BOARD OF CORRECTION
CITY OF NEW YORK

Third Report and Recommendations on 2025 Deaths in New York City Department of Correction Custody[1]

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Table of Contents

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 finding criminality or individual shortcomings, but on identifying systemic flaws and policy failures, and making recommendations to the New York City Department of Correction ("DOC" or "Department") and NYC Health + Hospitals/Correctional Health Services ("CHS"). CHS's response to these recommendations is appended to this report.

DOC operates eight housing facilities on Rikers Island and provides security at hospital prison wards in Manhattan and Queens. Additionally, DOC operates court pens in each of the five boroughs. In 2025, 15 individuals died while in custody or shortly after the court issued an order releasing them on their own recognizance. In a previous report titled "First Report and Recommendations on 2025 Deaths in New York City Department of Correction Custody," the Board detailed findings and recommendations concerning five deaths that occurred between February and March 2025. In its "Second Report and Recommendations on 2025 Deaths in New York City Department of Correction Custody," the Board covered seven deaths that occurred between June and September 2025. This report details the circumstances and recommendations related to the deaths of Edwin Ramos, Aramis Furse, and Kyron Randall, who died in November and December 2025.

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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.

Board staff responded to the respective facilities where each person died within 24 hours of receiving notification from DOC. BOC's investigations consist of collecting and reviewing all relevant DOC, CHS, New York City Office of the Chief Medical Examiner ("OCME"), Emergency Medical Services ("EMS"), and hospital records. In addition, staff reviewed relevant fixed surveillance videos and footage from body-worn cameras. Lastly, staff interviewed both uniformed and non-uniformed staff as well as individuals in custody.

Some matters of concern staff discovered during these investigations include:

- The "B" post officers assigned to Mr. Furse's and Mr. Randall's housing areas abandoned their assigned posts multiple times during their tours.
- The "B" post officer left Mr. Randall in his cell, unsupervised and unsecured, for 24 minutes during his medical emergency.
- Logbook entries recorded by the officer in Mr. Randall's housing area reflecting consistent 30-minute tours are inaccurate, as video footage shows the officer did not tour according to policy.
- The "B" post officer in Mr. Randall's housing area did not conduct tours in accordance with DOC Directive #4514R-C, which requires officers assigned to cell areas to conduct visual observations at 30-minute intervals, observing signs of life in each person in custody.
- Multiple cell windows in Mr. Furse's housing area were partially or completely covered, obstructing correction officers' views into the cells.
- Individuals in Mr. Ramos' housing area appeared to possess drug paraphernalia.
- Individuals in custody in Mr. Furse's housing area accessed unauthorized cells during lockout periods, congregating in single cells designated for one person.
- Housing area staff allowed individuals in Mr. Furse's housing area to remain locked out after 9:00 pm lock-in. After the 9:00 pm mandatory lock-in period, individuals were out of their cells and covered stationary cameras with tissues.

Deaths in Custody

1. Edwin Ramos

Age	38
Date of death	November 21, 2025
Admission date	August 15, 2025
Cause of death	Pending
Facility at time of death	Otis Bantum Correctional Center ("OBCC")
Bail amount	$20,000

Mr. Ramos entered DOC custody as a new admission on August 15, 2025. Intake staff at the Eric M. Taylor Center ("EMTC") secured him in a new admission holding pen and began the screening process. After completing the DOC portion of the screening, CHS staff examined Mr. Ramos. During the exam, CHS staff identified two health conditions. The clinician noted Mr. Ramos was obese and had elevated blood pressure. For the next three days, Mr. Ramos was escorted to the clinic to check his blood pressure.

During the medical screening, Mr. Ramos told CHS staff that he used fentanyl and cocaine in the community. Urinalysis test results were negative for drugs. He requested to be enrolled in the Key Extended Entry Program ("KEEP"), a program for medication management of moderate to severe opioid use disorder. Records show Mr. Ramos did not meet the criteria outlined in the DSM-5[4] for moderate to severe opioid use disorder in keeping with federal Opioid Treatment Program ("OTP") guidelines and, therefore, did not qualify for enrollment in the KEEP

[4] According to the United States Centers for Disease Control and Prevention ("CDC"), the DSM-5 (Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition) defines Opioid Use Disorder ("OUD") as a problematic pattern of opioid use leading to clinically significant impairment or distress. OUD is demonstrated by two of 11 criteria occurring within a year, including taking opioids in larger amounts or over a longer period of time than intended, a persistent desire or unsuccessful attempts to reduce or control opioid use, continued opioid use causing inability to fulfill work, home, or school responsibilities, exhibiting withdrawal symptoms, among others.

program. CHS determined that general population housing was clinically appropriate for Mr. Ramos.[5]

On August 18, 2025, DOC assigned Mr. Ramos to a new admission dormitory area in EMTC. Two days later, he was transferred to a dormitory area at the Rose M. Singer Center Enhanced Supervision Housing ("RESH") Annex.[6] While in the RESH Annex, he received an infraction for his role in an assault on staff. The hearing captain found him guilty on all charges at the hearing.

