**BOARD OF CORRECTION**
**CITY OF NEW YORK**

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

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The New York City Board of Correction ("Board" or "BOC") investigates the circumstances of deaths in custody,[2] pursuant to New York City Charter § 626(i)(2)[3] and § 3-10(c)(2) of Title 40 of the Rules of the City of New York.[4] These investigations do not focus on criminality or individual shortcomings. Instead, BOC investigations focus on identifying possible areas for improvement and making recommendations to the Department of Correction ("DOC" or "Department") and/or NYC Health + Hospitals/Correctional Health Services ("CHS") to prevent future deaths.

DOC houses individuals in custody on Rikers Island across eight facilities that include the Robert N. Davoren Center ("RNDC"), Eric M. Taylor Center ("EMTC"), Rose M. Singer Center ("RMSC"), Rose M. Singer Center Enhanced Supervision Housing ("RESH") and its Annex ("RESH-Annex"), George R. Vierno Center ("GRVC"), North Infirmary Command ("NIC"), Otis Bantum Correctional Center ("OBCC"), and West Facility. Individuals with health conditions that require hospital-level intervention can be housed in the Bellevue Hospital Prison ward located in Manhattan and the Elmhurst Hospital Prison Ward in Queens. Additionally, DOC operates court pens in all five boroughs.

15 individuals died in DOC custody in 2025. 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 2025 and March 2025. This report covers seven deaths that occurred between June 2025 and September 2025. During this three-month period, EMTC reported three deaths, GRVC reported two, and Bellevue and West Facility each reported one death in custody. The Board will

[2] Based on feedback from the United States Department of Justice's Bureau of Justice Statistics, the Board considers "death in custody" to be instances when a person dies in the custody of the Department of Correction or those whose deaths are attributable to their time in custody, including those who are declared brain dead before their release from custody.

[3] 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.

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

issue a separate report on the deaths of Edwin Ramos (died November 21, 2025), Aramis Furse (died December 7, 2025), and Kyron Randall (died December 22, 2025).

Following each reported death, Board staff launched an investigation that entailed gathering all relevant logbooks and records, reviewing DOC surveillance, speaking with uniformed correctional staff and individuals in custody, and, in some instances, taking photographs of the area where the incident occurred. Staff also reviewed medical records from CHS, Bellevue Hospital, and Richmond University Medical Center.

Some matters of concern discovered during the investigation include:

- Uniformed staff left their assigned post without notifying their supervisor on two occasions.
- Uniformed staff failed to conduct housing area tours consistent with policy in the PACE unit, which houses individuals diagnosed with serious mental illnesses.
- Uniformed staff did not instruct the suicide prevention aide ("SPA") to tour the mental observation housing area, as policy requires per Directive #4017R-D.
- Correctional staff failed to escalate a concerning observation discovered while rounding.
- DOC failed to staff the PACE housing area with the appropriate number of uniformed staff members according to Operations Order #10/08.
- Uniformed staff failed to keep cell doors secured during the lockout period.
- Uniformed staff permitted multiple individuals to congregate in a single occupancy cell during the lockout period.
- DOC staff failed to offer basic life-saving aid after discovering an individual in distress.

## Deaths in Custody

### 1. Benjamin Kelly

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| **Age** | 37 |
| **Date of death** | June 20, 2025 |
| **DOC admission date** | May 30, 2025 |
| **Cause of death** | Suicide by Hanging |
| **Facility at time of death** | EMTC |
| **Bail amount** | $2,500 |

NYPD officers arrested Mr. Kelly in Queens on May 28, 2025. Later that same day, NYPD officers transported Mr. Kelly to Jamaica Hospital after he complained of experiencing an elevated heart rate and difficulty breathing. On May 30, two days after being admitted to the hospital, he was discharged. The discharge paperwork noted that he required further psychiatric care but not an inpatient setting. Shortly after being discharged from the hospital, he arrived at EMTC as a new admission. During the DOC screening, Mr. Kelly advised uniformed correctional staff that, before entering custody, he used drugs and alcohol. He informed medical

staff about his habit of smoking one pack of cigarettes a day, drug and alcohol use, as well as frequent marijuana usage, the latest being two days before his arrest. Urinalysis testing results showed that there was cocaine in Mr. Kelly's system.

As recommended by Jamaica Hospital staff, on May 31, a CHS mental health clinician evaluated Mr. Kelly before DOC assigned him to a housing area. During the assessment, Mr. Kelly informed the clinician that he had been admitted to the hospital for concerns related to his mental health diagnoses of schizoaffective disorder and bipolar disorder 50 times, with his longest stay lasting six months and his most recent admission occurring at Jamaica Hospital's psychiatric ward one week before being arrested. He further informed the clinician that prior to his arrest, hospital staff prescribed him Haldol Decanoate, Haldol tablets, Cogentin, and Benadryl. In addition to the diagnoses and hospital admissions, the clinician noted Mr. Kelly had a history of self-harm that included head banging and superficial cuts. At the completion of the evaluation, the clinician recommended assignment to a mental observation housing area.[5]

On June 1, 2025, DOC transferred Mr. Kelly to a cell mental observation housing area in EMTC. On June 5, Mr. Kelly was seen by a psychiatric nurse practitioner and prescribed mental health medication. On June 6, five days after arriving in the area, DOC staff reported Mr. Kelly was involved in three incidents. The first incident occurred at 2:00 pm. The officer reported that they observed Mr. Kelly banging his head against the wall and scratching his arms with an unknown object. DOC staff escorted him to the clinic. Medical staff examined him upon arrival. According to the injury report, he did not sustain any injuries. A mental health evaluation followed. The clinician noted during the evaluation that Mr. Kelly was agitated, crying, uncooperative, loud, and throwing chairs. Subsequently, they placed him on suicide watch.[6]

The second incident occurred the same day in the old clinic after the initial evaluation,[7] at 3:06 pm. Officers stationed in the clinic reported Mr. Kelly was being disruptive and refused to comply with direct orders to stop banging his head on the wall, which led to a use of force incident. Reports note uniformed staff utilized upper control holds to secure Mr. Kelly against the wall, applied restraints, and escorted him out. Mental health staff performed another evaluation. Mr. Kelly reported that he did not take his medication the night before and that he was hearing voices and seeing things coming from the wall. Additionally, he stated he did not want to be on Rikers Island and requested to go to Bellevue Hospital. The clinician described Mr. Kelly's behavior as

[5] Mental observation housing is designed for individuals in custody whose mental health condition requires a higher level of observation than those in general population.

[6] Suicide watch is the one-on-one constant observation of an individual by an assigned correctional officer.

