BOARD OF CORRECTION
CITY OF NEW YORK

Second Report and Recommendations on 2023 Deaths in New York City Department of Correction Custody[1]

February 9, 2024

[1] Co-Authored by Director of Special Investigations Rahzeem Gray and Special Investigations Coordinator Imahnni Jeffries. Many thanks to General Counsel Melissa Cintrón Hernández and Executive Director Jasmine Georges-Yilla for their insight and comments, and to the members of the Board of Correction's Committee on Deaths, Near Deaths, and Serious Injuries (the "Committee"): Committee Chair Joseph Ramos, Board Chair Dwayne C. Sampson, Dr. Rachael Bedard, and Jacqueline Pitts.

I. INTRODUCTION & METHODOLOGY

The New York City Board of Correction ("Board" or "BOC") investigates deaths in custody[2] pursuant to New York City Charter §626(h)[3] and §3-10(c)(2) of Title 40 of the Rules of the City of New York.[4] These investigations focus on noting deficiencies in correctional practices, identifying areas for improvement and making recommendations to the Department of Correction ("DOC" or "Department") and Correctional Health Services ("CHS") to prevent future deaths. The New York City jail system, under DOC's jurisdiction, operates eight facilities on Rikers Island, five borough courts, and two hospital prison wards.

Nine individuals died in DOC custody in 2023. The Committee's *First Report and Recommendations on 2023 Deaths in New York City Department of Correction Custody*, published on November 9, 2023, detailed the investigations into the deaths of Marvin Pines, Rubu Zhao, Joshua Valles, and Felix Taveras. As noted in the Committee's previous report, the death of Ricky Howell will not be covered in this report or any future report. Mr. Howell passed away at Bellevue Hospital while in custody on July 6, 2023. DOC and medical records show that Mr. Howell had been receiving hospital level care since his admission to custody. The Office of the Chief Medical Examiner of the City of New York ("OCME") informed DOC's Health Affairs Unit that Mr. Howell's cause of death was "natural," due to Squamous Cell Carcinoma of the Tonsils, a terminal illness.

This report focuses on four deaths that occurred in the last half of 2023 – William Johnstone, Curtis Davis, Donny Ubiera, and Manish Kunwar. Board investigators interviewed people in custody and staff, reviewed DOC records and video footage in the jails, CHS and Health and Hospital ("H+H") medical records, and OCME records as part of its investigations. OCME records are not currently available for all decedents listed. In those instances, causes of death are labeled as suspected rather than confirmed.

A comprehensive review of each death revealed the following lapses in security practices that impacted efficient supervision of those in custody:

[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] "The board, or by written designation, a member of the board or the executive director, may conduct hearings, or study or investigate any matter within the jurisdiction of the department, and the board may make recommendations and submit reports of its findings to the appropriate authorities."

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

- In two of the four deaths, the "B" post correction officer had exited the unit in the hours before the death, leaving the area without direct supervision for a period of time before the incidents.
- In two instances, cell doors were unsecured, allowing people in custody to enter and exit their cells without the assistance of a correction officer.
- Correction officers did not tour in accordance with policy during two incidents.
- In all four cases, the decedents covered their cell windows completely, obstructing the correction officer's view.
- Investigators identified deficient or inaccurate logbook entries in three cases.

Another concern highlighted throughout this report is the number of medical visits individuals missed while they were in DOC custody. People often come into custody suffering from chronic diseases, mental health issues, addiction problems, or lack of access to quality care outside of confinement. This makes access to healthcare while incarcerated all the more important to people who spend prolonged periods in custody. In two of the cases covered in this report, a patient missed more than one medical appointment in the month prior to their deaths.

The Committee does not highlight the above trends to assert that DOC or CHS staff's actions, or lack thereof, contributed to an individual's death; but to note areas for improvement and make recommendations with the aim of preventing future operational failures. The Board provided CHS and DOC with advance copies of this report and an opportunity to comment. Their written responses, if any, are appended to this report.

II. DEATHS IN CUSTODY

1. WILLIAM JOHNSTONE

Age	47
Date of death	July 15, 2023
DOC admission date	March 28, 2023
Cause of death	Pending OCME confirmation
Facility at time of death	George R. Vierno Center ("GRVC"), general population housing
Bail amount	$40,000

CHS records show that, during his new admission medical screening[5] on March 28, 2023 at the Eric M. Taylor Center ("EMTC"), William Johnstone informed medical staff that he was diagnosed with congestive heart failure, diabetes, and high blood pressure, and that he received treatment for tuberculosis in the community. In addition to medical conditions, Mr. Johnstone explained that he used crack/cocaine, marijuana and

[5] CHS clinicians conduct medical and mental health evaluations of people who enter DOC custody to determine the most appropriate housing assignment based on their medical needs, separate from DOC's security screening for classification.

smoked one pack of cigarettes a day. Mr. Johnstone further admitted to accidentally overdosing in the past and spending time in a rehabilitation facility for his drug use. CHS records show that Mr. Johnstone tested positive for cocaine via urinalysis testing.

During intake, Mr. Johnstone disclosed previous and current mental health issues, which included diagnoses of schizophrenia (with hallucinations), bipolar disorder, Post-Traumatic Stress Disorder ("PTSD"), and depression. He reported that he "recently" spent time in an inpatient psychiatric program at Harlem Hospital and informed the clinician he was on psychiatric medication prior to being arrested. Lastly, he admitted to having current thoughts of self-harm or suicide. As a result of CHS's intake screening, a referral was made for a mental health evaluation, which was conducted by a mental health clinician on March 28.

CHS staff's review of Mr. Johnstone's medical records from the community found that he frequented the hospital emergency room for leg and chest pain after using cocaine and K2. Additionally, the review shows that, prior to his incarceration, he took Sertraline (antidepressant), Benztropine (anti-tremor), Trazadone (antidepressant and sedative), and Aripiprazole (antipsychotic). On March 29, 2023, CHS staff signed an order for Mr. Johnstone to receive several medications to treat ongoing medical and mental health issues.

CHS mental health staff designated Mr. Johnstone to mental observation housing.[6] Mr. Johnstone was placed in a dormitory-style mental observation unit in EMTC after completing a mental health assessment, on March 29, 2023. One week later, DOC transferred him to a cell-style mental observation unit at GRVC. Mental observation units offer programming such as creative arts, therapeutic activity, managing aggression and violence, illness management and recovery, amongst other services.

On April 4, 2023, Mr. Johnstone endorsed thoughts of wishing to be dead or to "overdose on drugs again" while speaking to a mental health clinician. Over the course of his incarceration, Mr. Johnstone refused to attend five mental health visits and one psychiatric medication reevaluation appointment. He was also scheduled for a routine, monitoring electrocardiogram ("EKG") appointment but DOC failed to produce him for this appointment. It was rescheduled and canceled 50 times. When he was finally produced for the EKG, Mr. Johnstone refused to have the test done.

After three weeks in the mental observation unit during which he was repeatedly noted to engage in drug use on the unit, Mr. Johnstone was transferred to a general population unit.

