BOARD OF CORRECTION
CITY OF NEW YORK

First Report and Recommendations on 2024 Deaths in New York City Department of Correction Custody[1]

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

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(h)[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 of improvement and making recommendations to the Department of Correction ("DOC" or "Department") and Correctional Health Services ("CHS") to prevent future deaths.

In 2023 and early 2024, BOC published two reports on deaths in custody, which included the findings from our investigations of eight 2023 deaths in DOC custody. This report details Board staff's findings and recommendations regarding two deaths in custody that occurred in early 2024, Chima Williams and Manuel Luna. The two deaths occurred in January 2024: the first at the Eric M. Taylor Center ("EMTC") and the second at the George R. Vierno Center ("GRVC"). Board staff responded to the facilities in both instances on the day of the deaths to collect documentation, interview people in custody and staff, and review DOC surveillance video.

Roy Savage's death in custody, which occurred on March 22, 2024 at Bellevue Hospital, will not be covered in this report or any subsequent report. Mr. Savage was transferred to Bellevue Hospital in November 2023 from Albany Medical Center Hospital. DOC records show he never left the hospital following his admission. Medical records note he had been receiving care for a terminal illness while in custody.

Some concerns highlighted in this report include:

- Failure to keep correctional staff up to date in their cardiopulmonary resuscitation ("CPR") training certifications.
- Delays in facility leadership notification to DOC's Central Operations Desk ("COD") once a person has been declared deceased.

[2] Based on feedback from the United States Department of Justice's Bureau of Justice Statistics, the Board considers "deaths 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.

- Inaccurate and incomplete logbook entries and record keeping.
- Lack of cell door security.
- Correctional staff assigned a person in custody to a cell without a mattress.
- Keeping persons in custody in the same housing area after repeated involvement in fights and use of force incidents in that unit.
- Recreation at EMTC, which is not currently being afforded in compliance with BOC Minimum Standards.

The concerns are highlighted in hopes of preventing future operational failures that may or may not contribute to deaths and other serious adverse outcomes.

Deaths in Custody

1. Chima Williams

Age	43
Date of death	January 4, 2024
DOC admission date	December 24, 2023
Cause of death	Unknown (awaiting OCME report)
Facility at time of death	EMTC, general population housing
Bail amount, if any	$25,000

Chima Williams underwent DOC's new admission screening[5] at Brooklyn Criminal Court on December 24, 2023. During the screening, the correction officer noted on the Suicide Prevention Screening form that Mr. Williams had experienced a significant loss within the past six months. On the Discharge Planning Questionnaire, the correction officer noted Mr. Williams drank alcohol one to three times a month and had spent time in a program for alcohol or drugs.

After the initial screening, DOC transferred Mr. Williams to EMTC to complete the new admission process, which included a medical assessment.[6] CHS staff met with Mr. Williams in the clinic on December 25, 2023. During the screening, Mr. Williams shared that he had high blood pressure, smoked half a pack of cigarettes a day, and received mental health care in the community before his arrest. Although blood pressure was raised as a concern, his vitals were normal and the only listed problem per records was

[5] The intake process consists of a thorough search of the individual and their property. Security officers also screen individuals through questionnaires regarding suicide prevention, discharge planning, classification, and the Prison Rape Elimination Act ("PREA").

[6] The purpose of CHS' medical and mental health intake evaluations is to identify clinical needs, which can include housing recommendations.

cigarette use. In addition, although Mr. Williams admitted to receiving mental health care at one time, he denied having any current mental health needs.

On December 26, 2023, following the medical assessment, Mr. Williams was transferred to a general population[7] dormitory-style new admission housing area. On January 4, 2024, EMTC staff afforded recreation to people in custody for the first time since Mr. Williams moved into the unit nine days prior. Recreation was afforded in the gym, as the outdoor recreation yard is not currently in use. Board staff reviewed Department surveillance video which shows that, per DOC Directive #4508R-E,[8] correction officers searched people in custody as they exited the housing area at 8:53 am to be escorted to the gym. At 8:55 am, seven people in custody were in the gym, supervised by four correction officers.