[7] The old clinic is the location where CHS staff perform medical exams and mental health evaluations for newly processed individuals.

goal oriented and prescribed him a "stat", or immediate, dose of Haldol to counter symptoms, which Mr. Kelly accepted without incident. CHS also changed the dosage of his medication and prescribed him additional mental health medication. DOC correctional staff escorted him to the de-escalation area.[8]

While in the de-escalation unit, Mr. Kelly had a third incident. Officers reported that, at 3:40 pm, they observed him using an unknown object to harm himself. Officers returned him to the clinic to be seen by medical and mental health staff. Reports do not indicate he sustained any injuries. The clinician examined him again before DOC returned him to his housing area. Later that day, after being placed on suicide watch, a clinician conducted rounds in the unit. Before departing the area, the clinician spoke to Mr. Kelly. He endorsed suicidal ideation, and reported a plan to buy a gun and kill himself.

On June 7, 2025, DOC transferred Mr. Kelly into a dormitory-style mental observation housing area. Shortly after transferring into the dormitory, records note he slipped and fell in the bathroom, prompting the "B" officer[9] to activate a medical emergency. Medical staff responded, placing Mr. Kelly onto a stretcher and departing the area. Records do not indicate that he experienced any injuries. After medical staff examined him, DOC staff escorted him back to the housing area. Later the same day, mental health staff spoke with him twice while in the area performing rounds. The clinician reported that Mr. Kelly displayed coping skills and adjusted to the new environment. Additionally, the clinician reported Mr. Kelly said he felt "okay."

On June 11, 2025, after an evaluation, a clinician determined Mr. Kelly no longer needed to be on suicide watch. According to CHS records, the clinician found that he did not appear to be in acute psychiatric distress and showed no signs of being a risk to himself or others.

Shortly after the clinician discontinued Mr. Kelly's suicide watch, DOC staff reported that he became aggressive and started to throw trash and the trash bin around the housing unit. According to DOC records, Mr. Kelly refused direct orders to cease his actions, prompting officers to utilize chemical agents. Uniformed staff removed Mr. Kelly from the unit and escorted him to the de-escalation area. Officers then escorted him to the clinic, where a clinician evaluated him. The clinician determined that Mr. Kelly's behavior was goal oriented in that he sought a transfer

[8] As defined in § 6-03(b)(3) of Title 40 of the Rules of the City of New York, de-escalation confinement means the holding of an incarcerated person in a cell immediately following an incident where the person has caused physical injury or poses a specific risk of imminent serious physical injury to staff, themselves or other incarcerated persons.

[9] 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.

to the hospital or admission to the PACE unit. He repeatedly verbalized wanting to be moved to either of the two due to fear of being housed in an open dormitory setting. After meeting with the clinician, uniformed staff escorted him back to the mental health dormitory. Later in the day, DOC staff transferred him to a cell mental observation area after learning CHS discontinued his suicide watch status.

On June 14, 2025, Mr. Kelly had an in-person visit with his parents in EMTC. Ms. Kelly, Mr. Kelly's mother, met with Board staff following her son's death and provided information regarding her son's mental health treatment and his demeanor during their visit. Prior to June 14, Ms. Kelly last saw Mr. Kelly on June 9, 2025 in court, where he appeared coherent and well. Ms. Kelly reported a drastic deterioration in Mr. Kelly's demeanor and behavior on June 14. Mr. Kelly was drooling, incoherent, confused, crying, having trouble breathing, and reported feeling dizzy and afraid. Mr. Kelly told his parents he could not sleep.

Following the visit, Ms. Kelly contacted 311 to report that her son was starting to hallucinate. According to the complaint and Ms. Kelly's statements to Board staff, Mr. Kelly thought an insect crawled up his nose, claimed there were dead bodies in the wall, and that something was trying to grab him from the floor. According to those reports, Ms. Kelly stated that her son should not be on Depakote and advised that he should be on Clozaril. Ms. Kelly informed Board staff that Depakote had, historically, not been helpful for his symptoms. CHS records do not reflect that Mr. Kelly was prescribed Depakote during his incarceration; although, on June 6, CHS started him on Valproic acid, which is a similar medication. 311 forwarded the complaint to DOC's Office of Complaint and Grievance Services ("OCGS"). OCGS received the complaint on June 14. Records do not show that OCGS staff forwarded the complaint to CHS. OCGS staff closed the complaint on July 29 following Mr. Kelly's death, without noting any follow-up actions or how the complaint was addressed before his death.

311 transferred Ms. Kelly to CHS Operations on June 14. CHS records note that Ms. Kelly informed CHS Operations staff that Mr. Kelly was in distress, crying and needed medication. The CHS Operations team forwarded the complaint to mental health staff at EMTC. A clinician attempted to speak with Mr. Kelly cell-side shortly thereafter, but Mr. Kelly did not want to speak with them. According to health records, Mr. Kelly yelled at the clinician to get away from his cell.

On June 20, 2025, DOC staff reassigned Mr. Kelly to another cell to allow maintenance staff to inspect and repair the cell he previously occupied. Video footage and phone logs captured Mr. Kelly calling his mother, agitatedly expressing concerns about bail, before entering his newly assigned cell. Mr. Kelly entered the cell for the final time at 1:51 pm on June 20. Video footage

confirms the area did not have a SPA[10] on duty on this day. Video also captures the "B" officer touring the area at 2:04 pm. During the tour, the officer did not appear to look inside Mr. Kelly's cell. At 2:33 pm and 2:59 pm, the officer toured again and appeared to look inside all cell windows. When the "B" officer looked in Mr. Kelly's cell at 2:59 pm, they observed linen around his neck affixed to the window and blood trickling from his nose. The "A" post officer[11] activated a medical emergency after learning of Mr. Kelly's condition. The "A" officer also opened the cell for the "B" officer to enter. The "B" officer removed the linen and began to apply aid in the form of chest compressions and cardiopulmonary resuscitation ("CPR") while awaiting the arrival of medical staff.

Medical staff arrived in under five minutes, at 3:02 pm, with medical supply bags, a gurney, a Lund University Cardiopulmonary Assist System ("LUCAS") device, an Automated External Defibrillator ("AED"), and an oxygen tank. According to CHS records, upon their arrival, Mr. Kelly was on the floor, supine, with apparent dried blood on his face and chest. Additionally, medical staff noted he was unresponsive, cyanotic, with fixed and dilated pupils, and without a pulse. Medical staff administered five doses of Narcan and administered four epinephrine doses in addition to performing CPR. Medical staff discontinued their efforts at 3:31 pm.

DOC's Special Investigation Unit assigned staff to investigate the incident. Investigators did not identify wrongdoing by staff at the time and therefore has not recommended disciplinary action as of the date of this report's publishing. DOC informed the Board that these investigations are ongoing.

The Office of the Chief Medical Examiner ("OCME") determined Mr. Kelly's official cause of death was suicide by hanging.