[6] Mental Observation is a special housing category for an individual whose mental illness requires a higher level of observation than those in general population, and who may be at risk of suicide.

According to CHS records, Mr. Johnstone used K2, despite being asked not to do it, which "caused him and others to engage in behavior that's disruptive to the therapeutic environment." During a mental health assessment on April 20, 2023, CHS staff had found Mr. Johnstone to be stable and without signs of psychosis or acute distress. Mr. Johnstone denied suicidal ideation. A CHS entry signed on April 26, 2023 notes that, given his high functioning and psychiatric stability (was usually calm, cooperative, logical, linear, organized, took care of himself, and advocated well), he was better suited for general population level of care. CHS further determined that he did not require suicide watch. Once mental health staff completed the paperwork required to clear Mr. Johnstone for general population, DOC transferred him to a cell-style general population housing area at GRVC.

Board staff confirmed through a review of jails surveillance footage that a "B" post correction officer[7] was assigned to the GRVC unit on the morning of July 15, 2023, the day of Mr. Johnstone's death. This "B" post officer allowed people in custody to freely enter and exit cells without the assistance of a correction officer, in contravention of DOC policy.[8] Additionally, from 10:00 am to 12:03 pm, the "B" post correction officer only conducted two tours of the area. DOC's general population rounding policy requires correction officers to conduct 30-minute tours of their assigned housing unit to visually inspect all individuals in all areas. After conducting the 12:03 pm tour, the "B" post correction officer left the unit and did not return until 1:46 pm. Despite being off post for over one hour and 30 minutes, the "B" post logbook does not reflect their absence. It notes that the "B" post officer performed tours of the area at 12:30 pm and 1:00 pm when video evidence does not support this documentation, before signing off the post at 1:30 pm for personal reasons.

Based on Board staff's observations of surveillance footage, the "B" post officer reentered the unit at 1:46 pm. At 1:47 pm, the "B" post officer performed a tour of the area and noticed that Mr. Johnstone's cell window appeared to be covered by magazine clippings. The correction officer peered through the open food slot and discovered Mr. Johnstone unconscious. The "B" post officer immediately ran to the "A" post to notify the "A" post officer and retrieve Narcan.[9] At 1:49 pm, the "B" post officer entered the cell. Jail surveillance cameras did not capture the events within Mr. Johnstone's cell and the "B" post officer did not turn on their body-worn

[7] "B" post officers are also known as floor post officers, who interact with and directly supervise people in custody inside the living area.

[8] DOC's Directive #4009R-C "Lock-In, Lock-Out," sets forth that if an individual is locked out during the optional lock-out period and needs to retrieve personal items from their cell, they may do so with the assistance of the "B" officer.

[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 overdose on opioids. Trained staff members and incarcerated individuals are qualified to administer Narcan if an individual displays unresponsiveness, slow or no breathing, blue or grey lips and/or fingernails, or snoring or gurgling sounds.

camera.[10] However, DOC's Health Affairs report indicates the correction officer administered three applications of Narcan and performed chest compressions.

CHS records note that medical staff arrived at 2:00 pm, ten minutes after receiving the call for medical assistance at 1:50 pm. They administered Narcan, two epi-pens, and performed cardiopulmonary resuscitation ("CPR") using a Lund University Cardiopulmonary Assist System ("LUCAS") device, which provides mechanical chest compressions to patients in cardiac arrest. BOC staff's video review confirmed medical staff reached the area at the indicated time and rendered aid in Mr. Johnstone's cell.

At 2:30 pm, Emergency Medical Services ("EMS") also responded to the unit and attempted CPR via a LUCAS device, per a DOC report. At 2:43 pm, EMS technicians departed GRVC for Mount Sinai Queens Hospital with Mr. Johnstone. Mount Sinai records note that he arrived intubated and unresponsive, and received five additional epinephrine doses, multiple dextrose 50 percent injections, as well as other emergency aid efforts. Mount Sinai's Emergency Department notes reflect that Mr. Johnstone achieved a return of spontaneous circulation several times, but ultimately became bradycardic and lost pulses. A bedside sonogram of his right femoral found deep vein thrombosis, along with multiple small clots and a large thrombus in the heart. Hospital staff pronounced Mr. Johnstone deceased within one hour of his arrival at the hospital, at 3:50 pm.

Per DOC's Health Affairs Unit report, a search of Mr. Johnstone's property found medication for blood pressure, cholesterol, and diabetes. They also located a burnt mop string (often used for smoking illicit substances) and a bottle of Mylanta, an over-the-counter medication used to treat an upset stomach, heartburn, and acid indigestion.

DOC's Health Affairs Unit report also reflects that OCME staff performed an autopsy on July 17, 2023 to determine the cause of Mr. Johnstone's death. The report notes that his preliminary cause of death was a clot in his heart and a pulmonary embolism in his lung. OCME found that overall, his death "appears to be a natural death due to heart disease with a history of drug abuse as a contributing factor." However, his confirmed manner and cause of death are still pending.

[10] DOC Operations Order #1/22, effective May 13, 2022, sets forth that body-worn cameras are distributed to uniformed members of the service assigned to steady posts throughout the Department. The same policy dictates that staff shall activate their camera to record all interactions with individuals in custody throughout their tour, unless it is unsafe or impractical to do so, when a malfunction or other mechanical issue impeding the use of the device exists, or recording is prohibited.

At the conclusion of GRVC leadership's initial investigation of Mr. Johnstone's death, the "B" post officer received a 30-day suspension for abandoning their assigned post without permission from a supervisor and for entering the "A" station without properly being relieved. Similarly, the "A" post officer received a 15-day suspension for allowing the "B" post officer to sit inside the "A" station without authorization. Additionally, the captain assigned to the housing unit received a seven-day suspension for not observing whether the individuals in their care were living and breathing and for failure to inspect every housing unit cell. Following their suspension, DOC demoted the captain and assigned them to modified duty.

2. CURTIS DAVIS

Age	44
Date of death	July 23, 2023
DOC admission date	June 2, 2023
Cause of death	Suicide (hanged self)[11]
Facility at time of death	GRVC, general population housing
Bail amount	$30,000

On June 2, 2023, Curtis Davis entered DOC custody and underwent new admission medical and mental health screening at EMTC. During the screening, Mr. Davis disclosed that he had attempted to kill himself in the past and was currently having thoughts of hurting or killing himself. Mr. Davis also told the clinician that he was depressed, had mental and emotional problems, had a history of past treatment for mental health problems, spent time in a hospital for mental health problems, and believed his thoughts were controlled or heard by others. In addition to his mental health history, Mr. Davis informed the clinician that he experienced an unspecified head injury and loss of consciousness because of that injury in the past.

The examining medical provider completed a referral form to expedite a comprehensive mental health assessment. During the mental health assessment, the provider engaged Mr. Davis in a discussion about his stressors and provided supportive therapy. Mr. Davis was determined to be appropriate for general population housing with mental health follow-up on the basis that he presented well, denied current suicidal thoughts on repeat evaluation, and displayed no abnormalities. Following the mental health assessment, Mr. Davis received prescription orders for Zoloft (antidepressant) and Benadryl (antihistamine) to counter his anxiety and depression. Mr. Davis was encouraged to return for mental health services if he experienced acute mood alteration or worsening symptoms.