At 8:57 am, Mr. Williams and three people in custody took turns shooting a basketball and started to play a game. At 9:23 am, mid-game, Mr. Williams went to the bathroom. He returned to the basketball court at 9:24 am and the game continued. Three minutes later, people in custody momentarily stopped the game so Mr. Williams could take a break. Mr. Williams used this time to fix something on his shoe. He then got back up and continued the game.

At 9:43 am, Mr. Williams collapsed after shooting the basketball. According to one incarcerated individual, "[Mr. Williams] looked like he was stretching." After Mr. Williams did not get up for one minute, people in custody checked on him then summoned correction officers present in the gym. The four correction officers walked over and observed Mr. Williams on the floor. One correction officer checked Mr. Williams' pulse and another utilized an institutional radio to activate a medical emergency. In addition, a person in custody removed their shirt and used it to fan Mr. Williams.

Beyond the one pulse check, correction officers did not attempt to perform CPR or administer Narcan.[9] DOC leadership informed Board staff that additional pulse checks were not necessary because at that time, Mr. Williams "had a pulse." Similarly, the

[7] DOC Directive #4020R-B, effective November 18, 2019, states that general population housing is designated for individuals who have undergone the new admission screening process, including medical and security screenings, and have been determined to not require any type of special housing. General population housing areas shall be designated based on the individual's classification score.

[8] DOC Directive # 4508R-E, Control of and Search for Contraband, states that pat frisks shall be conducted on people in custody whenever they leave or enter a housing area.

[9] Naloxone (Narcan) is a life-saving medication that can reverse the effects of an overdose on opioids, a class of drugs that include heroin, fentanyl, and strong prescriptions painkillers.

incident reports completed by correction officers state, “Mr. Williams showed signs of life, was breathing, and had a pulse.” Board staff are unable to independently verify these claims because correction officers did not activate their body worn cameras.[10] The stationary camera[11] that recorded the recreation session was not close enough to Mr. Williams to affirm these statements. During Board staff’s visit to Mr. Williams’ last recorded housing area, one person in custody indicated that, “they wanted to help but correction officers told [him] not to touch [Mr. Williams].”

CHS records note, and Board staff confirmed via a review of surveillance videos, that medical emergency staff entered the gym at 9:49 am. Immediately upon arrival, medical staff performed CPR, administered three applications of Narcan, four doses of Epinephrine and Bicarbonate, and utilized a heart monitor. Medical staff attempted various means to resuscitate Mr. Williams after they observed him “on the floor, unresponsive to stimulation, with no spontaneous breathing or heart rate, and with fixed dilated pupils,” according to their records. Despite their efforts, a CHS doctor pronounced him deceased at 10:17 am.

A preliminary investigation conducted by investigators from the Office of the Chief Medical Examiner (“OCME”) on January 4, 2024, notes Mr. Williams had no signs of trauma. A preliminary autopsy conducted by the OCME on January 5, 2024 notes Mr. Williams had an enlarged heart with no blockages or blood clots. The results of OCME’s toxicology report were negative. Mr. Williams’ confirmed cause of death remains pending at the time of this report’s publishing.

[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.

[11] EMTC Command Level Order # 06/18R states that all recreation sessions shall be recorded with a handheld video camera. The camera shall be pointed in the direction of the area providing the best view of the general yard session or highest concentration of persons in custody. In the event of any unusual incidents, the recreation "B" officer is responsible for utilizing the video camera to capture the event.

2. Manuel Luna

Age	30
Date of death	January 19, 2024
DOC admission date	October 5, 2023
Cause of death	Unknown (awaiting OCME report)
Facility at time of death	GRVC, general population housing
Bail amount, if any	$25,000

On October 5, 2023, Manuel Luna was processed as a new admission at Manhattan Criminal Court. During the screening, Mr. Luna stated to correction officers that he was thinking about killing himself, expressed shame and embarrassment because of his current charge, showed signs of depression, and appeared anxious, afraid, and angry. Additionally, he stated he used alcohol and drugs every day during the past 12 months, felt bad, and had immediate mental health needs. After Mr. Luna completed the initial screening, DOC transferred him to EMTC to complete the new admission process.