[10] DOC Directive #4017R-D, Observation Aide Program, requires that Observation Aides ("Suicide Prevention Aides" or "SPA") be assigned to all special housing areas where the entire population of incarcerated individuals has been placed under observation. These areas include mental health housing areas, restrictive housing, protective custody housing areas, intake areas, and new admission housing areas. This directive further orders that correction officers assigned to the "B" post tour every 30 minutes, ensuring signs of life for all incarcerated individuals in the area. If an SPA is not assigned during a particular period, an additional correction officer must be assigned to the housing area and the officer must conduct tours every 15 minutes until an adequately trained SPA arrives for their shift.

[11] "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.

## 2. James Maldonado

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| **Age** | 56 |
| **Date of death** | June 20, 2025 |
| **DOC admission date** | June 20, 2025 |
| **Cause of death** | Acute intoxication due to the combined effects of fentanyl, morphine, and methadone |
| **Facility at time of death** | EMTC |
| **Bail amount** | $25,000 |

On June 18, 2025, NYPD officers arrested Mr. Maldonado in Richmond County. On June 19, police officers observed Mr. Maldonado on the floor of a holding cell exhibiting signs of lethargy and, appearing to be unwell before he was arraigned. In response, officers transported him to Richmond University Medical Center ("RUMC"). RUMC staff examined Mr. Maldonado and did not find he was in distress. During the exam, Mr. Maldonado informed staff that two days before his arrest, he took fentanyl and consequently felt like he was experiencing opioid withdrawal.

On June 20, Mr. Maldonado was discharged from the hospital and police officers transported him back to Richmond Criminal Court. Mr. Maldonado and 11 other individuals were escorted onto DOC's Transportation Division bus for transfer to Rikers Island. The bus departed Richmond Court at 1:50 pm. The correctional bus dropped off individuals at multiple facilities on Rikers before arriving at the EMTC sallyport at 4:23 pm.

A DOC incident report noted that while enroute to EMTC after departing RMSC, numerous individuals said they had to use the bathroom. DOC staff walked toward the rear of the bus to explain that they would have access to a bathroom once they arrived at EMTC. After reaching the rear of the bus, uniformed staff observed Mr. Maldonado slanted toward his right side with his mouth open. EMTC intake staff were informed that there was a medical emergency via DOC radio. Medical staff assistance was also requested. DOC intake staff boarded the bus, bringing Narcan.[12] DOC staff administered one Narcan application and checked Mr. Maldonado's pulse.

Medical staff arrived at the sallyport at 4:31 pm. According to CHS records, upon their arrival, Mr. Maldonado was unresponsive, without a heartbeat or pulse, and his pupils were fixed and dilated. DOC staff removed Mr. Maldonado from the bus at the request of medical staff. Medical staff began to perform various lifesaving measures that included the use of Narcan and epinephrine, and CPR. After their attempts to revive Mr. Maldonado were unsuccessful, they

[12] 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.

discontinued their efforts. Following a final assessment and confirmation with the medical team, Mr. Maldonado was pronounced deceased by a CHS Urgicare provider at 4:49 pm.

DOC staff searched the individuals that were left on the bus and K-9 staff inspected the vehicle. Records note staff did not recover contraband. DOC Special Investigation Unit staff responded and commenced an investigation, which is still ongoing. Investigators did not uncover wrongdoing by uniformed staff as of the date of this report's publishing.

OCME determined Mr. Maldonado's official cause of death was acute intoxication due to the combined effects of fentanyl, morphine, and methadone.

## 3. Christian Collado

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| **Age** | 51 |
| **Date of death** | July 9, 2025 |
| **DOC admission date** | October 26, 2024 |
| **Cause of death** | Stage 4 Ampullary Adenocarcinoma with Liver Metastasis |
| **Facility at time of death** | Bellevue Hospital |
| **Bail amount** | Remand |

Mr. Collado was diagnosed with a terminal illness in 2022. After entering custody in 2024, DOC transported him to Bellevue Hospital for treatment over 75 times.

On June 25, 2025, while housed in a medical dormitory in NIC, CHS staff activated a 911 EMS transport after performing an exam. Medical staff noted that Mr. Collado was experiencing several medical issues, such as difficulty walking and abdominal pain, and he appeared malnourished. CHS requested an EMS transport due to Mr. Collado's extensive medical history. EMS arrived within minutes and transported Mr. Collado to Bellevue Hospital for further evaluation. Hospital staff admitted him upon arrival. DOC staff, as well as medical staff, observed him around the clock.

On July 8, 2025, medical staff reported Mr. Collado had two episodes of expelling dark brown/black emesis (vomit). Additionally, lab tests showed his condition worsened. Bellevue staff contacted Mr. Collado's relative. On July 9, Mr. Collado was pronounced deceased.

## 4. Edwin Quispe

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| **Age** | 33 |
| **Date of death** | July 22, 2025 |
| **DOC admission date** | May 21, 2025 |
| **Cause of death** | Compression of neck |
| **Facility at time of death** | EMTC |
| **Bail amount** | Remand |

On May 21, 2025, Mr. Quispe underwent new admission screening at EMTC. Records show that it was his first time in DOC custody. Screening officers noted that he appeared "ok." CHS mental health staff received a request from the court to perform a psychiatric exam. During the medical screening, CHS staff completed a stat referral to expedite a mental health screening for Mr. Quispe after he shared that he heard and saw things that were not there. Although medical staff prepared the stat referral, the mental health team already planned to evaluate Mr. Quispe in response to the court's request once he completed the medical portion of the new admission screening.

As requested by the court, a mental health clinician examined Mr. Quispe at 1:02 pm on May 21. He reported seeing a psychiatrist in Ecuador before coming to the United States but, since arriving, he had not seen one. The clinician reported that he did not present a threat to himself or others. The only concern noted was that he reported auditory hallucinations that sound like "wind" for the past two weeks. Following the exam, the clinician preliminarily diagnosed him with adjustment disorder with anxiety and found that he was stable for general population housing with mental health follow-up. He was scheduled to be reevaluated on May 28.

DOC staff assigned Mr. Quispe to a new admission general population dormitory-style housing area after he completed the new admission screening. CHS could not meet with Mr. Quispe on May 28 due to a conflicting court date. CHS rescheduled the follow-up evaluation for June 6.

On June 6, after meeting with a clinician, Mr. Quispe was started on a medication to treat his symptoms of depression. In addition, the clinician noted Mr. Quispe presented well and did not exhibit signs of wanting to harm himself. The clinician placed him on the schedule to be reevaluated on June 23. DOC staff produced Mr. Quispe to the clinic to see the clinician on June 23. CHS records reflect no change; he was organized, logical, and did not seem to be internally preoccupied. Following the evaluation, the clinician wrote a new prescription for Prazosin to alleviate nightmares, an increased sertraline dosage, and scheduled a reevaluation two weeks out. At the follow-up evaluation on July 7, the clinician noted Mr. Quispe did not show worsening symptoms and did not show signs of being internally preoccupied. He presented with logical and linear thinking. The one concern Mr. Quispe raised during the evaluation was regarding the nightmares he experienced. He shared that they were more vivid and likely caused by the increase in the sertraline dosage. The clinician reduced the sertraline to the previous dosage.