After spending two weeks at EMTC in maximum classification dormitory-style housing, DOC transferred him to a maximum classification cell-style housing area in GRVC on June 12, 2023.

[11] As confirmed by OCME's autopsy report.

According to CHS records, on June 13 and June 16, 2023, Mr. Davis missed psychiatric medication prescription reevaluation appointments due to CHS rescheduling these appointments. These appointments were not made up before June 22, 2023.

On June 22, 2023, Legal Aid reported to CHS that they heard that Mr. Davis had possibly attempted suicide. CHS staff completed a referral and placed Mr. Davis on a call down list to be seen by a mental health clinician. DOC escorted him to the mental health area before the day's end. CHS records show that, during the evaluation, Mr. Davis stated he was experiencing "difficulties controlling life stressors, feels stressed, irritable, with excessive worry, overthinking, intermittent low mood and issues with sleep due to incarceration and being separated from his children." Additionally, he reported that the Zoloft medication caused him stomach pain and was not helpful in countering the symptoms he experienced before starting the medication. He also stated he no longer wanted to hurt himself and would not do anything like that. Mr. Davis remained in general population housing with mental health follow-up by a clinician/psychiatrist.

On June 29, 2023, Mr. Davis did not attend a psychiatric medication reevaluation appointment because, per CHS records, he was "not produced." However, DOC records reflect that he refused to attend this reevaluation.

CHS records show that DOC produced Mr. Davis to his next scheduled mental health appointment on July 10, 2023, the third time he was seen by mental health staff during his incarceration. His two previous mental health encounters occurred on June 3, 2023 (initial psych assessment and treatment plan) and June 23, 2023 (comprehensive treatment plan). During the July 10 assessment, Mr. Davis presented as stable, alert, and cooperative, and appropriately engaged in talk therapy and discussed his feelings. He did not offer psychiatric complaints and reported some symptom relief due to medication compliance. Mr. Davis stated, "I'm doing a little better. I think the meds are working. I think I need to be on a higher dose though. I have court next week." According to CHS, Mental Health Clinicians ("MHCs")[12] cannot prescribe or adjust medication. Mr. Davis was scheduled for a follow-up psychiatric appointment on July 13, 2023.

According to CHS records, correction officers did not produce Mr. Davis to his subsequent scheduled psychiatric medication reevaluation assessment on July 13, 2023. However, DOC records instead reflect that CHS rescheduled this appointment. CHS records also note that DOC failed to escort him to six scheduled sick call appointments from July 6 through July 14, 2023. DOC records do not reflect whether Mr. Davis missed any of these appointments because he

[12] MHC does not reference clinicians in the general sense of the term; it references a specific title within CHS.

refused to attend. In two separate instances, CHS staff closed the requests after Mr. Davis missed three consecutive appointments, per CHS triage protocol.

DOC assigned Mr. Davis to a cell located on his unit's top tier. According to people in custody who spoke with Board investigators after his death, Mr. Davis normally left his cell to use the phone, watch television, and eat during lockout periods. DOC provided Board investigators with Mr. Davis's call history and recordings. During a call made to an unidentified male on July 21, 2023, Mr. Davis stated "I'm ready to hang it up. I might just end this s--t. I asked people to help."

Through surveillance footage review, Board investigators observed Mr. Davis out of his cell at 8:50 pm, on July 22, 2023 – the day before his death. Mr. Davis entered the cell with food and two bottles full of water right before the 9:00 pm lock-in.[13] After the lock-in was partially completed (some individuals remained out of their cells after 9:00 pm), the "B" post correction officer failed to conduct consistent tours every 30 minutes and periodically left the unit, leaving the area unsupervised.

On July 23, 2023, the "B" post correction officer continued making infrequent tours and leaving the unit unsupervised. Jails surveillance footage shows that the "B" post correction officer left the unit at 2:07 am and did not return until 4:22 am. Although the "B" post officer failed to perform tours to verify that all people in custody were alive and breathing every 30 minutes,[14] the "B" post logbook reflects the correction officer rounded per policy every 30 minutes. In addition to inaccurate logbook entries and unsecured cell doors, Board investigators discovered that Mr. Davis's cell window was completely covered, obstructing the correction officer's view. The "B" post officer did not instruct Mr. Davis to remove the materials covering the cell window.[15]

After the "B" post correction officer returned to their assigned post at 4:22 am, they conducted a tour almost one hour later at 5:04 am. During the tour, the "B" officer manually unlocked cell doors to allow individuals out of their cells.

When the "B" post officer unlocked Mr. Davis's cell at 5:05 am, they found him upright, his body leaning on the wall, feet on the floor, linen around his neck, and unresponsive. According to DOC

[13] DOC Directive 4009R-C on Lock-In/Lock-Out, effective October 2, 2020, sets forth that individuals shall not be confined to their cells except during certain lock-in periods, including at night, for no longer than eight hours in any 24 hour period, beginning no earlier than 2100 hours.

[14] DOC Teletype Order No. HQ-2438-0 dated October 20, 2023 requires that correction officers make 30-minute unscheduled rounds of their assigned housing unit for the visual inspection of all individuals in all areas (e.g. tiers, bathrooms, showers, common areas and dayroom) including their cells or beds.

[15] DOC Security Bulletin dated January 4, 2013 states that at no time shall an inmate be allowed to cover his/her cell window or otherwise create an obstruction of correction staff to observe the inmate.

reports,[16] the "B" post officer removed the linen, began chest compressions, and instructed individuals nearby to notify the "A" post officer that there was a medical emergency. The "B" post officer continued chest compressions until medical staff arrived at 5:13 am**.** Medical staff took over resuscitation efforts for 30 minutes. Medical staff also administered one application of Narcan, utilized a defibrillator and attempted CPR via a LUCAS device. CHS records note that, upon their arrival to the unit, Mr. Davis was without a pulse or respiration, cold to the touch, and cyanotic (blue or purple discoloration of the skin due to deficient blood oxygenation), with a ligature mark on the left side of his neck and signs of rigor mortis. EMS pronounced Mr. Davis deceased at 5:51 am.

Individuals in custody expressed surprise that Mr. Davis took his life. According to statements collected by DOC staff from individuals in the unit, "Mr. Davis was cool. He didn't look like he would do that. He was quiet. He usually would watch TV and eat from the top tier."

GRVC leadership conducted an internal investigation of the events after EMS declared Mr. Davis deceased. Following the investigation, an assistant deputy warden ("ADW") received a 14-day suspension for failing to tour the area in the absence of an assigned captain. The "B" post officer received a 30-day suspension for being off post and the "A" post officer received a 15-day suspension for allowing the "B" post officer to sit on an unauthorized post for two hours.

