. BOC's investigation revealed that the tour PIPE had been offline 48 hours before Mr. Cozart's death. DOC has since corrected the issue and tour PIPES are now operable in this area.

Accessing and congregating in unauthorized cells

Uniformed staff assigned to Mr. Cozart's housing area failed to enforce Directive #4009R-C, which prohibits individuals from accessing unauthorized cells, and Directive #4517R, which prohibits multiple individuals from occupying a single cell. Correctional staff's failure to enforce the policies created opportunities for individuals to engage in unauthorized activities, including contraband-related behavior.

Failure to ensure timely access to medical care

DOC reports note that correctional staff activated a medical emergency for Mr. Price after noticing he was unwell. However, according to CHS, DOC did not communicate to clinic staff that Mr. Price was experiencing a medical emergency. After DOC correctional staff in the clinic learned Mr. Price was ambulatory, they asked the floor officer to escort him to the area. As requested, the floor officer walked him to the area.

Upon arrival at the clinic, correctional staff secured Mr. Price in a holding pen and documented the incident in DOC's clinic logbook as a "walking medical emergency." CHS clinic staff do not have access to the DOC clinic logbook and were not advised that he had presented as experiencing medical distress or discomfort. Around the same time, CHS departed for a medical emergency in another housing area. Logbooks indicate that CHS providers responded to that housing area, escorted the individual back to the clinic to complete treatment, and subsequently released the individual back to the housing unit.

According to the DOC clinic logbook entrance, there were no CHS medical providers present in the clinic at 3:00 pm. As a result, Mr. Price remained in the holding pen

without being evaluated for approximately four hours, despite appearing to exhibit signs of distress during that time. At 5:03 pm, CHS activated an EMS transport for him.

Possession of contraband

Individuals in Mr. Cozart's unit appeared to be in possession of contraband resembling a white cigarette, in violation of the Person in Custody Rule Book, Section 103.11, which prohibits individuals from making, possessing, selling, or exchanging narcotics, controlled substances, or drug paraphernalia. The floor officer assigned to the unit was actively conducting tours while individuals openly engaged in contraband-related activity. Despite these activities occurring during the officer's tour, they did not intervene to stop or address the misconduct.

Additionally, BOC observed individuals in Ms. Ramkellawan's unit congregating and sharing medication, in violation of Section 103.13 of the Person in Custody Rule Book. This rule prohibits people in custody from selling or exchanging prescription or non-prescription medication and from possessing prescription medication that has not been authorized by medical staff. Individuals in the unit exploited areas outside of the floor officer's immediate line of sight to engage in contraband-related activity without detection or intervention. While the officer conducted tours of the dormitory, bathroom, and dayroom, and monitored the pantry and institutional feeding, individuals took advantage of unsupervised portions of the housing area to exchange or use contraband behind the officer's back.

Recommendations to DOC

1. Reinforce and retrain staff on basic supervision, touring, and logbook entry practices, including but not limited to, correction officers' responsibility to remain on post and remain vigilant. Training should also focus on accurately and legibly documenting personal breaks, meals, tours, and incidents in

logbooks, and tour units as required by Directive #4514R-C and rules and regulations 2.30.010 and 7.05.0904.[16]

2. Facility leadership must designate supervisors to periodically review surveillance video to identify correctional staff who frequently demonstrate poor touring and documenting practices inconsistent with policy. Correctional staff found to be operating outside of policy must meet with facility leadership before returning to their post. If deemed necessary, they should also be scheduled for refresher training in the identified areas of deficiency.[17]

3. Housing area correctional staff must immediately notify their immediate supervisor when they observe the presence or use of contraband and intervene to confiscate it. DOC staff must arrange an unscheduled search of the unit immediately after such notification is received and drug test the individuals in custody assigned to that unit.[18]

4. Utilize the Video Monitoring Unit for its intended purpose as noted in Operations Order # 2/19, to support facilities in identifying security concerns that include individuals using and/or in possession of illegal substances and tobacco.[19]

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[16] As recommended in *the Third Report and Recommendations on 2025 Deaths in [NYC DOC] Custody*, *Second Report and Recommendations on 2025 Deaths in [NYC DOC] Custody, First Report and Recommendations on 2025 Deaths in [NYC DOC] Custody, Second Report and Recommendations on 2024 Deaths in [NYC DOC] Custody*, and *Second Report and Recommendations on 2023 Deaths in [NYC DOC] Custody.*