On October 29, 2025, two months after entering DOC custody, CHS received Mr. Ramos' medical record from the New York State Office of Mental Health. Unlike what Mr. Ramos stated at intake, records showed a history of behavioral health diagnoses, such as psychoactive substance-related disorders, alcohol-related disorders, cocaine use disorder, tobacco-related disorders, major depressive disorder, unspecified psychotic disorders, and unspecified anxiety disorders. In addition, the records also mention Type 2 Diabetes Mellitus.

Later in the month, at 1:00 pm on October 30, 2025, correctional staff in Mr. Ramos' housing area activated a medical emergency after learning he was experiencing pain in his right shoulder and chest for two consecutive days. CHS staff arrived at 1:06 pm. Medical responders assisted him onto a gurney and departed the area for the clinic. Once in the clinic, CHS staff checked his blood pressure. It was elevated, at 199/118. The on-site doctor ordered a stat dosage of clonidine to bring down his blood pressure. Repeat blood pressure was 195/110. CHS staff called EMS to request a hospital transport. Following treatments and EMS arrival, Mr. Ramos' blood pressure was 134/88; 20 minutes later it was 134/91. EMS departed the clinic with Mr. Ramos for Elmhurst Hospital. Elmhurst staff examined Mr. Ramos and did not find any abnormalities, which prompted them to process him for discharge back to Rikers Island.

On October 31, 2025, Elmhurst staff discharged Mr. Ramos from the hospital. Correctional staff transferred him to a general population housing area in the

[5] General population housing is designed by custody level for individuals who do not require special housing.

[6] General population dormitory at RMSC that exclusively houses men.

George R. Vierno Center ("GRVC"). Upon his return that day, CHS staff prescribed him a 10-day supply of amlodipine and lisinopril, commonly known to treat high blood pressure.

On November 6, 2025, correctional staff transferred Mr. Ramos to a general population dormitory in OBCC. He remained in this unit incident-free until November 20, 2025.

On November 20, Mr. Ramos' housing area had a "B" post officer assigned to the unit.[7] Despite having a "B" post officer, video surveillance captured several individuals in possession of or smoking unknown paraphernalia during the "B" officer's shift. At 6:14 pm, while the officer sat at the "B" post desk by the housing area entrance, one individual sat on Mr. Ramos' bed and appeared to a roll slim, white paraphernalia resembling a cigarette. Individuals appeared to smoke the paraphernalia at 6:18 pm but quickly extinguished it before the "B" officer reached their area during their tour. Mr. Ramos was not one of the individuals smoking the paraphernalia.

At 7:15 pm, the individuals lit new paraphernalia that resembled a cigarette while the officer conducted another tour. At 10:44 pm, six individuals gathered between two beds and appeared to share the contraband resembling a cigarette while the "B" officer was seated at the "B" post. During this time, video showed the officer exiting the unit twice from 6:50 pm through 6:54 pm and 9:54 pm through 10:05 pm.

At 11:24 pm, video surveillance captured Mr. Ramos removing an unknown item from a folder next to his bed and placing the contents in his mouth. At 11:56 pm, shortly after ingesting the item, he entered the bathroom holding a roll of toilet paper. He appeared lethargic as he suddenly leaned over the bathroom partition. He exited the bathroom for a moment then reentered at 12:00 am. At 12:05 am, appearing to be done using the bathroom, he stood up and suddenly fell forward, face down. An individual in the unit entered the bathroom moments after Mr.

[7] DOC uses the term "B" post when referring to a correction officer assigned to a housing area floor post. "B" post officers interact with and directly supervise people in custody inside the living area.

Ramos fell to the floor. The individual appeared to alert the "B" post officer, which prompted them to enter the bathroom. Once inside, the "B" officer observed Mr. Ramos on the floor with a white sheet over his body. Subsequently, the "B" officer appeared to call out for the "A" post officer and advise them to activate a medical emergency.[8] Body-worn video captured the officer state that Mr. Ramos was appearing to have a seizure. Video footage also captured the officer removing the sheet and pulling up Mr. Ramos' pants. The officer then turned Mr. Ramos onto his side, at which time he could be heard snoring and slightly moving his right hand.

The "B" officer started rubbing Mr. Ramos' arm and checked his pulse. The officer then instructed an individual in the bathroom to go to the "A" station window to retrieve Narcan[9] from the "A" post officer. At 12:10 am, five minutes after observing Mr. Ramos in distress, the "B" post officer administered Narcan. At 12:11 am, the officer administered a second dose of Narcan and began chest compressions.