3. DONNY UBIERA

Age	33
Date of death	August 22, 2023
DOC admission date	March 29, 2023
Cause of death	Acute methadone intoxication[17]
Facility at time of death	GRVC, mental observation housing
Bail amount	Remanded

On March 29, 2023, Donny Ubiera was discharged from Kirby Forensic Psychiatric Center and transferred to the Anna M. Kross Center ("AMKC"), a DOC facility on Rikers Island that previously housed people in custody who had acute mental health issues. Per CHS records, Mr. Ubiera was admitted to Kirby "on complaint of being confused, disorganized, unable to [] work with his legal team, and was found unfit to stand trial."

AMKC correctional intake officers booked Mr. Ubiera into the jail as a new admission. Following his intake screening, CHS referred Mr. Ubiera to an initial psychiatric assessment given his recent discharge from Kirby Forensic Psychiatric Center. During this assessment, Mr. Ubiera told the clinician he used cocaine, K2, and marijuana and drank alcohol regularly. He also informed the

[16] BOC staff are unable to visually verify the events that took place inside Mr. Davis's cell because surveillance camera angles do not capture a view into the cell.

[17] As confirmed by OCME's autopsy report.

clinician he suffered from depression, anxiety, insomnia, and schizophrenia. Records from the community note that Mr. Ubiera had completed a 28-day outpatient substance use program at Cornerstone, as well as a 90-day inpatient substance use program at St. Christopher's Inn in Graymoor. CHS records do not indicate when he completed both programs. He also underwent psychiatric hospitalization at Pilgrim Psychiatric Center in 2019 and New York-Presbyterian/Columbia University Irving Medical Center in 2021.

CHS prescribed Mr. Ubiera medication to treat his mental health diagnoses of schizophrenia and bipolar disorder and assigned him to a mental observation housing area. After residing in an AMKC mental observation unit for six weeks, Mr. Ubiera was transferred to a mental observation area in GRVC on May 9, 2023. After CHS staff observed him throwing out the medication, a staff pharmacist at GRVC recommend that his medications be crushed and delivered in liquid. Despite the switch, a psych note dated August 1, 2023 states that he continued to throw out the medication. This prompted CHS to require that Mr. Ubiera take his medication under direct observation by a registered nurse.

According to CHS medical records, correction officers at AMKC and GRVC produced Mr. Ubiera to all scheduled bi-weekly mental health psychiatric and reevaluation appointments. Mental health visits generally occur within the therapeutic housing units and do not require escort.

DOC's Inmate Information System ("IIS") shows that, after Mr. Ubiera transferred to GRVC, he spent time in three mental observation units. GRVC's Mental Health Unit Chief informed Board investigators that the frequent moves between mental health areas were due to the units closing so DOC could make repairs and improvements to the areas.

According to a report written by DOC uniformed staff assigned to the housing area, on August 21, 2023 at the beginning of the "B" post officer's shift, correctional staff instructed all individuals to remove cell window coverings. According to the same report, everyone complied with the order. On August 22, 2023, Board staff visited Mr. Ubiera's cell after his death and observed that the window was partially covered with linen.

Logbook entries and Board investigators' observations of jails surveillance footage confirm that on August 22, 2023 – the day of Mr. Ubiera's death – his housing area was staffed with a "B" post correction officer, a suicide watch officer, and a suicide prevention aide ("SPA").[18] The suicide watch officer was assigned to conduct one-on-one constant supervision of a separate person in custody, not Mr. Ubiera. Through video footage review, Board staff found that the "B" post

[18] SPAs monitor incarcerated individuals identified as suicide risks and are trained to recognize the warning signs of suicidal behavior in incarcerated individuals who have not previously been identified.

officer made tours every 30 minutes consistent with policy; however, the SPA performed just two tours between 12:00 am and 6:00 am, using a DOC flashlight. The SPA failed to perform tours consistent with DOC policy.[19]

People in custody told "City & State New York" that: "Around 1:30 a.m. on Tuesday, Carrillo [another person in custody] said, he could hear Ubiera calling for help and banging on his cell door while gasping for air, seemingly unable to breathe. Both Carrillo and the other person in custody said that the correction officers on the unit failed to respond to Ubiera's repeated calls for help."[20] Based on Board staff's review of footage, the "B" post officer toured at approximately 1:28 am and did not show any signs of hearing anyone in distress. Jails surveillance footage does not capture audio.

At 5:00 am, on August 22, 2023, the "B" post officer offered people in custody the opportunity to lock out of their cells. At 5:05 am, the "B" post officer instructed the "A" post officer via DOC radio to close the cells on the lower tier. At 5:12 am, the "B" post officer instructed the "A" post officer via DOC radio to close cells on the top tier. Before Mr. Ubiera's cell on the top tier was closed at 5:12 am, the "B" post officer stepped into his cell to check on him. The "B" post officer observed Mr. Ubiera on the bed unresponsive, which prompted him to report the medical emergency via DOC radio to the "A" post officer, while simultaneously calling out to the suicide watch officer.

Per DOC uniformed staff incident reports, the "B" post officer moved Mr. Ubiera from the bed to the floor and administered CPR. DOC records show that the last CPR training session the "B" post officer received was in 2018, in violation of DOC Operations Order 11/16.[21] The suicide watch officer rushed over to assist the "B" post officer performing CPR. While the suicide watch officer rendered aid, the "B" post officer ran to the "A" station to fetch Narcan at 5:14 am. The suicide watch officer's written report indicates Narcan was not available in the "A" station. The "B" post officer returned to Mr. Ubiera's cell without Narcan and continued CPR.

Jail surveillance footage shows that the suicide watch officer went to another housing area to fetch Narcan at 5:15 am. Before the suicide watch officer returned, an additional correction

[19] An observation aide shall conduct vigilant patrols of the housing area at irregular interval not to exceed ten (10) minutes between tours. Therefore, a minimum of six (6) vigilant patrols of their assigned areas shall be conducted per tour.

[20] Price K. (2023, Aug. 23). *Dying man's cries for help at Rikers Island went unheeded, fellow detainees say*. City & State New York. https://www.cityandstateny.com/policy/2023/08/dying-mans-cries-help-rikers-island-went-unnoticed/389684/

[21] The CPR/AED certification shall remain in effect for a period of twenty-four (24) months from the date of completion.

officer and a captain responded to the medical emergency at 5:19 am. According to uniformed staff incident reports, the responding correction officer administered three applications of Narcan and assisted with CPR while awaiting medical staff. Footage shows medical staff arriving at the unit at 5:27 am. They administered two additional applications of Narcan and utilized the LUCAS device and an Automated External Defibrillator ("AED") machine. At 5:51 am, an Urgicare doctor[22] suspended resuscitation efforts and declared Mr. Ubiera deceased.

OCME confirmed Mr. Ubiera died of acute methadone intoxication. People in custody told Board investigators and media outlets that Mr. Ubiera ingested methadone purchased from another individual in the unit.

DOC did not suspend any staff following Mr. Ubiera's death. GRVC's Assistant Commissioner did not identify any wrongdoing by correctional staff during their investigation.