CHS records note that medical staff examined Mr. Luna at the EMTC clinic on October 6, 2023. During the medical examination, he disclosed having an extensive mental health history that includes a suicide attempt, current thoughts of wanting to harm or kill himself, and feeling hopeless. He also reported a history of post-traumatic stress disorder, bipolar disorder, borderline personality disorder and schizophrenia, spending time in a psychiatric hospital, and receiving mental health treatment in the community before his arrest. In addition to his mental health history, Mr. Luna reported having asthma, heart disease and a pacemaker. He also admitted to using heroin six times a day for the past seven years, accidentally overdosing in the community, drinking alcohol five or six times a day, and participating in a substance abuse program prior to arrest. Urinalysis at the time of screening was only positive for marijuana.

Medical staff referred Mr. Luna for a mental health evaluation after completing the medical screening. The referral form notes Mr. Luna had opioid use disorder and a history of alcohol withdrawal. Mr. Luna was enrolled in CHS's methadone treatment program known as the Key Extended Entry Program ("KEEP").

A mental health clinician evaluated Mr. Luna on October 6, 2023. After the evaluation, the clinician recommended that Mr. Luna be assigned to a mental observation housing area.[12] Subsequently, a correction officer escorted him to a dormitory-style mental observation housing area at EMTC.

[12] 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.

On October 8, 2023, medical staff received the results of a COVID-19 test Mr. Luna consented to during the intake screening. CHS records note that the test came back positive. CHS notified DOC and Mr. Luna was transferred to a Communicable Disease Unit ("CDU")[13] at West Facility for quarantine purposes. While in the CDU, medical staff encountered Mr. Luna daily during rounds.

DOC records show that, on October 11, 2023, Mr. Luna caused a self-inflicted injury after breaking the television inside his cell and received medical attention. Per the injury report, Mr. Luna sustained a laceration to his right index finger, an abrasion to his left hand, and superficial scratches on his left arm. All wounds were cleaned with hydrogen peroxide and repaired with Dermabond. After the incident, Mr. Luna informed a clinician during rounds that he broke the television because he was upset about not receiving methadone earlier that morning. Subsequently, the clinician entered a note in Mr. Luna's chart that he would be likely to engage in similar behavior in the future and diagnosed him with adjustment disorder accompanied by a mixed disturbance of emotions and conduct.

DOC records show that Mr. Luna was transferred to a mental observation housing area at the Otis Bantum Correctional Center ("OBCC") on October 17, 2023. A review of the misbehavior reports generated by OBCC staff indicate Mr. Luna was involved in nine fights between October 28, 2023 and December 24, 2023, while in the unit. In eight of the nine fights, medical records note no serious or visual injuries. In one instance, medical noted swelling in his right hand. X-ray results revealed no fracture or dislocated bones. Per a DOC report, on December 25, 2023, Mr. Luna was rehoused and assigned to another mental observation dormitory-style housing area at OBCC due to excessive fighting in his previous housing area.

On January 11, 2024, DOC reports indicate Mr. Luna was involved in a tenth fight in the new mental observation unit. Per the injury report, no injuries were sustained as a result.

On January 17, 2024, an OBCC clinician determined that Mr. Luna no longer required a mental observation housing level of care and cleared him for general population, on the basis that he presented a stable mood, socialized with peers, was 86 percent compliant with medication and endorsed suicidal ideation for secondary gain. Mr. Luna would continue to receive mental health follow-up care in general population housing.

[13] Per Directive #4020, Department Definitions of Inmate Categories, individuals who require isolation to reduce the spread of communicable diseases that are caused by infectious agents that can transmitted from person to person are sent to CDUs.

On January 18, 2024, OBCC correction officers escorted Mr. Luna to the intake area for transfer to GRVC. DOC logbooks show that Mr. Luna transferred to a general population unit at 2:23 am on January 19, 2024. The "B" post officer[14] assigned him to a cell without a mattress, according to DOC records.