At 12:15 am, CHS staff arrived with portable emergency response equipment, including a flat board, a CPR disposable mask, and a medical supply bag. According to CHS records, Mr. Ramos was on the floor in a supine position, and his skin appeared to be discolored. Body-worn camera footage shows a nurse instructing that EMS be immediately notified at 12:17 am, and a DOC captain relaying the message to Central Control. The DOC captain began administering chest compressions while the nurse placed automated external defibrillator ("AED") pads on Mr. Ramos. At 12:20 am, CHS staff noted that the reading on the AED device was "not flat" and that Mr. Ramos had a pulse. Staff administered a third dose of Narcan before placing Mr. Ramos on a flat board and carrying him to the clinic at 12:21 am, arriving at 12:25 am. EMS arrived at the clinic at 12:37 am and immediately provided fluids intravenously, administered five doses of epinephrine, and completed intubation. The Urgicare physician administered an additional dose of

[8] "A" post officers remain inside the "A" station, colloquially known as the "bubble." The "A" station is the housing area's secured control room and cannot be accessed by people in custody.
[9] Per DOC Directive #2/22, effective June 30, 2022, Naloxone (Narcan) is a life-saving medication in the form of a nasal spray that can reverse the effects of an opioids overdose. Trained staff members and incarcerated individuals can administer Narcan if an individual displays unresponsiveness, slow or no breathing, blue or grey lips and/or fingernails, or snoring or gurgling sounds.

epinephrine and administered sodium bicarbonate. EMS administered one round of calcium before departing the facility with Mr. Ramos. EMS transported Mr. Ramos to Mount Sinai Queens, where he was pronounced deceased at 1:25 am.

Immediately after CHS departed the housing area with Mr. Ramos, the "B" post officer exited the bathroom and conducted a tour of the area. The officer observed an individual sleeping on a bed holding what appeared to be lit contraband. The contraband resembled a cigarette as it was slim and white. The officer removed the contraband without waking the individual and continued the tour. In addition to confiscating contraband following the incident, all individuals in custody housed in Mr. Ramos' unit were drug tested. Some individuals refused to cooperate. Most tested negative. However, test results for four individuals were presumed positive. Reports do not indicate the substance for which the individuals tested positive.

DOC dispatched a Special Search Team to Mr. Ramos' housing area. The team searched all individuals in custody in the unit, their beds, property, and community areas. Staff did not recover drug-related contraband.

DOC's Special Investigations Unit assigned staff to investigate this incident. Their investigation is ongoing; however, preliminary findings do not identify wrongdoing or staff misconduct.

OCME has yet to provide the Board with records on Mr. Ramos' cause of death.

2. Aramis Furse

Age	32
Date of death	December 7, 2025
Admission date	May 3, 2025
Cause of death	Pending
Facility at time of death	OBCC
Bail amount	$45,002

Aramis Furse arrived at EMTC as a new admission on May 3, 2025. During the new admission assessment, intake staff noted Mr. Furse had a history of using cocaine and consuming alcohol.

CHS staff examined Mr. Furse after he completed DOC's screening. He informed staff that he had a history of asthma and reported sustaining a head injury that caused him to lose consciousness one year earlier. In addition, he expressed feeling

depressed. The clinician made a stat referral for a mental health evaluation. Urinalysis testing returned positive for cocaine and marijuana.

A mental health clinician evaluated Mr. Furse shortly after he completed the medical screening. Mr. Furse denied feeling suicidal, hopeless or worthless, or having current mental health or emotional problems. He did state that he was depressed due to being on Rikers Island for the second time. The clinician diagnosed him with adjustment disorder with depressed mood. CHS determined he was clinically appropriate for general population housing with mental health follow-up. On May 5, 2025, almost 48 hours after entering custody.[10] Mr. Furse was assigned to a new admission general population dormitory in EMTC.

On May 14, 2025, Mr. Furse called CHS's Health Triage Line[11] to report that he was feeling depressed and that he felt like hurting others, but not himself. Later that same day, a clinician met with Mr. Furse and diagnosed him with other specified depressive disorder, as well as cocaine use disorder. The clinician referred him to the KEEP program. CHS reviewed his records and determined that he did not meet the federal OTP criteria for enrollment in KEEP. Although CHS did not enroll him in KEEP, the team scheduled supportive counseling and a mental health follow-up.

On May 22, 2025, one week after Mr. Furse met with mental health to discuss feelings of depression, he had a follow-up visit. He reported increased depression symptoms since the last meeting and other concerns, such as feeling sad, sleep deprived and frustrated to the point where he displays anger by punching a wall. The examiner prescribed melatonin on May 23 and sertraline on May 26.