On July 16, Mr. Quispe filed a complaint with OCGS. The complaint alleged that he slipped in the shower two days earlier, which caused him to sustain an injury to the back of his head. He claimed DOC staff were aware of the incident but had yet to bring him to the clinic. OCGS staff forwarded the complaint to CHS and closed it out. OCGS paperwork does not reflect if Mr. Quispe was seen in the clinic. Per CHS, Mr. Quispe was not produced to the clinic for his injury while DOC asserts that he waited in the clinic to see a provider before he returned to the housing area.

On July 19, DOC staff transferred Mr. Quispe to another dormitory-style general population area. Staff assigned him to a bed mid-dormitory. On July 22, three days after transferring to the area, Mr. Quispe's housing area had "A"[13] and "B" post officers. On that day, at 6:39 am, the "A" post officer signed off the post and departed the area without notifying the area supervisor to receive authorization to leave the post, as required in teletype No. HQ – 02438-0. Subsequently, the "B" post officer signed off the "B" post and assumed the "A" post without notifying the supervisor of the post change. This decision left the housing area without a "B" post officer.

Shortly after the "B" post officer exited the unit to assume the "A" post, DOC surveillance video captures Mr. Quispe getting out of bed and entering the bathroom at 7:03 am, approximately 23 minutes after the "B" post officer left the post. Mr. Quispe spent the next three minutes in the bathroom, near the shower, appearing to look up at something. At 7:06 am, he walked out of the bathroom and returned to his bed. He appeared to pick up something from underneath his pillow and return to the bathroom. He re-entered the bathroom at 7:06 am and walked beyond the shower curtain, which, from that point on, is obstructed from camera view to allow for privacy.

Video footage shows numerous individuals entering the bathroom after Mr. Quispe stepped inside. No one appeared to notice Mr. Quispe's presence at first. At 7:50 am, an individual entered the bathroom, walked beyond the shower curtain and observed Mr. Quispe with a ligature around his neck, hanging from the shower bar. DOC reports confirm there was institutional linen around his neck tied to the shower bar. The individual reported his observation to the officer stationed at the "A" post. The officer verified the sighting and activated their personal body alarm, or PBA, and called for medical emergency assistance.

Following the request for assistance, surveillance video shows that, at 7:54 am, DOC supervisory staff and nearby officers responded to the scene. According to DOC reports, the first supervisor to arrive instructed the "A" post officer to remove the linen from Mr. Quispe's neck, place him on the floor, and begin life-saving aid in the form of chest compressions. As instructed, the "A" post officer performed chest compressions until he was relieved by another officer responding to the area. The officer continued chest compressions until medical staff arrived at 7:56 am. CHS

[13] "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.

records note that when their staff arrived, Mr. Quispe was on the bathroom floor, unresponsive and absent a pulse. He had no spontaneous breathing and had fixed and dilated pupils, skin discoloration, and ligature marks on his neck. In response, the medical team administered multiple doses of Narcan and epinephrine, performed CPR using a LUCAS device, and inserted an endotracheal tube in an attempt to keep Mr. Quispe's airway passage open. Resuscitation efforts lasted over 30 minutes. Mr. Quispe's condition did not improve. Medical staff discontinued their efforts and the Urgicare doctor declared him deceased at 8:28 am.

OCME investigators responded and searched Mr. Quispe's personal belongings and performed a preliminary exam. OCME investigators recovered a practice braided ligature by Mr. Quispe's bed. They also found a note in a sock. Additionally, OCME investigators determined the ligature marks on Mr. Quispe's neck matched the ligature pattern found by his bed.

DOC's Special Investigation Unit dispatched staff to investigate the incident. Once staff concluded their investigation, they authorized the suspension of the "A" post officer for 30 days for abandoning their assigned post and leaving the facility prior to the end of their tour.

OCME determined that Mr. Quispe's cause of death was compression of neck, while the manner of death is undetermined.

## 5. Ardit Billa

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| **Age** | 29 |
| **Date of death** | August 23, 2025 |
| **DOC admission date** | February 25, 2025 |
| **Cause of death** | Pending |
| **Facility at time of death** | GRVC |
| **Bail amount** | $25,000 |

On February 23, 2025, NYPD officers arrested Mr. Billa in Brooklyn. On February 24, while still in police custody, Mr. Billa complained to officers about hearing voices and requested to go to New York Presbyterian Brooklyn Methodist Hospital to be medicated. That same day, officers transported him to the hospital's emergency room. On February 25, Mr. Billa returned to the police precinct after being discharged from the hospital. That same day, Mr. Billa entered DOC custody. He underwent new admission screening at EMTC. During the screening, Mr. Billa informed intake staff that he used heroin and crack in the community. He also informed staff that he received treatment for his mental health issues in the community. From a review of court documentation, intake staff learned the court requested Mr. Billa receive a mental health evaluation before he was assigned housing. DOC staff generated a request for him to be seen by mental health.

On February 26, Mr. Billa informed medical staff that he smoked one pack of cigarettes a day in the community. When medical staff asked him about any alcohol or drug use in the past two

weeks, he responded "no." A urinalysis sample collected by medical staff tested positive for cocaine. Before completing the screening, medical staff completed a stat referral for Mr. Billa to be evaluated by mental health after finding out he had thoughts of wanting to kill himself, felt hopeless, heard voices, and experienced anger and anxiety issues.

On February 27, a clinician evaluated Mr. Billa. The clinician noted he had a history of auditory hallucinations and behaving based on delusional beliefs, and a history of anxiety due to psychotic symptoms. After completing the evaluation, the clinician diagnosed Mr. Billa with Other Specified Schizophrenia Other Psychotic Disorder, prescribed him Seroquel and Ativan, and completed paperwork recommending his assignment to mental observation housing.

On February 28, DOC assigned Mr. Billa to a dormitory-style mental observation housing area in EMTC. On March 8, DOC staff transferred him to another dormitory mental observation housing area at OBCC. On March 10, two days after arriving, he was involved in a fight involving multiple persons in custody. Following the incident, DOC staff produced him to the clinic to be seen for any possible injuries. According to the injury report, he sustained nasal swelling, nose bleeding, and a 2.5-centimeter laceration under his right eye. Medical staff sent him to Bellevue Hospital for further evaluation. Hospital staff assessed and treated Mr. Billa's injuries. Lab tests revealed Mr. Billa had been exposed to RSV, causing him to test positive for this airborne virus. Hospital staff informed DOC that Mr. Billa tested positive for RSV and, therefore, must be isolated from the population.