At 5:00 am on January 19, 2024, Mr. Luna locked out of his cell for breakfast. After locking out, the correction officer made no attempt to ensure Mr. Luna's cell door was locked.[15] Mr. Luna entered and exited his cell throughout the day without the correction officer's assistance.[16] Board staff's review of video footage show that Mr. Luna made a telephone call, watched television, played chess, and socialized with individuals in the unit before he entered his cell for the final time, at 5:59 pm. Video shows the "B" post correction officer routinely toured the unit, as policy requires,[17] every 30 minutes. At 7:17 pm, during a tour, the "B" post correction officer stopped and opened the door to Mr. Luna's cell, then suddenly closed it. There are no logbook entries or written reports that explain why the "B" post correction officer opened Mr. Luna's cell.

At 8:45 pm, a captain entered the area with a mattress intended for Mr. Luna. Per DOC records, once the captain reached Mr. Luna's cell, they observed him on his back, on the metal bed frame, unresponsive. DOC records indicate the captain knocked on the cell door to get Mr. Luna's attention. He did not respond. After the captain failed to receive a response, they entered the cell, turned on the light and observed that Mr. Luna's face was pale in color and foam discharged from his mouth. The captain checked Mr. Luna's pulse, activated a medical emergency via the departmental radio, and proceeded to perform CPR. The "B" post correction officer retrieved Narcan from the "A" post, returned to the cell and administered one application, in addition to assisting with CPR.

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[14] DOC uses the term "B" post when referring to a correction officer assigned to a housing area floor post.

[15] DOC Rules and Regulations No. 4.35.050 states that, after the established lock-in time, all cells are to remain locked. If it is found necessary for any reason to open the cell of a person in custody, two (2) officers must be present in the housing area. In the event of an attempted suicide, the officer who first observes the incident may enter the cell alone after notifying any officer or superior officer for assistance. Every precaution must be taken to prevent an escape or an assault on the officer.

[16] DOC Directive # 4009R-C, Lock-In/Lock-Out, states that at each optional lock-in/lock-out period, individuals who wish to retrieve personal items from their cells may do so only with the assistance of an officer.

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

BOC staff confirmed via a review of surveillance footage that medical staff arrived at 8:50 pm and took over resuscitation efforts. Medical staff conducted a finger stick check, utilized the Automated External Defibrillator ("AED"),[18] the Lund University Cardiopulmonary Assist System ("LUCAS")[19] device, and administered five doses of Epinephrine and four applications of Narcan. At 9:10 pm, Fire Department of New York Emergency Medical Services ("EMS") entered the area but, by that time, efforts to revive Mr. Luna were discontinued. At 9:19 pm, a CHS Urgicare doctor pronounced him deceased.

OCME investigators' preliminary findings notes no signs of trauma and no ligature marks. A search of Mr. Luna's personal items yielded three albuterol inhalers and one crushed white pill with unidentified stamping, which was later tested and determined to be aspirin. OCME preliminary findings did not identify fatal internal injuries or signs of trauma, nor did they note the results of any toxicology screens.

BOC will update this report to include the confirmed causes of death for Mr. Williams and Mr. Luna once the autopsy reports are received from the OCME.

Key Findings

Medication and clinic access

In therapeutic housing areas, CHS administers certain medications on-unit, but methadone and other medications are administered in the clinic and require DOC production. Medical records note that, from October 25, 2023 through January 12, 2024, correction officers did not produce Mr. Luna to the clinic (control observation booth) to receive methadone on eight occasions. Additionally, records note that, when nursing staff distributed direct observation therapy medication in the housing area, Mr. Luna did not respond when called to receive his medication on 15 different occasions. During the same period, DOC did not produce Mr. Luna to three on-site telehealth cardiology appointments.

[18] Per DOC Operations Order #11/16, an AED is a portable medical device that connects to a patient via two chest pads. Once the chest pads are in place, trained DOC and/or CHS staff will turn the device on, and its computer will analyze the patient's need for a shock. The electric shock is meant to restore the patient's heart rhythm to a normal pattern.
[19] A mechanical chest compression device.