From May through November 2025, Mr. Furse received three infractions for fighting, assaulting staff, and refusing to follow facility rules.

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[10] According to Operations Order #22/07, effective December 14, 2007, newly processed individuals must be provided with appropriate housing within 24 hours of their arrival into the custody of the Department.

[11] CHS's Health Triage Line is a channel of communication for patients to contact CHS directly about their non-emergency health concerns.

On December 6, 2025, surveillance video showed all individuals locked in their cells while the unit was on lockdown. Despite the lockdown at 7:50 pm, individuals began to exit their cells. They appeared to pass a white rolled cigarette and access unassigned cells. DOC policy prohibits multiple individuals from occupying a single cell and from being inside a cell that is not their own. During this time, the "B" officer was on the unit and observed individuals out of their cells.

At 8:03 pm, the officer conducted a tour while individuals accessed unauthorized cells. During the tour, the officer did not stop at Mr. Furse's cell. At the time, another individual was inside Mr. Furse's cell with him and remained there for the next 30 minutes. During the subsequent tour, at 8:36 pm, the officer observed the other person in custody inside Mr. Furse's cell, prompting them to utilize the DOC radio to ask the "A" post officer to open the cell. Once open, the "B" officer directed the individual to step out. They complied, exiting the cell without further interaction. Mr. Furse's cell was then closed. The officer returned to the "B" desk.

A short time later, at 9:12 pm, the officer walked the unit, communicating with individuals who were outside of their cells. From 9:12 pm through 9:18 pm, video footage showed the "B" officer conducting the institutional lock-in. The area captain entered the housing and conducted a tour after the individuals were locked in. After the captain completed their tour and exited the unit, individuals began to exit their cells and resume rolling and passing contraband resembling a white rolled cigarette. The officer did not appear to instruct the individuals to return to their cells. Throughout this, Mr. Furse remained in his cell.

At 9:55 pm, the "B" post officer exited the unit and entered the "A" station. While the "B" officer was off post, individuals gathered in two cells, appearing to roll paraphernalia that resembled a white cigarette. They used tissues to cover two stationary fixed cameras in the area directly above the cells.

At 10:13 pm, 18 minutes later, the "B" officer reentered the unit and returned to their post. One individual was on their knees, crawling to their cell as the "B" officer entered the unit. The "B" officer did not appear to offer aid or inquire why the individual was crawling on the floor.

The “B” officer conducted a tour at 10:20 pm. During the tour, the officer briefly stopped and flicked the lights inside Mr. Furse’s cell, then continued touring. Logbook entries around this time reflect routine entries stating, “nothing to report.”

Shortly after completing the tour, the “B” officer exited the unit at 10:59 pm.

At 11:03 pm, while the “B” officer was off post, an individual appeared to slide something resembling a cigarette under Mr. Furse’s door. One minute later, a group of individuals stopped at Mr. Furse’s cell to check on him. They flicked the lights multiple times and appeared to have a four-minute exchange with him before walking away. At 11:14 pm, 15 minutes after departing the area, the “B” officer reentered the unit.

In the early hours of December 7, individuals checked on Mr. Furse multiple times after passing suspected contraband under his door. At 12:43 am, multiple individuals entered Mr. Furse’s cell. The “B” officer then approached the cell. The individuals exited, closing the cell door behind them.

From 1:12 am through 2:00 am, individuals stopped by Mr. Furse’s cell numerous times to check on him through his cell window. According to people in custody, they alerted the “B” officer of Mr. Furse's condition after hearing him make “weird noises” at 2:00 am. The officer responded and observed him unresponsive, which prompted them to utilize the DOC radio to advise the “A” post officer to activate a medical emergency. The “B” officer administered one application of Narcan while awaiting medical staff.

CHS staff entered the unit at 2:10 am. According to CHS reports, responders found Mr. Furse in bed, water and vomit on the bed, the floor, and his mouth. He showed no signs of breathing, had no pulse, his pupils were fixed and dilated, and he was not responding to any stimuli. The team moved him from the bed to the floor and began chest compressions. In addition, they connected him to a LifePak to monitor his vital signs, administered two doses of Narcan and Glucagon, and connected him to a Lund University Cardiopulmonary Assist System (“LUCAS”) device. EMS and Urgicare arrived at 2:30 am and continued aid. At 2:47 am, EMS departed the area with Mr. Furse for transport to Mount Sinai Queens Hospital.

At 3:14 am, Mount Sinai staff called DOC to inform them Mr. Furse passed away.

After being notified of Mr. Furse's death, DOC dispatched a Special Search Team and K-9 unit to report to Mr. Furse's housing area. The search team found 66 pills inside of a cup located on the desk in the cell, two burnt rolled up papers on the sink, and a burnt piece of paper on the floor in the doorway of the cell. In addition, the search team found a three-inch piece of plexiglass in the common area.