On March 16, Bellevue staff discharged Mr. Billa. DOC staff then transferred him back to Rikers Island and housed him in a communicable disease unit ("CDU")[14] sprung in West Facility, where he remained from March 16 to April 8. From April 8 through July 11, Mr. Billa was involved in six more incidents that led to disciplinary infractions while in mental observation units in GRVC. DOC staff found him guilty on five out of the six charges.

On July 29, CHS staff completed paperwork to make Mr. Billa eligible for the Program for Accelerated Clinical Effectiveness (PACE)[15] at GRVC. The move was intended to improve several areas such as engagement in treatment, behavioral control, frustration tolerance, insight, medication compliance, and diagnostic clarification.

On August 1, DOC staff transferred Mr. Billa to the PACE unit. PACE clinical staff provide a higher level of mental health care to individuals diagnosed with a serious mental illness. As such, clinical

[14] CDU is a medical therapeutic unit at the West Facility, comprised of single cells designed to isolate individuals with a communicable disease.

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

staff are to round at a minimum of once per day. This unit is also required to have two “B” post officers.

Video surveillance shows that, on August 22, the unit had one “B” post officer. Surveillance video captures a CHS employee covering their nose as they entered the area at 7:34 pm. Once in the area, the employee appeared to remove a small bottle of air freshener from their jacket and spray it in the air. The CHS employee then appeared to briefly look through his cell window. The encounter lasted no more than 15 seconds. Before walking away from the cell, the employee again sprayed the air freshener, this time directly in front of Mr. Billa’s cell.

At 7:54 pm, another CHS employee appeared to speak with Mr. Billa. The encounter was no more than 15 seconds. At 9:34 pm, the “B” post officer walked off the post and entered the “A” station. The unit was left without supervision until the officer returned to post at 11:29 pm. While the officer was off post, the assigned SPA conducted one tour of the area at 9:47 pm. The tour lasted less than five minutes. At 9:52 pm, the SPA entered their cell but exited in under 30 seconds to return to the dayroom. According to DOC policy, the SPA should have made a tour every ten minutes, which would total six tours over one hour. The “B” post officer should have toured every 30 minutes.

At 11:32 pm, the “B” post officer reentered the unit to tour with the area supervisor who just arrived. DOC reports note that while the supervisor and the officer passed Mr. Billa’s cell, they observed him on the floor in an unusual position, with his back against the toilet, arm upright, holding an unknown object. The supervisor continued with the tour after believing they observed Mr. Billa move his arm slightly. At 11:39 pm, minutes after completing the tour, the “B” post officer returned to Mr. Billa’s cell and appeared to spray air freshener in front of the cell door. Shortly after spraying air freshener, at 11:43 pm, the “B” post officer exited the unit and reentered the “A” station, this time for a total of seven minutes. The SPA toured the area while the officer was off post. The officer returned to the “B” post at 11:50 pm.

At 12:03 am on August 23, within minutes of returning to the post, the “B” post officer toured the area. The area supervisor returned to the area with two officers at 12:21 am and commenced to tour. During the tour, they stopped at Mr. Billa’s cell. They attempted to get his attention by sliding a mop stick under the cell door and poking his foot. After multiple attempts went without a response, the supervisor instructed the “A” post officer to open Mr. Billa’s cell. The area supervisor stepped into the cell and observed Mr. Billa unresponsive, covered in feces from head to toe, with his head submerged in the toilet. According to reports, feces covered Mr. Billa’s nose, eyes, and mouth.

With the assistance of DOC staff, the area supervisor removed Mr. Billa’s head from the toilet and pulled him by his feet onto the tier. The supervisor then activated a medical emergency at

12:25 am and instructed staff to perform chest compressions. DOC staff alternated performing chest compressions until medical staff arrived.

Medical staff entered the unit at 12:30 am. The response team arrived with a gurney, a LUCAS device, an oxygen tank, an AED, and a medical supply bag. They reported Mr. Billa was on the floor outside his cell with his face caked in feces, which was thick in the nose, mouth, and eyes. His pupils were fixed and dilated, he had no pulse, and he showed all signs of dependent lividity. For over 30 minutes, the response team attempted to resuscitate Mr. Billa. At 12:58 am, the Urgicare doctor pronounced him deceased.

A OCME investigator responded to GRVC shortly afterwards. The investigators found unused ligature – headphone wires – and two orders of protection in Mr. Billa's cell. In addition, investigators found that there were feces in the form of a handprint on the ceiling and all around the cell. Additionally, investigators observed light bruises on Mr. Billa's left rib, skin blotching on his shoulder, and light rigor mortis. There were no signs of trauma, physical abnormalities, or mouth discharge.

DOC's Special Investigation Unit assigned staff to investigate the incident. Based on the information uncovered during the investigation, they authorized the suspension of the housing area supervisor, the "A" post officer, and the "B" post officer for 28 days each, due to the following rule violations:

- The area supervisor failed to conduct meaningful tours.
- The "A" post officer allowed the "B" post officer to exit their post and remain on an unauthorized post for an extended period of time.
- The "B" post officer failed to conduct meaningful tours and abandoned their post for an extended period.

Mr. Billa's cause of death remains pending as the Board awaits autopsy records from the OCME.

## 6. Jimmy Avila

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|---|---|
| **Age** | 44 |
| **Date of death** | August 30, 2025 |
| **DOC admission date** | August 29, 2025 |
| **Cause of death** | Hanging |
| **Facility at time of death** | West Facility |
| **Bail amount** | Remand |

On August 27, 2025, Mr. Avila was arrested in the Bronx. On August 29, while still in police custody, officers transported him to the emergency department at Lincoln Hospital for a medical and mental health assessment. Shortly after arriving at the hospital, staff discharged him back to police custody. Officers transported him to Bronx Court, where he was remanded to DOC custody.

On August 29, Mr. Avila arrived at EMTC as a new admission. DOC intake staff noted he appeared "ok" and did not require special housing. On August 30, medical staff began their screening, which included collecting a urinalysis sample and a mental health screening. The urinalysis tested positive for cocaine. In addition, medical staff learned he had high blood pressure, periodontal disease, and kidney disease. During the mental health screening, Mr. Avila informed medical staff that, before entering custody, he tried to kill himself and was hospitalized multiple times to receive treatment for his schizophrenia disorder and bipolar disorder diagnoses; however, he denied active suicidal ideation. The examiner referred him to mental health for an evaluation.

A mental health clinician evaluated Mr. Avila that same day. Clinicians diagnosed him with cocaine use disorder, schizoaffective disorder-bipolar type, wrote a prescription for him to receive Aripiprazole, Atorvastatin, Hydrochlorothiazide, and acetaminophen, and completed paperwork to house him in a new admission mental observation housing area.