Recreation

Minimum Standard § 1-06(c) requires DOC to afford recreation seven (7) days per week in an outdoor recreation area, except in inclement weather, when the indoor recreation area shall be used. In Mr. Williams' housing area, recreation was afforded once in 15 days**,** from December 20, 2023 to January 4, 2024, according to DOC records**.** The outdoor recreation space at EMTC has not been in operation since March 2020, therefore individuals housed in EMTC are not currently receiving recreation outdoors as required by BOC's Minimum Standards. Recreation is instead offered in an indoor gym. DOC informed the Board that construction is underway to divide the recreation yard at EMTC into smaller, separate recreation yards, after which they will become operational. DOC expects construction to be completed by the end of May 2024.

Inaccurate/incomplete logbook entries

The Department utilizes physical handwritten logbooks as a record keeping tool for daily events and serious incidents that occur in each housing area and common space. 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."

EMTC Command Level Order #06/18R, effective May 16, 2018, states that the recreation "A" officer is responsible for maintaining the post logbooks, work orders, and all allocated paperwork.

A review of the recreation logbook shows the "A" officer failed to record an entry noting the medical emergency and actions taken by staff to assist Mr. Williams at the time of his death.

Unsecured cell doors

Per DOC Directive #4009R-C on 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. "Individuals who choose to remain locked in within this timeframe may request to lock out of their cells at the hourly optional lock-in/lock out period." In addition, at each optional lock-in/lock-out period, individuals who wish to retrieve personal items from their cells may do so only with the assistance of an officer. Video reviewed by Board staff shows the "B" post correction officer was on post but failed to enforce this policy the day Mr. Luna died. Multiple persons in custody accessed their cells throughout the day, without the assistance of the correction officer.

Outdated training certifications

Per DOC Teletype Order No. HQ -0285-0, effective December 12, 2023, the Division of Training and Development is tasked with conducting a one-day training course in CPR, AED, and first aid. Assistant deputy wardens, captains, and correction officers shall be retrained and recertified bi-annually. Leadership staff at EMTC informed Board staff that two of the four officers supervising recreation at the time of Mr. Williams' medical emergency had outdated CPR certifications. Similarly, the captain at GRVC who discovered Mr. Luna unresponsive also had an outdated training certification.

COD notification delay

DOC's COD is a centralized unit that is tasked with receiving notifications and information related to unusual incidents and disseminating that information accordingly. DOC Directive #5000R-A, Reporting Unusual Incidents, 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 both instances, the EMTC and GRVC tour commanders reported the incidents to COD over one hour after CHS declared Mr. Williams and Mr. Luna deceased.

Personal Hygiene

Per Minimum Standard § 1-03(h)(1)(iv), upon admission to a facility, all persons in custody shall be provided, at Department expense, with an issue of bedding, including but not limited to: two sheets; one pillow; one pillowcase; one mattress; one mattress cover; and sufficient blankets to provide comfort and warmth. That was not the case for Mr. Luna. A correction officer assigned him to a cell without a mattress. Over 18 hours passed before DOC was observed on video entering the unit with a mattress for him.

Disciplinary Action

Per DOC reports, an internal investigation directed by facility leadership did not find correction officers at fault in the deaths of Mr. Williams or Mr. Luna. Therefore, no disciplinary measures were taken against staff.

Recommendations to DOC

1. DOC must update DOC Operations Order #2/22 on Naloxone (Narcan), effective June 30, 2022, to require that Narcan be available in the gym.

2. DOC must afford recreation in the outdoor main yard at EMTC that has not been in use since 2020. It can accommodate multiple units at a time and offers a track, exercise equipment, basketball hoop, and handball court. The space is not usable at the moment due to neglect over time. Alternatively, DOC is prepping the smaller recreation yard for services. Currently, it lacks the equipment available in the main yard.
3. DOC must ensure no people in custody are assigned to a cell or bed without a mattress.
4. DOC must reiterate to staff the importance of recording an incident in the area logbook, as soon as feasible. DOC must randomly audit logbooks following an incident to ensure correction officers are complying with orders.
5. DOC should encourage facility leadership to notify COD of unusual incidents within the allotted time frame to avoid a delay to BOC investigations.[20]
6. DOC must schedule recertifications trainings to ensure staff are up to date with certifications and properly trained to respond to incidents.[21]
7. DOC must ensure compliance with DOC Operations Order #1/22, requiring correctional staff to activate their body-worn cameras to record all interactions with individuals in custody throughout their tour.

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