4. MANISH KUNWAR

Age	27
Date of death	October 5, 2023
DOC admission date	September 28, 2023
Cause of death	Suspected overdose
Facility at time of death	EMTC, mental observation housing
Bail amount	$30,001

On September 28, 2023, DOC transportation officers transferred Manish Kunwar to EMTC from the Queens courthouse. EMTC intake officers booked Mr. Kunwar into the facility as a new admission and started the screening to identify an appropriate housing assignment. After Mr. Kunwar completed the DOC screening, CHS medical and mental health staff assessed him. During the medical assessment, Mr. Kunwar disclosed a history of substance use, which included crack cocaine, heroin, marijuana, K2, spice, synthetic marijuana, alcohol, and cigarettes. In addition, Mr. Kunwar shared that, before his arrest, he accidentally overdosed.

At the initial psychiatric assessment on September 28, Mr. Kunwar told the clinician he had a history of receiving mental health treatment for several diagnoses, including bipolar disorder, schizophrenia, adjustment disorder with anxiety, and depression. Through a record review, CHS became aware of ten psychiatric hospitalizations, with the earliest occurring at the age of 16, in Nepal.

CHS staff referred Mr. Kunwar to a methadone treatment program known as the Key Extended Entry Program ("KEEP"). CHS staff also wrote a prescription for Mr. Kunwar for alcohol

[22] An emergency medicine doctor staffed 24/7, situated at West Facility to respond to emergencies and triage urgent situations.

withdrawal and mental health medication to be filled by the pharmacist. CHS records show Mr. Kunwar received methadone on September 30, October 1, October 3, and October 4.

During an initial psychiatric assessment on September 28, 2023, CHS referred Mr. Kunwar to mental observation housing. On September 29, 2023, correction officers transferred him to a mental observation housing area in EMTC.

Mr. Kunwar remained in mental observation housing in EMTC, without incident, until an Urgicare doctor pronounced him deceased on October 5, 2023.

Video footage and DOC logbooks show the unit was staffed with a "B" post officer the day of Mr. Kunwar's death. However, they also show that there was no SPA present in the unit to make tours, as required in mental health housing areas by DOC's directive on the Observation Aide Program.[23] Although video footage and logbook entries place a "B" post officer in the unit at 5:42 am, the "B" post officer failed to make tours consistent with policy in the absence of a suicide prevention aide from 1:31 am to 5:42 am.[24] Additionally, the "B" post officer failed to make any tours after 4:34 am. Instead of making required tours, the "B" post officer assisted the pantry worker in sorting out the breakfast trays and delivered them to people in the cells. BOC's review of surveillance footage revealed that the "B" post officer stopped at Mr. Kunwar's cell to offer him breakfast at 5:42 am. The "B" post officer knocked on the cell door, and after not receiving a response, opened the cell. The "B" post officer observed Mr. Kunwar on the bed unresponsive, which prompted them to activate a medical emergency using a DOC radio. Body-worn camera footage reviewed by BOC investigators confirms that the "B" post officer performed chest compressions until medical staff arrived.

At 5:48 am, medical staff arrived and continued resuscitation efforts. CHS records note medical staff administered four applications of Narcan and utilized the LUCAS device before the Urgicare doctor pronounced Mr. Kunwar deceased at 6:20 am.

OCME investigators reported to the facility to perform a preliminary investigation after receiving notification that an individual in custody expired. Preliminary findings note that Mr. Kunwar was

[23] DOC Directive #4017R-D, effective April 8, 2022, states "Observation Aides shall be assigned to all special housing areas where the entire population of incarcerated individuals has been placed under observation. This includes Mental Health housing areas, Restrictive housing, Protective Custody, Intake, and New Admission areas."

[24] Per DOC Rules and Regulations, correction officers must be alert and check for signs of life when touring. In addition, DOC Directive #4017R-D, effective April 8, 2022, states "If an Observation Aide is not assigned during a particular period of time, an additional Correction Officer shall be assigned to the housing area. The Correction Officer must conduct tours every fifteen minutes…"

foaming at the mouth and indicate that the unofficial cause of death was a drug overdose or pulmonary edema. In addition, the report notes there were no signs of trauma.

After the Urgicare doctor declared Mr. Kunwar deceased, EMTC leadership conducted an internal investigation into his death. At the conclusion of the investigation, leadership took disciplinary action against two correction staff assigned to the housing area: the area captain and "B" post officer. According to a DOC suspension notice, the area captain was placed on modified duty for two days and the "B" post officer received a 30-day suspension for failing to look inside each cell during unscheduled tours, while tapping the tour wand to the wall. The same suspension notice notes that the "B" post officer used both the correction officer and captain's tour wands while touring.

III. KEY FINDINGS

1. Insufficient touring

The Board encourages proper touring and supervision by correctional staff and therefore will continue to include it as a finding in BOC reports until it becomes common practice. The Board recognizes the Department is looking to correct this deficient practice by introducing tour wands to record staff's housing area tours; this is a good path forward and the Board will continue to monitor the success of this new measure. BOC investigators anticipate requesting tour wand records immediately following a death to learn if correctional staff are making rounds to ensure persons in custody are not in distress, ill, injured, or dead while in their cells.

BOC learned through a review of jail surveillance footage that correctional uniformed staff inadequately performed tours of assigned areas in two of the four deaths covered in this report. As indicated in prior reports, DOC has several policies that address the need for constant supervision, therefore consistent and timely tours should occur. DOC Directive #4517R, Inmate Count Procedures, state correction officers are responsible for the care, custody, and control of people in custody and therefore must remain in their assigned areas and conduct visual observations at 30-minute intervals in general population areas. Additionally, DOC's Rules and Regulations, Section 7.05.090 titled General Supervision, directs that correction officers "shall be constantly alert, while on duty, observing everything that takes place on post within sight or hearing and shall constantly patrol the post during the tour of duty."

In **Mr. Johnstone's** general population cell-style unit, the "B" post officer conducted only two tours of the housing area between 10:00 am and 12:03 pm. At a minimum, the "B" post officer should have toured five times in that timeframe. In addition, at 12:03 pm, the "B" post correction officer left the unit and did not return until 1:46 pm. There was no other DOC correctional staff present within the unit during their absence. Based on DOC's policies regarding constant

supervision in general population housing areas, the “B” post officer did not comply with proper procedures. The officer received a 30-day suspension for abandoning their assigned post without permission from a supervisor. Similarly, the "A" post officer received a 15-day suspension for allowing the "B" post officer to sit inside the "A" station without authorization.

The “B” post officer assigned to **Mr. Davis’s** general population housing area left their post for over two hours, from 2:07 am to 4:22 am. When they reentered the area, the “B” post officer waited until 5:04 am to tour, 42 minutes after their return. Based on this policy violation, the “B” post officer received a 30-day suspension for being off post and the “A” post officer received a 15-day suspension for allowing the “B” post officer to sit on an unauthorized post of two hours.

It is also essential for uniformed staff supervisors, such as captains and ADWs, to tour as required. DOC Rules and Regulations section 2.25.010, requires captains to conduct tours at “frequent intervals.” Uniformed supervisors must ensure that correction officers fulfill their duties effectively. The captain assigned to the housing unit where Mr. Johnstone passed away received a seven-day suspension for being non-observant while touring the unit. Following a preliminary investigation into the circumstances surrounding Mr. Davis’s death, DOC suspended an ADW for seven days for failing to tour the area in the absence of an assigned captain.