DOC housed Mr. Avila in the CDU after learning that a relative of Mr. Avila's worked at EMTC. CDU is designated as a medical therapeutic unit, but it is not a mental observation unit. Records show that DOC often utilizes CDU cells for security placements. In these areas, DOC staff follow a general population touring schedule, rounding every 30 minutes.[16] However, CHS has indicated that any person in custody housed in the CDU who would have otherwise been housed on a mental observation or PACE unit needs to be rounded on every 15 minutes in the absence of an SPA by DOC because of their mental health designation. "B" post officers in mental observation units are required to tour every 15 minutes in the absence of an SPA.

At 9:31 am, DOC staff escorted him to his cell. At 9:33 am, area staff moved him to another cell nearby. Neither reports nor the area logbooks specify what prompted staff to reassign Mr. Avila from one cell to another.

Surveillance video confirms uniformed staff assigned to the area performed rounds every 30 minutes as required in general population. During the tour at 2:27 pm, uniformed staff appeared to stop at Mr. Avila's cell and speak with him. Staff did not report any concerns from the brief engagement. Uniformed staff continued to round, performing tours at 3:03 pm and 3:27 pm. Nothing unusual was reported after touring.

At 3:29 pm, the pharmacy technician entered the unit to dispense medication. The technician went cell to cell, providing medication to individuals in the unit. At 3:32 pm, the technician reached Mr. Avila's cell. The "B" post officer opened his food slot, also referred to as the cuffing

[16] In general population areas, correction officers responsible for the care, custody, and control of people in custody remain in their assigned areas and conduct visual observations at 30-minute intervals.

port, to allow the technician to medicate him. Mr. Avila did not approach the cell window to receive his medication, prompting the technician to call out to him. Mr. Avila did not respond to the calls, which led the "B" post officer to unlock the cell door and enter. Once inside, the officer observed him unresponsive, with institutional linen around his neck affixed to the upper part of the bed frame, lying on his stomach halfway underneath the bed. The "B" post officer removed the linen and activated a medical emergency at 3:33 pm. While awaiting medical staff, DOC staff in the area ("B" post officer and area supervisor) did not attempt to offer aid to Mr. Avila.

CHS staff responded to the request for medical assistance in under seven minutes, at 3:40 pm. The responding staff tried various means to resuscitate Mr. Avila, such as chest compressions, CPR, epinephrine doses, and provided saline fluids through an IV. All attempts to revive Mr. Avila were unsuccessful. Urgicare staff pronounced him deceased at 4:29 pm.

OCME investigators responded to the scene and began their preliminary review. The investigators noted Mr. Avila had petechiae on his eyes and lips (small flat, red or purple spots caused by bleeding from broken capillaries), which is consistent with death by suicide.

DOC Special Investigation Unit staff searched Mr. Avila's cell following the incident. Staff did not recover contraband. Disciplinary action was issued against a captain for failure to conduct meaningful tours. DOC's internal investigation is still ongoing.

The Office of the Chief Medical Examiner ("OCME") determined Avila's official cause of death was suicide by hanging.

## 7. Carlos Cruz

| | |
|---|---|
| **Age** | 43 |
| **Date of death** | September 3, 2025 |
| **DOC admission date** | April 27, 2024 |
| **Cause of death** | Acute MDMB-4en-PINACA intoxication |
| **Facility at time of death** | GRVC |
| **Bail amount** | $100,000 |

On April 26, 2024, NYPD officers arrested Mr. Cruz in Staten Island. Shortly after entering custody, officers transported him to the RUMC emergency department after he showed signs of being intoxicated. Medical staff at RUMC examined Mr. Cruz and then discharged him to police custody without providing or prescribing medication. Three to four hours after returning from the hospital, officers contacted EMS. Police records do not specify what prompted the call but do indicate that when EMS arrived, Mr. Cruz refused medical treatment.

On April 27, 2024, Mr. Cruz arrived at EMTC to begin the new admission screening. At intake, DOC staff flagged the court's request for Mr. Cruz to receive medical and mental health attention once in custody. Later in the day, after DOC staff completed their screening, medical staff

examined him in the clinic. Part of the screening included a urinalysis test, which tested negative for drugs. Mr. Cruz informed medical staff that he smoked one pack of cigarettes a day, used marijuana, and drank alcohol two to four times a month. In addition, he shared that he has a history of head trauma, has epilepsy, and required medication daily to prevent seizures. Medical staff prescribed him a stat dose of Keppra, an anti-epileptic medication, before leaving the clinic. Additionally, he shared several concerns with medical staff such as thoughts of wanting to hurt or kill himself and previous hospitalizations for psychiatric reasons, which prompted them to refer him for a mental health evaluation.

On April 29, 2024, mental health staff completed their assessment. The clinician noted Mr. Cruz had a history of receiving treatment at hospitals in Brooklyn and Staten Island, predominately for substance use, had engaged in self-harm multiple times, and used alcohol and marijuana regularly in the community. After completing the assessment, the clinician diagnosed Mr. Cruz with adjustment disorder with mixed disturbance of emotions and conduct, alcohol use disorder, and cannabis use disorder. In addition, the clinician determined that general population with mental health follow-up was the most appropriate designation. Shortly after being cleared for general population, DOC staff assigned him to a new admission general population dormitory.

On May 6, 2024, Mr. Cruz was transferred from general population housing to a mental observation unit. From May 6, 2024 through July 22, 2025, DOC records indicate Mr. Cruz was housed in various units, including general population and mental observation units, across five facilities on Rikers Island. While housed in GRVC, DOC staff observed him in distress twice, on August 15 and August 22, 2025. On August 15, officers observed him engaging in self-injurious behavior by banging his head on a cabinet in a clinic cubicle. On August 22, officers observed him in distress in the housing area, which prompted them to activate a medical emergency. Medical staff assessed him in the clinic following both incidents. Following the second incident, medical staff attributed the distress to the possibility of being under the influence of substances.

Mr. Cruz did not receive his prescribed direct observation therapy (“DOT”) seizure medication daily as required. Records show that from August 1, 2025 through September 3, his adherence rate for Keppra was about 53%, and his compliance rate for Carbamazepine was about 52%. Medical records note that DOC last produced him to the medication window at 7:45 pm on September 1. Medical records note that the medication was not administered.

On September 3, 2025, Mr. Cruz had another medical emergency. On that day, surveillance video captures uniformed staff assigned to the “B” post walk off the post to enter the “A” station. The officer remained on the “A” post for 26 minutes. While the “B” officer was in the “A” post, the floor was without direct supervision. Multiple cell windows in the unit were obstructed and the

"B" post officer did not enforce current policy[17] regarding securing cell doors. Surveillance video recorded numerous individuals in custody entering and exiting cells without the "B" post officer's assistance.