[17] As recommended in *the Third Report and Recommendations on 2025 Deaths in [NYC DOC] Custody.*

[18] As recommended in *the Third Report and Recommendations on 2025 Deaths in [NYC DOC] Custody. Also, included a similar recommendation in the First Report and Recommendations on 2025 Deaths in [NYC DOC] Custody, First Report and Recommendations on 2023 Deaths in [NYC DOC] Custody, Third Report and Recommendations on 2022 Deaths in [NYC DOC] Custody,* and *Second Report and Recommendations on 2022 Deaths in [NYC DOC] Custody.*

[19] As recommended in *the Third Report and Recommendations on 2025 Deaths in [NYC DOC] Custody, First Report and Recommendations on 2025 Deaths in Custody, Second Report and Recommendations on 2025 Deaths in [NYC DOC] Custody, Second Report and Recommendations on 2024 Deaths in [NYC DOC] Custody, First Report and Recommendations on 2024 Deaths in [NYC DOC] Custody,* and *First Report and Recommendations on 2023 Deaths in [NYC DOC] Custody.*

5. Enforce BOC Minimum Standard §1-04 (a)(b)(1), which prohibits more than one individual occupying a single cell.[20]

6. Relieve observation aides from duty when found to operate outside of the Observation Aide Program.

7. Reassign medication escort staff who are failing to monitor medication as policy requires. Additionally, prohibit these staff members from future medication escort assignments.

8. Ensure equipment used to record correctional staff tours is operable before distributing it to staff. Require staff in possession of inoperable equipment to report defective equipment to their area supervisor and record a logbook entry reflecting equipment is not usable.

Joint recommendations to DOC and CHS

1. Establish a protocol for clinic correctional staff to promptly and clearly relay all calls for medical assistance involving individuals in custody to the appropriate CHS clinical staff to ensure timely and appropriate notification by DOC to CHS.

2. Reiterate that their respective staff must report safety concerns and failure to adhere to policy to their supervisors, particularly in the event they observe people in custody receiving medication without appropriate supervision.

[20] As recommended in *the Third Report and Recommendations on 2025 Deaths in [NYC DOC] Custody and Second Report and Recommendations on 2025 Deaths in [NYC DOC] Custody.*

NYC Department of Correction Response to Board of Correction's "First Report and Recommendations on 2026 Deaths in New York City Department of Correction Custody"

The Department understands the Board's responsibility to investigate circumstances of deaths in custody as per its Minimum Standards. At the time of publication, the deaths of all individuals identified in the report remained under investigation by either the NYS Attorney General or the NYC Department of Investigation. Consequently, the Department is unable to provide a substantive response. The Department does, however, plan to review and respond to the Board's recommendations when appropriate do so.

NYC HEALTH+ HOSPITALS

Correctional Health Services

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September 24, 2026

Dear Ms. Cintrón Hernández,

Please find below NYC Health + Hospitals/Correctional Health Services' (CHS) public-facing response to recommendations to CHS in the NYC Board of Correction's "First Report and Recommendations on 2026 Deaths in New York City Department of Correction Custody."

Joint recommendations for DOC and CHS

1. *Establish a protocol for clinic correctional staff to promptly and clearly relay all calls for medical assistance involving individuals in custody to the appropriate CHS clinical staff to ensure timely and appropriate notification by DOC to CHS.*
2. *Reiterate that their respective staff must report safety concerns and failure to adhere to policy to their supervisors, particularly in the event they observe people in custody receiving medication without appropriate supervision.*

CHS' response

1. Health care providers must be notified in a timely and clear fashion in order to most effectively provide medical assistance. Accordingly, CHS will support DOC as it establishes its protocol for DOC staff to promptly and appropriately relay all calls for medical assistance involving individuals in custody to the appropriate CHS clinical staff.
2. CHS will also reiterate to its staff that they are expected to escalate to their supervisors safety concerns or failures to adhere to policy, including instances where patients may be receiving medication without appropriate supervision or observation.

Sincerely,

Jeanette Merrill

Jeanette Merrill, MPH
Senior Assistant Vice President