Tour wands are a feature that enables correctional staff to track and record their tours at designated points within facility areas. Correction officers utilize a hand-held battery-operated device that records data using wall-mounted touch memory buttons. These buttons are located at specific pre-determined locations as designated by wardens. Once the wand contacts the button, the time stamp is registered in a DOC database, as per Operations Order #01/23, effective March 7, 2023. The Operations Order sets forth that “[c]orrection officers assuming “B” and “C” posts in celled and de-escalation housing units shall conduct tours of their assigned areas at a minimum of twice per hour at periods not to exceed thirty (30) minutes between tours.” Tour wands are a marked improvement in DOC’s touring policy and can represent an effective tool in their supervisory and tracking arsenal. However, this can only happen if correctional staff conduct their required tours and follow the protocols set forth in Operations Order #01/23. Simply tapping the tour wand to the touch memory button does not suffice; correction officers and supervisors must visually verify all occupied cells to ensure that all people within are safe, alive, and do not require medical assistance.

The “B” post officer assigned to **Mr. Kunwar’s** housing area at the time of his death conducted tours and used the tour wand; however, video footage confirms that the officer did not look inside each cell as they toured. The same “B” post officer also used a captain’s tour wand at one point to conduct his tour, which registered tours by a captain that in fact did not take place.

2. Inaccurate or incomplete logbook entries

The Department utilizes physical handwritten logbooks to keep track of most events and incidents that occur within the jails. Accurate and complete logbook entries are a critical tool that allows the Department to measure compliance with sound correctional practices and orders across the jails. They are also imperative for investigations, as they represent a contemporaneous account of serious incidents. DOC Directive #4514R-C on Housing Area Logbooks, states: "Logbook entries must be made without undue delay and must be recorded legibly, accurately, and concisely, in chronological order using military time." Three incidents described in this report involved incomplete or inaccurate logbooks entries.

Jail surveillance video captured the "B" post officer assigned to **Mr. Johnstone's** housing area leaving their post at 12:03 pm. They did not return until 1:46 pm. Despite being off-post, the officer documented, in the "B" post logbook, that visual tours of the areas were conducted at 12:30 pm and 1:00 pm, before they signed off the post at 1:30 pm.

The "B" post logbook for **Mr. Davis's** housing unit at the time of his death reflects that the "B" post officer conducted tours every 30 minutes between 2:07 am and 5:04 am. DOC video footage shows, however, that the "B" post officer exited the housing area at 2:07 am and did not return until 4:22 am. After reentering the area, they waited almost one hour before making a tour. Additionally, after the correction officer documented Mr. Davis's medical emergency in the "A" and "B" post logbooks, they did not complete further entries, such as the time medical staff arrived and departed, nor did they note the form of aid provided.

Logbook entries on the day of the **Mr. Ubiera's** passing also lack information about DOC and medical staff's effort to resuscitate him. Lastly, correction officers assigned to **Mr. Kunwar's** housing area failed to record the medical emergency, arrival and departure of medical staff, and the form of aid rendered by DOC and medical staff in the "A" and "B" post logbooks.

3. Cell window coverings

Per DOC Security Bulletin #001/13, Cell Window Obstruction/Officer Safety, at no time shall a person in custody be allowed to cover their cell window or to otherwise obstruct correctional staff's observations of a person in custody. BOC investigators found that in all the incidents described in this report, the decedents covered their cell windows, preventing staff from looking inside their cells.

Mr. Johnstone placed magazine clippings over his cell window, prompting the "B" post officer to check on him by looking through the open food slot. Institutional linen completely covered **Mr. Davis's** cell window, obstructing the "B" post officer's view inside the cell. After two attempts to

get Mr. Davis to remove the linen by knocking on the cell door, the "B" post officer unlocked the cell door using a key. Once they opened the door, the officer observed Mr. Davis unresponsive. Similar fact patterns were identified in the circumstances surrounding **Mr. Ubiera** and **Mr. Kunwar's** deaths.

4. Unsecured cells

DOC's lock-in and lock out schedule are set forth in Directive #4009R-C Lock In/Lock Out, effective August 4, 2014. The mandatory lock-in time is 9:00 pm and the lock out time is 5:00 am. A review of jail surveillance footage shows that, in **Mr. Davis** and **Mr. Johnstone's** units around the time of their deaths, correction officers did not enforce this policy. People in custody freely entered and exited their cells in the presence of the "B" post officer. The "B" post officer made no effort to escort the individuals to their cells. The "B" post logbook lacks entries noting that these concerns were reported to the area captain.

5. Medical concerns

Mr. Davis called the CHS health triage line on July 6, 2023, and requested referrals for two non-urgent issues. CHS made specialty referrals at the time of the call to address his requests. On July 10, CHS closed the request after DOC failed to produce him. On July 11, CHS opened a new ticket for Mr. Davis after he called the hotline and requested to be seen. On July 14, CHS closed out the request after DOC failed to produce him. CHS informed the Board that their staff closed out the request after reviewing information gathered during the initial health triage call and determining that it was a lower acuity visit that was appropriate for closure.

6. Narcan

Naloxone, commonly known by brand name "Narcan," is a nasal spray designed to help reverse the effects of a known or suspected opioid overdose. CHS distributes naloxone kits to the Department's "A" stations for use in the housing units, and the Department is charged with stocking Narcan in other areas of the jails frequented by persons in custody. People in custody can request naloxone from the unit's "A" station when they suspect someone is suffering from an overdose. CHS offers trainings to people in custody interested to learn how to use Narcan, and DOC has trained correctional staff on its use.

DOC reports note that, on the day of **Mr. Ubiera's** death on August 22, the housing area "A" post did not have Narcan available. According to written correctional staff reports, uniformed staff searched the "A" post but could not locate it, prompting one of the correction officers to leave the unit and retrieve it from a nearby housing area. CHS reported that the building's Narcan supply was audited on July 11, 2023, and at the time there were two Narcan kits in place. CHS records do not reflect that they received a Narcan replenishment request from DOC between July

11 and August 22. Per DOC's directive on Narcan, effective June 30, 2022, Narcan kits shall be available in all housing area "A" stations. The same policy also notes that CHS will immediately replenish used or expired Narcan kits after receiving notification from DOC.

7. CPR certifications

Per Operations Order #11/16, Automated External Defibrillator, effective July 12, 2016, DOC shall train and certify members of service in the use of CPR and AEDs. The certification must remain in effect for a period of twenty-four months from the date of completion. Staff who have not been trained and certified in CPR/AED are prohibited from using CPR techniques or the AED device. The "B" post officer assigned to **Mr. Ubiera's** housing area did not have an active CPR certification at the time of Mr. Ubiera's death, when he performed CPR. DOC records show that the officer last received CPR training in 2018.