Mr. Cruz was one of the individuals to access an unauthorized cell. At 7:01 pm on September 3, he walked out of his cell and entered a cell assigned to another individual. At 7:44 pm, individuals in the unit began to crowd around the cell, giving the impression something occurred. At 7:49 pm, an individual notified the "B" post officer that Mr. Cruz was in need of medical attention. The officer checked on Mr. Cruz and found him on the floor with his eyes open, appearing to have a seizure, which prompted them to activate a medical emergency. Video surveillance captures the "B" post officer shaking Mr. Cruz and calling out to him while awaiting medical staff.

Medical staff arrived in the area at 7:58 pm. Responding staff reported that when they arrived, Mr. Cruz was unresponsive on the floor, pulseless with dilated pupils and discolored skin, and rigid. Medical staff attempted CPR using a LUCAS device, administered five Narcan applications and two epinephrine applications through an endotracheal tube, and provided oxygen via intubation but his condition did not improve. Urgicare staff pronounced him deceased at 8:35 pm.

On September 4, DOC sent officers from the Strategic Response Team to Mr. Cruz's housing area. During the search, an officer found a 6x6 inch white sheet of paper soaked in an unknown substance inside a zip lock bag in a cell assigned to another individual. DOC Special Investigations staff collected the contraband and sent it for testing, which returned positive for Naphyrone, also known as NRG-1.

DOC investigators also conducted an internal review following the incident. At the conclusion of their review, they recommended that the "B" post officer be suspended from duty without pay for failure to conduct meaningful tours, failure to ensure housing area doors were secured, and failure to conduct basic life-saving measures once Mr. Cruz was discovered on the ground.

[17] Directive #4009R-C states that Optional lock-in/lock-out periods shall be afforded in accordance with "Lock-in and Lock-Out Schedule." Individuals may be locked in their cells during optional lock-in/lock-out periods. Individuals choosing to remain locked-in during an optional lock-in/lock-out period may request to lock-out of their cells at the hourly optional lock-in/lock-out 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/lock-out period. At each optional lock-in during which individuals are permitted to lockout of (or lock-in) their cells, individuals who wish to do so may return to their cells to retrieve personal items and shall not be required to be locked in their cells as a result. The retrieval shall be done as expeditiously as possible and shall be limited to no more than the minimum time required to retrieve the needed or desired items.

OCME investigators responded and commenced their preliminary review. Records note that investigators did not discover any signs of trauma.

OCME determined Mr. Cruz's official cause of death was acute MDMB-4en-PINACA intoxication, otherwise known as an accidental overdose.

## Key Findings

DOC staff abandoned assigned posts

DOC Rules and Regulations #7.05.070 prohibits correctional staff from leaving their post without approval from their supervisor or without being properly relieved. On July 22, 2025, at EMTC, DOC staff assigned to the "A" post in Mr. Quispe's housing area ended their tour early, before the relief officer arrived. In addition to leaving post, the "A" post officer did not contact the area supervisor to advise they left their assignment before the relief officer arrived.

On August 23, 2025, uniformed staff assigned to a "B" post in a GRVC housing area for individuals diagnosed with serious mental illnesses walked off the post and entered the housing area "A" station for roughly two hours. DOC records, such as the housing area "A" post logbook and staff incident reports, do not indicate that the "A" post officer attempted to have the staff member leave their area and return to the "B" post.

Staff assigned to this housing area did not follow DOC's Rules and Regulations #2.30.030 and #3.05.130, which respectively state: "correction officers shall not permit any unauthorized person or employee on their post," and "members of the department shall not leave their post without the permission of a supervisor or until they have been properly relieved."

Inconsistent tours and inaccurate logbook entries

DOC Directive #4017R-D requires correctional staff to tour mental health housing areas every 15 minutes in absence of a SPA or in the event the SPA cannot perform tours. The directive also requires SPAs to tour every 10 minutes. The SPA on duty in Mr. Billa's housing area did not conduct tours every 10 minutes. From 9:30 pm on August 22 to 12:30 am on August 23, the SPA conducted two tours. As the SPA rounds were infrequent, the assigned "B" post staff should have toured every 15 minutes. From 9:34 pm to 11:29 pm on August 22, "B" post staff did not make a single tour. Although tours did not occur, the housing area "B" post logbook reflects staff conducted 30-minute tours.

Correctional staff failure to escalate concerns

DOC staff failed to communicate or escalate concerns to uniformed supervisory staff or maintenance staff regarding the conditions they observed in Mr. Billa's cell, such as excessive bad odor and feces smeared on the walls.

A CHS supervisor failed to appropriately respond to concerns reported by a CHS treatment aide about Mr. Billa. Although the CHS treatment aide notified the on-site clinical supervisor of concerns regarding Mr. Billa on August 22, the supervisor did not discuss or escalate the concerns appropriately.

Lack of documentation on hospital referral evaluation

CHS policy on referrals for acute psychiatric hospitalizations guides mental health clinicians when they are determining if it is appropriate to refer a patient to the hospital for inpatient psychiatric care. It sets forth five indicators to consider when making that determination, including but not limited to:

> i) Imminent danger to self or others;
> ii) Inability to care for basic needs in the jail setting;
> iii) Complex psychopathology that requires inpatient observation and assessment;
> iv) Symptoms that are complicated by medical co-morbidities typically managed in a hospital; and/or
> v) Uncontrolled symptoms as a result of medication non-adherence. (Policy #: MH 28)

Mr. Kelly had a diagnosis of schizoaffective disorder, was not adhering to medication, and refused to meaningfully engage mental health staff. Accordingly, Mr. Kelly exhibited at least two of five indicators described above (complex psychopathology that requires inpatient observation and assessment and uncontrolled symptoms as a result of medication non-adherence) and a hospital referral should have been considered. However, there is no documentation in Mr. Kelly's health chart that he was assessed to determine if a transfer to a higher level of psychiatric care was appropriate.

Mr. Billa was transferred to a PACE unit due to multiple altercations and uses of force that were determined to stem from paranoia secondary to serious mental illness in the setting of poor medication adherence. During the three weeks that he resided on PACE, documentation indicates that Mr. Billa's cell was filthy and malodorous. Several mental health assessments were unable to be completed due to his unwillingness to leave his cell or engage with the mental health team. During this time, his medication adherence was reported as less than 15%. Accordingly, Mr. Billa exhibited at least three of five indicators described above (inability to care for basic needs in the jail setting, complex psychopathology that requires inpatient observation and assessment, and uncontrolled symptoms as a result of medication non-adherence) and should have been assessed to determine if hospitalization was appropriate. CHS informed Board staff that the CHS provider who observed Mr. Billa's general condition on August 14, including medication adherence, failed to initiate a referral to hospital for evaluation.