DOC's Special Investigations Unit assigned staff to investigate this incident. The investigation led to the "B" post officer receiving a 30-day suspension for:

- Failing to observe signs of life in each individual in the unit.
- Failing to be constantly alert while on duty, observing everything that takes place on the post within sight or hearing, and constantly patrolling the post during the tour of duty.
- Conduct unbecoming of an officer or employee.
- Conduct of nature to bring discredit to DOC.
- False logbook entries.

The Board has not received OCME records reflecting Mr. Furse's cause of death.

3. **Kyron Randall**

Age	33
Date of death	December 22, 2025
Admission date	July 2, 2023
Cause of death	Pending
Facility at time of death	GRVC
Bail amount	$25,000

Kyron Randall entered DOC custody in June 2023. During the new admission medical screening, he informed CHS that he periodically used crystal meth, methadone, suboxone, marijuana, K2, and drank alcohol in the community. He also informed CHS of prior diagnoses of post-traumatic stress disorder ("PTSD"), bipolar disorder, manic disorder, schizophrenia, and social disorder, and previously prescribed medications for related symptoms.

Due to Mr. Randall's previous mental health history, which included chronic suicidal ideation and depression, CHS advised DOC that mental observation housing was most appropriate for him.[12]

From July 2023 through January 2024, CHS placed Mr. Randall on suicide watch multiple times and referred him to Bellevue Hospital eight times. Throughout his incarceration, CHS reported that Mr. Randall demonstrated persistent and severe psychiatric decompensation as well as poor medication compliance, from zero to 14 percent. CHS records note that, despite transfers to specialized units such as the Program for Accelerated Clinical Effectiveness ("PACE") unit,[13] and continued efforts to encourage medication compliance, Mr. Randall's psychiatric condition remained unstable and could not be safely managed within DOC custody.

Subsequently, in May 2024, the judge assigned to Mr. Randall's case rendered him unfit to stand trial and remanded him to the custody of the New York State Office of Mental Health. On May 30, 2024, Mr. Randall was transported to Mid-Hudson Forensic Psychiatric Center, where he remained for restoration treatment until July 2, 2024.

On July 2, 2024, Mr. Randall returned to DOC custody. He underwent new admission screening at GRVC. During the screening, Mr. Randall once again advised CHS that he periodically used cocaine, marijuana, amphetamine, and heroin and drank alcohol in the community before being arrested. In addition, he disclosed that he had a history of schizophrenia. After completing the screening, based on Mr. Randall's previous and current mental health diagnoses, CHS advised DOC to assign him to the PACE unit.

Mr. Randall was housed in the PACE unit for the rest of his incarceration. Between June 2025 and October 2025, he received three infractions: two for engaging in a physical altercation with another person in custody resulting in injuries, and the

[12] Mental observation housing is designed for individuals in custody who have significant mental health needs and would benefit from increased patient-provider engagement and enhanced treatment.

[13] PACE houses individuals diagnosed with a serious mental illness who require a higher level of care.

other for engaging in a struggle with the same person in custody, which did not result in injuries. The hearing captain dismissed the first two infractions but found him guilty of the third infraction. Mr. Randall's housing assignment was not affected as a result of the guilty disposition.

CHS records from admission in July 2024 through December 15, 2025 show that Mr. Randall generally took his medication, missing only a few doses. Beginning on December 16, 2025 through December 21, he went without medication. According to CHS records, Mr. Randall did not receive his medication for various reasons, including being at court, at the hospital, "no response," and refusal. Per CHS, medications are available to patients prior to leaving and upon return from court; if a patient doesn't receive a medication, for any reason, including non-production, it is available at the next distribution time.

CHS notes reflect that Mr. Randall was fully oriented during an assessment at 9:43 am on December 18, 2025. He complained of having a stomachache, stating, "[w]hen I went to court, they fed us hummus, and that didn't sit well with my stomach." CHS staff advised Mr. Randall to follow up with the nurse about his stomachache, but he declined. The case was discussed with the clinical supervisor, and that afternoon, at 1:55 pm, the unit nurse returned to Mr. Randall's cell and attempted to speak to him. He refused. Later in the day, at 5:14 pm, another CHS staff member checked on Mr. Randall. He again complained about having a stomachache and loose stool. The nurse attempted to get him to exit the cell to check his vital signs, but he refused, stating that he preferred to stay in his cell for now.

In the days that followed, on December 19 and 20, CHS staff made multiple attempts to get Mr. Randall out of his cell so he could be examined. Each time he refused, stating that he felt better.