8. COD notification delay

DOC's Central Operations Desk ("COD") is a centralized unit that is tasked with receiving notification and information related to unusual incidents and disseminating that information. Board staff, as well as multiple DOC units, receive COD notifications via e-mail when issued. DOC policy requires that deaths or serious injuries of people in custody, as well as instances when people in custody are unconscious, be reported to COD via telephone within 15 minutes "so that, if/when assistance is required, it can be provided without undue delay." The reporting time frame starts when it becomes apparent to the tour commander that an unusual incident has occurred.

In all four instances, tour commanders reported the incidents to COD in timeframes exceeding 15 minutes. A review of CODs by Board investigators uncovered that tour commander reporting times for all four incidents ranged from 24 minutes to one hour and 11 minutes after receiving notification of the death. The tour commander called and reported the death of **Mr. Johnstone** to COD 1 hour and 11 minutes after becoming aware of his passing. A notification to COD was made 24 minutes after **Mr. Davis's** passing. In the case of **Mr. Ubiera**, it took the tour commander one hour and 10 minutes to report it to COD; while for **Mr. Kunwar**, 43 minutes passed before the tour commander informed COD of the death.

9. Notification to the Board

The Department has a proactive obligation to immediately notify the Board, as well as other oversight and investigative city and state agencies, of deaths that occur in their custody. It is essential for the Board to receive consistent and timely notifications. This enables Board investigators to report to the jails and begin their investigations without undue delay.

DOC leadership did not directly notify Board members or staff of two of the four deaths mentioned in this report. Board staff learned of **Mr. Davis** and **Mr. Ubiera's** deaths through COD e-mail notifications, which as mentioned in the previous finding, can sometimes be significantly delayed. In both instances, COD disseminated the e-mails over three hours after being notified by GRVC leadership of the person's passing.

DOC Commissioner Lynelle Maginley-Liddie, however, directly notified the Board's Executive Director of the death of Chima Williams on January 4, 2024. The Board encourages the Department to continue proactively and timely notifying the Board of deaths in custody.

10. Mental health and drug use histories

"New York Times" reporting found that half the people in City custody have been diagnosed with a mental illness, describing Rikers Island as New York's largest mental institution.[25] All of the individuals whose deaths are covered in this report had self-reported mental health histories prior to incarceration, and some described drug use and treatment in the community.

Mr. Johnstone disclosed to CHS staff at intake that he had a mental health history, which included having thoughts of wanting to kill himself, admission to an inpatient psychiatric facility and prescribed mental health medication. He also admitted to using drugs, spending time in a drug treatment facility for methadone and accidentally overdosing before his arrest. CHS records reflect that Mr. Johnstone continued to use drugs while in custody.

During his intake screening, **Mr. Davis** told CHS staff that he had mental and emotional problems, including depression, had a history of past treatment for mental health problems, had thoughts of suicide, and believed his thoughts were controlled or heard by others.

Mr. Ubiera had a history of drug use that included spending time at an inpatient and outpatient facility, as well as history of serious mental illness.

Lastly, **Mr. Kunwar** disclosed to CHS staff that, before entering DOC custody, he attempted to kill himself, was diagnosed with bipolar disorder, and received mental health treatment in the community. He also disclosed a history of drug use and self-reported that he accidentally overdosed once. CHS assigned him to a mental health unit and placed him on methadone medication to reduce withdrawal symptoms while in custody.

[25] Ransom J. & Harris A. (2023, Dec. 29). *How Rikers Island Became New York's Largest Mental Institution*. The New York Times. https://www.nytimes.com/2023/12/29/nyregion/nyc-rikers-homeless-mental-illness.html

IV. RECOMMENDATIONS[26]

To DOC and CHS jointly

1. CHS and DOC report that they are now conducting joint reviews of each death in custody, which was recommended by the Board in its last five reports on deaths in custody. This review must include the exchange of relevant clinical information (not including a full review of a person's entire medical history if not relevant). DOC and CHS must relay their findings to the Board, which is authorized, by law, to investigate deaths in custody and offer recommendations to prevent further incidents. Issues regarding confidentiality and protected health information (PHI) must be resolved by each agencies' legal departments and, if necessary, the New York City Law Department.[27]
2. CHS records note that DOC failed to produce Mr. Johnstone to over 50 EKG X-ray appointments. CHS informed the Board that there are processes in place to monitor and escalate non-production to DOC, including escalating requests for production in urgent situations. DOC must improve its medical escort practices, including maximizing staff availability in these posts, to ensure that patients are seen for their scheduled appointments without undue delays, even when there are no acute concerns.
3. Historically, there have been discrepancies in the number of missed medical appointments and the reason for each missed appointment (lack of escorts, refusals, cancelations, court, etc.) reported by both agencies. DOC and CHS must improve information-sharing so both agencies' records are consistent with each other and accurate.[28]

To CHS

1. CHS should review Mr. Davis's case for opportunities to improve suicide prevention practices for patients who may express repeated but inconsistent suicidal ideation.

To DOC

1. DOC should use these cases of lapses and serious outcomes when reinforcing and retraining staff on basic supervision, touring, and logbook entry practices, including but not limited to, correction officers' responsibility to be vigilant, remain on post, and to

[26] Several recommendations in this section were made in prior reports on deaths in custody. The Board has again included these recommendations or variations of them because, to date, DOC and CHS have not implemented them.
[27] A variation of this recommendation was made in *February & March 2022 Deaths in DOC Custody Report and Recommendations*, *Report and Recommendations on 2021 Suicides and Drug-Related Deaths in New York City Department of Correction Custody*, *Second Report and Recommendations on 2022 Deaths in New York City Department of Correction Custody*, *Third Report and Recommendations on 2022 Deaths in New York City Department of Correction Custody* and *First Report and Recommendations on 2023 Deaths in New York City Department of Correction Custody.*
[28] As recommended in *Second Report and Recommendations on 2022 Deaths in New York City Department of Correction Custody.*

document personal breaks, meals, and details regarding unusual incidents accurately and legibly.[29]

2. Multiple past Board reports highlighted DOC's obligation to ensure that correction officers and captains conduct regular tours and directly supervise people in custody, in accordance with DOC's own policies. Since then, DOC implemented the full-scale use of tour wands. DOC's tour wand policy must include an auditing procedure to measure the length of time between each tour wand tap on the stations around the housing area, to ensure that uniformed staff are carefully conducting visual inspections of individual cells to verify that those within are alive and breathing.[30]
3. DOC must ensure that correctional staff timely document accurate information in logbooks and other agency databases. DOC should transition out of the practice of keeping paper logbooks and develop an electronic log system. The electronic system should capture information triggered at the individual cell level. Until such a system is implemented, tour commanders should articulate an action plan to regularly audit logbooks against Genetec video footage and watch tour data at unpredictable times to ensure that rounds are taking place as required and to detect incorrect entries.[31]
4. DOC must continually train and enforce the "A" post officers' obligation to request replenishment of Narcan in the "A" stations when the remaining kits are expired or used.
5. GRVC's facility medication escort post description directs medication escort post officers to "[s]upervis[e] inmates as medication is being dispensed by positioning yourself to personally observe the inmates to ensure they ingest the medication, to prevent medication hoarding and unauthorized use[.]"DOC must ensure that correctional staff conduct a thorough visual inspection of an individual's mouth after they have received medication. This will help prevent an individual from hoarding medication and/or selling it to others.
6. 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

[29] This recommendation was made in *First Report and Recommendations on 2023 Deaths in New York City Department of Correction Custody.*

[30] A variation of this recommendation was made in *Report and Recommendations on 2021 Suicides and Drug-Related Deaths in New York City Department of Correction Custody*, *Second Report and Recommendations on 2022 Deaths in New York City Department of Correction Custody*, *Third Report and Recommendations on 2022 Deaths in New York City Department of Correction Custody*, and *First Report and Recommendations on 2023 Deaths in New York City Department of Correction Custody*.