Insufficient DOC staff assigned to the PACE unit

The PACE (mental health) unit was understaffed on August 23, 2025. Records note that on this day, the unit had one "B" post officer assigned to supervise the floor instead of two as required by Operations Order #10/08.

Unsecured cell doors

DOC staff assigned to the "B" post in Mr. Cruz's housing area did not secure the cell doors during their time on the post. It does not appear that staff tried to secure the cell doors after observing individuals freely, without their assistance, accessing their cells and other cells in the unit, in contravention with DOC Directive #4009R-C.

Individuals congregating in unassigned single cells

DOC Directive #4517R prohibits individuals from accessing cells that are not assigned to them. Per policy, "correction officers shall ensure each cell is occupied by the individual authorized to be in the cell. Furthermore, when touring, officers must push and pull on each cell door to ensure each cell is secure." Surveillance video captures staff assigned to Mr. Cruz's housing area overlooking individuals accessing various cells and not verifying each cell was secure.

Failure to offer aid to individual in distress

DOC staff did not attempt to offer Mr. Cruz any form of aid after finding him in distress. According to DOC Rules and Regulations #7.10.070: "in cases of an emergency requiring first aid, a staff member may administer first aid action until the arrival of medical personnel."

Housing assignment not consistent with disposition

CHS recommended that DOC assign Mr. Avila to mental observation housing at EMTC. DOC did not follow the recommendation. Instead, DOC assigned him to a CDU sprung at West Facility for security reasons because Mr. Avila's relative worked in EMTC. CHS records note that DOC explained the move was for "security reasons." Mental health areas are required to be staffed with an SPA rounding every 10 minutes and a "B" post officer touring every 30 minutes. In the absence of an SPA, uniformed staff would have toured more frequently, every 15 minutes.

Mental health history

Five out of the seven individuals whose deaths are covered in this report had documented mental health issues. CHS staff learned of individual's past mental health history during the new admission screening and scheduled follow-up accordingly. According to CHS records, all five individuals received medication to treat their mental health symptoms at the time of their deaths.

As noted in the Board's previous report,[18] the 2025 Mayor's Management Report showed an upward trend in the number of individuals in DOC custody eligible for specialized mental health discharge procedures (54% in FY24 to 57% in FY25). There was an upward trend of individuals in custody with a serious mental health diagnosis from FY24 (20.3%) to FY25 (20.7%), continuing the upward trend noted in FY23.

## Recommendation to CHS[19]

1. CHS staff should note considerations for a higher level of care, such as hospital care for acute psychiatric needs, in patients' health charts. Neither Mr. Kelly's nor Mr. Billa's charts include notes suggesting they were assessed for a referral to the hospital.

## Recommendations to DOC

1. DOC's Video Monitoring Unit ("VMU") is charged with the responsibility to "remotely monitor all facility inmate activity in real-time, promptly identify security concerns, and when necessary, make immediate notifications to the appropriate personnel so action can be taken to avoid potential incidents, whenever possible[.]" VMU could be a crucial tool in identifying poor touring practices, deficient supervision, unsecured and covered cell doors, as well as other incidents that pose a risk to individuals in custody and staff alike. DOC must immediately increase the number of staff assigned to VMU to expand this additional layer of supervision and support facility supervisors tasked with ensuring that tours are conducted pursuant to policy. For example, DOC can consider staffing VMU with officers the Health Management Division placed on medically monitored restriction ("MMR").[20]

2. 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

[18] First Report and Recommendations on 2025 Deaths in New York City Department of Correction Custody issued November 5, 2025.

[19] 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."

[20] Similar recommendations featured in *First 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 2023 Deaths in [NYC DOC] Custody,* and *Second Report and Recommendations on 2023 Deaths in [NYC DOC] Custody.*

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 7.05.090.[21]

3. When CHS determines mental observation housing is the most appropriate designation for an individual, DOC should not override the housing recommendation. If the housing recommendation presents some security or safety concerns, DOC must develop a protocol to ensure DOC touring practices in the individual's housing area are consistent with their mental health designation and CHS are able to provide the same level of mental health care afforded to those in mental observation units.

4. DOC should distribute memoranda and conduct updated trainings on providing prompt medical aid to an individual who is sick, impaired, unconscious, or injured. The memoranda and training should emphasize when to immediately call for medical assistance.[22]

5. Ensure all uniformed staff are current with training to identify the warning signs that an individual may be mentally ill or suicidal.[23] Require that staff found to have operated outside of the suicide prevention and intervention policy receive training before returning to a post that involves direct engagement and supervision of individuals in custody.

6. Reinforce SPA touring practices to officers, including their obligation to instruct SPA workers to tour housing areas six times a tour as specified in the Observation Aide Directive.

7. Ensure PACE is staffed with the appropriate number of officers as required by Operations Order #10/08, requiring that there should be two "B" post officers on the unit. This post should be considered critical for staffing purposes.

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[21] As recommended in *the 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.*

[22] Similar recommendation 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.*

[23] Directive #45421R-A, Suicide Prevention and Intervention, states staff shall complete a refresher training every three years to identify warnings signs an individual may be mentally ill or suicidal.

8. Post memorandum inside housing area "A" stations to remind "A" post officers that, per DOC Rule and Regulation #2.20.030, "[c]orrection officers shall not permit any unauthorized person or employee on their post."

9. Distribute teletypes reemphasizing that DOC prohibits officers from departing their assignment without their supervisors' approval or being relieved as required in DOC Rule and Regulation # 3.05.130.[24]

10. Comply with BOC Minimum Standard §1-04(a)(b)(1), which prohibits more than one individual occupying a single cell.

11. Regularly conduct de-escalation refresher trainings for all uniformed staff assigned to posts requiring ongoing engagement or direct supervision of people in custody.

12. DOC must implement safeguards to prevent OCGS staff from closing complaints related to medical and mental health concerns without forwarding these concerns in their entirety to the appropriate CHS unit.

[24] "Members of the Department shall not leave their post or place of assignment without the permission of a superior. Employees who are authorized to leave their post for any reason must return to the post as quickly as possible. If the nature of the employee's duties are such that the safety of the inmates or the facility/command is involved, employees shall not be permitted to leave until they have been properly relieved."

## NYC Department of Correction Response to Board of Correction's "Second Report and Recommendations on 2025 Deaths in New York City Department of Correction Custody"

The Department appreciates the Board's responsibility to investigate circumstances of deaths in custody as per its Minimum Standards. At the time of publication of the Board's report, the deaths of all individuals identified in the report remain under investigation by either the NYS Attorney General or the NYC Department of Investigation. Consequently, the Department is unable to provide a substantive response to the report at this time. When these investigations are closed, the Department would anticipate that the Board would afford the Department the opportunity to submit and publish a response.