At 5:19 am on December 21, video footage captured the "B" post officer exiting the unit, leaving it unsupervised for eight minutes until the area captain arrived to tour at 5:27 am. Not too long after the captain completed their tour and departed the unit, the "B" officer once again exited the unit at 5:58 am. The unit was left unsupervised until 8:42 am, when the "B" officer reentered the area.

Medical staff entered the unit at 10:08 am. They appeared to speak to Mr. Randall through the cell window. Following the interaction, they appeared to relay their observations to a group of officers at the "B" post desk. One officer then left the group to check on Mr. Randall. A second officer walked over to observe Mr. Randall, followed by CHS staff. At 10:11 am, it appears (via video footage) that CHS staff requested officers activate a medical emergency for Mr. Randall after finding him in bed with his pants pulled down and unable to provide intelligible answers to questions. They observed vomit soiling his bed and linen. The "B" officer subsequently communicated the need for medical attention to the "A" post officer, who activated a medical emergency at 10:11 am. Mr. Randall's cell remained closed during this time. While awaiting the emergency response staff a nurse talked with officers at the front of the housing area, by the "B" post desk.

The "A" post officer did not open Mr. Randall's cell again until CHS's emergency response staff arrived at 10:22 am. Upon arrival, they observed Mr. Randall in bed, his pants below his waist, awake and alert. Initially, emergency response staff spoke to Mr. Randall from outside the cell. However, at 10:29 am, an emergency response staff member entered the cell, but exited after 20 seconds. Shortly after, the same staffer reentered the cell for 15 seconds, then continued to observe and speak to Mr. Randall from outside the cell. It appears that the emergency response staff member checked Mr. Randall's vital signs while in the cell, as records show that his breathing was shallow with a respiratory rate in the low 20s. He had a rash over his chest and body, and he was unable to stand. After observing Mr. Randall, emergency response staff requested EMS.

CHS responders report that Mr. Randall's weight, approximately 350 pounds, prevented them from transporting him to the clinic, so they requested that EMS report to the unit. While awaiting EMS, Mr. Randall fell out of bed. For the next 30 minutes, with the exception of the nurse briefly entering the cell two times, DOC and CHS staff observed him from outside his cell.

Eventually, CHS staff entered Mr. Randall's cell at 10:56 am, rolled him onto a blanket with assistance from three individuals in the unit, carried him out of the

cell, and placed him on a gurney. CHS staff connected him to a cardiac monitor and departed the area with him.

According to DOC, EMS arrived at GRVC at 11:00 am and entered the clinic at 11:03 am. At 11:07 am, CHS staff arrived at the clinic with Mr. Randall. By 11:15 am, EMS was measuring his blood pressure. Records show his airway and lungs were clear, he breathed normally, his eyes reacted to light, and he was able to provide his name. His blood pressure was high, and his oxygen levels were low, causing rapid breathing. His heart rate was normal. Repeat vital signs measurements by EMS showed his blood pressure dropped slightly, but oxygen remained low, and his heart rate slowed. Subsequently, EMS departed GRVC for Elmhurst Hospital with Mr. Randall at 11:33 am. While enroute to the hospital, EMS administered epinephrine, dexamethasone, and diphenhydramine intravenously.

EMS arrived at Elmhurst Hospital at 12:05 pm. Upon arrival, staff connected Mr. Randall to a Bilevel Positive Airway Pressure ("BIPAP") machine. Next, staff intubated him and provided more fluids intravenously. He was admitted to the Medical Intensive Care Unit for further evaluation. Although admitted, the unit did not have a bed, so he remained in the resuscitation and critical care room. Mr. Randall's condition began to worsen rapidly. His blood pressure dropped and his organs began to fail. Despite treatment, including multiple maximum doses of vasopressors, he lost consciousness. Elmhurst staff declared Mr. Randall dead at 12:57 am on December 22, 2025. According to hospital records, the preliminary cause of death is septic shock.

On December 22, DOC's Special Search Team and K-9 unit searched Mr. Randall's housing area. The search team did not recover any form of contraband. DOC's Special Investigations Unit did not note any concerns, violations, or wrongdoing during the investigation.

The Board has not received records regarding Mr. Randall's cause of death from OCME.

Key Findings

DOC staff abandoned assigned posts

The "B" post officer assigned to Mr. Furse's and Mr. Randall's housing area walked off post to enter the "A" station multiple times during their tours. Neither officer recorded a logbook entry reflecting that they notified their area supervisors. In one instance, the officer was off post for two hours and 44 minutes. DOC Rules and Regulations #7.05.070 prohibits correctional staff from leaving their post without approval from their supervisor or without being properly relieved. This lack of supervision allowed individuals in Mr. Furse's housing area to congregate on the tier and appear to use toilet paper to obstruct cameras. According to the DOC's Inmate Rule Book Section 1-03(c)(27), "[i]nmates shall not tamper with, destroy, or sabotage any security related devices or equipment."