[31] A variation of this recommendation was made in *February & March 2022 Deaths in DOC Custody Report and Recommendations, The Death of Layleen Xtravaganza Cubilette-Polanco 1991-2019*, *Report and Recommendations on 2021 Suicides and Drug-Related Deaths in New York City Department of Correction Custody, Second Report and Recommendations on 2022 Deaths in New York City Department of Correction Custody, Third Report and Recommendations on 2022 Deaths in New York City Department of Correction Custody* and *First Report and Recommendations on 2023 Deaths in New York City Department of Correction Custody*.

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.

7. When investigating the death of Mr. Johnstone, Board staff observed an unidentified detainee smoking in the vicinity of the "B" officer. Housing area correctional staff must immediately intervene in attempt to confiscate the drug paraphernalia. Staff shall also notify their area supervisor and document all actions taken in the housing area logbook. DOC must arrange an unscheduled search of the unit immediately after such notification is received, and drug test the individuals housed in that unit.[32]
8. The "B" post officer who administered CPR to Mr. Ubiera last received CPR training in 2018. DOC leadership must ensure that all uniformed staff attend CPR, AED, and First Aid training every two years in accordance with Teletype No. HQ-02859-0.
9. 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 properly supervise all areas where people in custody are held, proportionate to the census.[33]
10. "B" post officers and any other correctional staff present in units where SPAs are working must ensure that SPAs conduct tours every 15 minutes, as required by policy.
11. DOC supervisors must ensure that tour commanders are notifying COD of deaths and other reportable incidents within the timeframe set forth by DOC's directive.
12. DOC must stop the flow of contraband into the jails, whether it be through mail, visitors, or uniformed and civilian staff. The Department advised that randomized body scanning began on March 13, 2023 at RNDC. Additionally, the staff body scanner at OBCC became operational on July 25, 2023. A body scanner has also been installed at EMTC and the Department is working towards that scanner becoming operational. DOC informed the Board that it is not operationally feasible to scan every person coming and going from the facility due to time and space constraints. DOC further recognizes that body scanning not only allows DOC to recover contraband items on or inside persons entering DOC facilities, but also, importantly, body scanning serves as a deterrent. DOC must extend this practice

[32] A variation of this recommendation was made in *First Report and Recommendations on 2023 Deaths in New York City Department of Correction Custody.*

[33] A variation of this recommendation was made in *First Report and Recommendations on 2023 Deaths in New York City Department of Correction Custody.*

to other facilities and scan as many incoming staff as possible within the current time and space constraints, and explore ways to limit or eliminate those constraints.[34]

13. To ensure drugs are confiscated and do not cause harm to the population, DOC must create a regular contraband search schedule that covers all housing units and areas where people in custody are held.[35]

[34] As recommended in *Report and Recommendations on 2021 Suicides and Drug-Related Deaths in New York City Department of Correction Custody, Second Report and Recommendations on 2022 Deaths in New York City Department of Correction Custody,* and *First Report and Recommendations on 2023 Deaths in New York City Department of Correction Custody*.

[35] A variation of this recommendation was made in *Second Report and Recommendations on 2022 Deaths in New York City Department of Correction Custody* and *First Report and Recommendations on 2023 Deaths in New York City Department of Correction Custody*.

NYC HEALTH + HOSPITALS/CORRECTIONAL HEALTH SERVICES RESPONSE TO RECOMMENDATIONS CONTAINED IN THE NYC BOARD OF CORRECTION'S "SECOND REPORT AND RECOMMENDATIONS ON 2023 DEATHS IN NEW YORK CITY DEPARTMENT OF CORRECTION CUSTODY"

New York City Health + Hospitals/Correctional Health Service (CHS) has reviewed the Board of Correction's report, "Second Report and Recommendations on 2023 Deaths in New York City Department of Correction Custody."

CHS reiterates its concern regarding the Board's public disclosure, throughout the report, of protected health information. As noted in the previous report, CHS believes that, even posthumously, the privacy and confidentiality of a person's information should be respected and protected, in accordance with law.

While the Board did not identify any gaps in routine medical or mental health care in its report, the recommendations for CHS and the joint recommendations for CHS and DOC merit responses.

IV. Recommendations

To CHS and DOC, jointly:

1. "CHS and DOC report that they are now conducting joint reviews of each death in custody, which was recommended by the Board in its last five reports on deaths in custody. This review must include the exchange of relevant clinical information (not including a full review of a person's entire medical history if not relevant). DOC and CHS must relay their findings to the Board, which is authorized, by law, to investigate deaths in custody and offer recommendations to prevent further incidents. Issues regarding confidentiality and protected health information (PHI) must be resolved by each agencies' legal departments and, if necessary, the New York City Law Department."

Response: As the Board states, CHS and DOC have continued to review in-custody deaths immediately following each incident, which includes exchange of relevant information. BOC holds the authority to convene DOC and CHS for the Board's death reviews as timely as it wishes, separately from any independent and joint review each agency may conduct. It is unclear to CHS why the Board continues to cite the agencies for not relaying information when the Board has not recently made any formal and specific requests to convene a death review with both agencies.

2. "Historically, there have been discrepancies in the number of missed medical appointments and the reason for each missed appointment (lack of escorts, refusals, cancelations, court, etc.) reported by both agencies. DOC and CHS must improve information-sharing so both agencies' records are consistent with each other and accurate."

Response: CHS provides DOC with the names of individuals who require production for clinical purposes. The discrepancies noted for missed medical appointments are primarily driven by differences in how each agency tracks and labels missed visits. CHS uses the documentation in its electronic health record system to report the final outcome of clinical appointments from the CHS provider perspective.

To CHS:

1. "CHS should review Mr. Davis's case for opportunities to improve suicide prevention practices for patients who may express repeated but inconsistent suicidal ideation."

Response: CHS regularly reviews and updates suicide prevention protocols to meet the evolving clinical needs of our patients, and our experience in jail-based care. This occurs both as a part of, and separate from, internal death reviews. Our suicide prevention protocols were recently evaluated by the Nunez monitors, and they made no specific recommendations for change. Jail incarceration and detention is associated with psychological distress, and only a small subset of individuals who verbalize suicidal ideation go on to make suicide attempts in jail. CHS' protocols indicate that anyone expressing suicidal ideation should be referred for an immediate mental health assessment. This includes individuals who initially endorse, then rescind, suicidal ideation. The mental health clinician performing the evaluation considers all relevant clinical information when performing an individual risk assessment.