Lack of touring

The "B" officer assigned to Mr. Randall's housing area did not conduct tours in accordance with DOC Directive #4514R-C, which requires officers assigned to cell areas to conduct visual observations at 30-minute intervals, observing for signs of life in each individual.

Unsecured cell doors

The "B" post officer assigned to Mr. Furse's housing area observed individuals accessing cells other than those assigned to them during the lockout period. DOC Directive #4009R-C states, "[i]ndividuals may be locked in their cells during optional lock-in/lockout periods. Individuals choosing to remain locked-in during an optional lock-in/lockout period may request to be locked out of their cells at the hourly optional lock-in/lockout period. Individuals who are locked-out during this period may request to be locked-in their cell at any time during the optional lock-in/lockout period." In this instance, individuals did not need to make a request because area staff did not lock cell doors throughout the day during the lockout period.

Individuals out cell during the mandatory lock-in period

DOC Directive #4009R-C notes that mandatory lock-in begins at 9:00 pm. Once locked in, the next opportunity to exit the cell is 5:00 am, unless there are extenuating circumstances. After 9:00 pm on December 6 and before 5:00 am on

December 7, individuals in Mr. Furse's housing area were out of their cells, roaming the tier, and passing contraband that resembled a cigarette. The "B" officer observed the individuals but did not appear to make an effort to have them return to their cells. The "B" officer also did not record an entry in the "B" post logbook noting that they notified the area supervisor that individuals were out of their cells.

Individuals congregating in unassigned single cells

DOC Directive #4517R, "Inmate Count Procedures," prohibits multiple individuals from occupying a single cell. The policy states, "[c]orrection officers shall ensure each cell is occupied by the individual authorized to be in the cell. Single occupancy cells shall contain one individual." On December 6, 2025, from 8:04 pm through 8:34 pm, video footage showed another individual inside Mr. Furse's cell. During a tour, the officer observed the individual and instructed them to step out.

Inaccurate logbook entries

"B" post staff assigned to Mr. Randall's housing area recorded inaccurate logbook entries that reflect 30-minute tours. Video footage showed that at the time of the logbook entry, the "B" officer was off post. DOC Directive #4514R-C on housing area logbooks states that logbook entries shall be made accurately and without delay.

Adequate supervision of person in custody in distress

The "B" post officer assigned to Mr. Randall's housing area left him in his cell, unsupervised, for 24 minutes while he experienced a medical emergency. DOC Rules and Regulations #7.05.060 require officers to remain in close proximity to the individual's cell when there is a medical emergency in order to keep them under close observation.

CHS emergency response staff left Mr. Randall unattended while in distress

Emergency response medical staff did not perform continuous monitoring after finding Mr. Randall in distress, as required in CHS Medical Policies Section 10, Emergency Response. From 10:36 am to 10:41 am and 10:52 am to 10:55 am, CHS staff were away from the cell.

Presence of contraband

Through surveillance video, Board staff observed multiple individuals appearing to possess paraphernalia that resembled a white rolled-up cigarette, in violation of

DOC's Inmate Rule Book Section 1-03(c)(4)(103.11), which states that individuals shall not make, possess, sell, or exchange any number of narcotic paraphernalia or controlled substances.

Covered cell windows

Multiple individuals in Mr. Furse's housing area partially or completely covered their cell windows. DOC policy prohibits cell window coverings. DOC's Inmate Rule Book Section 1-03(c)(6)(105.24) states that individuals shall not block the view into or out of any cell by placing items on the cell window.

Mental health history

Mr. Ramos, Mr. Furse and Mr. Randall all had documented mental health diagnoses. While in custody, CHS mental health providers assessed them regularly and prescribed medication to treat the symptoms associated with their diagnosis.

The Board highlighted trends cited in the Preliminary Fiscal 2026 Mayor's Management Report ("MMR") in previous reports.[14] The 2026 preliminary MMR shows an upward trend of individuals in custody with a serious mental health diagnosis from FY24 (20.3%) to FY25 (20.7%) to FY26 (22.0%).

Recommendations[15]

To CHS

1. CHS should reinforce and retrain staff on the necessity and requirement of performing continuous monitoring after people in custody in medical distress, as required in CHS Medical Policies Section 10, Emergency Response.

[14] As noted in the first and second reports on 2025 deaths in Department custody.

[15] Pursuant to NYC Administrative Code 9-171(h), "the department or correctional health services shall respond to any recommendation included in any report about such death the board of correction posts pursuant to subdivision i of section 626 of the charter to state whether the department or correctional health services has determined to implement such recommendation and, where the department or correctional health services has determined not to implement such recommendation, the reasons for such determination."

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.[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.

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.[17]

4. The *Nunez* Federal Monitor's November 8, 2023 status report highlighted an audit conducted of cell doors, which found that:

> *"While the doors' operability may be part of the problem, merely ensuring the doors' good working condition has not resolved the*

[16] As recommended in *the 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] Similar recommendations featured in *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.*

issue of ensuring the doors are actually locked and secured. Were the underlying causes so rudimentary, the pervasive issues identified would not continue once those issues have been addressed. For instance, at RNDC, the Department installed 950 new doors over the past few years, yet incidents continue to occur in which doors were not properly secured. NCU's security audit in October 2023 revealed that "Cell doors were observed unsecured throughout the audit."[18]

DOC must address the 2023 audit's findings and conduct an updated audit, if necessary, which must aim to address these root issues. DOC must develop an action plan to ensure staff are securing cell doors and reporting malfunctioning doors promptly, along with any other identified causes of routinely unsecured cell doors, to be shared with the Board at least 30 days before implementation.

5. Per DOC protocol, housing area correctional staff must instruct individuals to remove all cell window obstructions. If verbal commands to remove all coverings does not take its desired effect, staff must immediately notify a supervisor and document the encounter in their logbook. Upon receiving notification, a DOC supervisor must physically remove the coverings. Uniformed supervisory staff must regularly monitor housing areas and audit logbooks to ensure staff follow protocol.[19]

6. Post and distribute notices advising individuals in custody to comply with Security Bulletin #001/13, Cell Window Obstruction/Officer Safety, effective

[18] *Status Report on DOC's Action Plan by the* Nunez *Independent Monitor* dated November 8, 2023, page 21.

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

January 4, 2013, or risk losing items in their cells used to obstruct staff's view.[20]

7. 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.[21] Improve record keeping to track and monitor individuals found to possess impermissible items.

8. Enforce BOC Minimum Standard §1-04 (a)(b)(1), which prohibits more than one individual occupying a single cell.[22]

9. Report refusals to lock-in at 9:00 pm to the Central Operations Desk ("COD") and respond accordingly as noted in Directive #4009R-C on lock-in/lockout, which may include requesting support from other DOC units. Improve reporting to track and monitor housing areas where individuals refuse to comply with the lock-in procedures.

10. Distribute teletypes reemphasizing that DOC prohibits officers from departing their assignment without their supervisors' approval or being relieved as required in DOC Rules and Regulations #3.05.130.[23]

11. Retrain staff operating outside of the protocol noted in DOC Rules and Regulations #7.05.060, which requires that they remain in close proximity to an individual in need of medical attention in order to keep them under close

[20] A variation of this recommendation was included in the *First Report and Recommendations on 2025 Deaths in [NYC DOC] Custody* and *Second Report and Recommendations on 2023 Deaths in [NYC DOC] Custody.*

[21] As recommended in the *First Report and Recommendations on 2025 Deaths in [NYC DOC] 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.*

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

[23] As recommended in the *Second Report and Recommendation on 2025 Deaths in [NYC DOC] Custody.*

observation in the event there is a need to render first aid until medical response arrives.[24]

12. Remain alert on post, as required in DOC Rules and Regulations #7.05.090, and report any individual observed tampering with DOC equipment.

[24] A variation of this recommendation was featured in *First Report and Recommendations on 2025 Deaths in [NYC DOC] Custody* and *Second Report and Recommendations on 2022 Deaths in [NYC DOC] Custody.*

NYC HEALTH+ HOSPITALS

Correctional Health Services

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April 28, 2026

Jasmine Georges-Yilla
Executive Director, New York City Board of Correction
2 Lafayette, Suite 1221
New York, New York 10007

Dear Ms. Georges-Yilla,

NYC Health + Hospitals/Correctional Health Services (CHS) accepts the recommendation the Board made to CHS in the *Third Report and Recommendations on 2025 Deaths in DOC Custody*.

Pursuant to NYC Administrative Code § 9-171(h), which stipulates that in most cases the NYC Department of Correction and NYC Health + Hospitals/Correctional Health Services "shall respond to any recommendation included in any report about such death the board of correction posts…to state whether the department or correctional health services has determined to implement such recommendation and, where the department or correctional health services has determined not to implement such recommendation, the reasons for such determination," CHS is providing the response below to the Board's recommendation.

BOC Recommendation: "CHS should reinforce and retrain staff on the necessity and requirement of performing continuous monitoring after people in custody in medical distress, as required in CHS Medical Policies Section 10, Emergency Response."

CHS Response: CHS will continue to reinforce with clinical staff the necessity of continuously monitoring patients who are in medical distress, as outlined in CHS Medical Policies Section 10, Emergency Response.

Sincerely,

Patsy Yang, DrPH
Senior Vice President