BOARD OF CORRECTION
CITY OF NEW YORK

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

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[1] Authored by Director of Special Investigations Rahzeem Gray. Thanks to the members of the Deaths, Near Deaths, and Serious Injuries Committee of the Board of Correction: Board Chair Dwayne C. Sampson, Committee Chair Jude Torchenaud, and Board Member Lauren Stossel.

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 identifying criminality or wrongdoing. Instead, BOC investigations identify areas where staff failed to follow policy or areas where policies do not exist, with the aim of making recommendations to the Department of Correction ("DOC" or "Department") and Correctional Health Services ("CHS") to improve conditions for individuals who live and work on Rikers Island.

DOC houses incarcerated individuals across eight[5] facilities on Rikers Island and two hospital prison wards, one located in Manhattan and the other in Queens. In addition to housing facilities, DOC operates five borough courts. Since January 1, 2025, DOC reported the deaths of 11 individuals. The Board's count is slightly higher at 12, since DOC's count excludes Ariel Quidone, who died on March 15, 2025. Mr. Quidone was released from DOC's custody on his own recognizance ("ROR") shortly before passing away. The circumstances that led to Mr. Quidone's hospital visit and release occurred while in custody. As customary, the Board investigated it in the same manner as the other incidents.

This report focuses on five individuals who died between January 1, 2025 and March 31, 2025: Ramel Powell, Terrence Moore, Ariel Quidone, Sonia Reyes, and Dashawn Jenkins. The Board will issue a report covering the remaining deaths at a later date.

The Otis Bantum Correction Center ("OBCC"), Manhattan Supreme Court holding pen, West Facility, and George R. Vierno Center ("GRVC") recorded one death each this year, while one individual died at Elmhurst Hospital shortly after being released from custody.

Board investigators reported to each facility, excluding Elmhurst Hospital, following each death and commenced an investigation by collecting and reviewing records from DOC, CHS, relevant hospitals, and the Office of the Chief Medical Examiner ("OCME"), reviewing DOC jails video

[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 deaths of people in custody including the review of all medical records of the deceased.

[5] This count includes Enhanced Supervision Housing in the Rose M. Singer Center, also known as RESH, and the Annex.

footage, interviewing staff and individuals in custody, and, in some instances, capturing photographs of the location where the incident took place.

Some of the findings are as follows:

- In two of the five deaths, DOC authorized the suspension of housing area staff.
- Uniformed staff did not immediately notify medical staff or activate a medical emergency after observing individuals who were unwell in two instances.
- In two of the five incidents, uniformed staff did not secure cell doors, allowing individuals to enter and exit their cells without a correction officer's assistance.
- In one instance, DOC correctional staff assigned to the "B" post exited the housing area and left the unit without direct supervision for 23 minutes. In addition, after returning to the post, they failed to conduct 30-minute rounds, as required by policy.
- In the one instance when DOC correctional staff did not conduct rounds according to policy, they recorded inaccurate entries in the logbook that reflected housing area tours performed every 30 minutes.
- Following the deaths of Mr. Powell and Mr. Jenkins, DOC staff searched their assigned housing areas and discovered drug paraphernalia.
- In four incidents, facility tour commanders delayed notification to the Central Operations Desk ("COD").

Deaths in Custody

1. Ramel Powell

Age	38
Date of death	February 19, 2025
DOC admission date	July 27, 2023
Cause of death	Acute MDMB-4en-PINACA intoxication
Facility at time of death	OBCC
Bail amount	$50,000

Ramel Powell was arrested on July 25, 2023, in Manhattan. Records note that during processing at the police precinct, Mr. Powell refused to be fingerprinted and verbalized suicidal thoughts. Police officers described Mr. Powell's behavior as that of an emotionally disturbed person, or "EDP", which prompted them to transport him to Mount Sinai Beth Israel's emergency department for psychiatric evaluation. On July 26, 2023, police officers returned to the courthouse with Mr. Powell after Beth Israel staff discharged him. Shortly after returning, police officers transported him to NYC Health + Hospital/Bellevue because he vocalized suicidal thoughts. Bellevue Hospital staff evaluated him that same day, which resulted in his return to the courthouse to await arraignment. Upon his discharge from Bellevue Hospital, medical staff attached a letter to his court documents requesting that CHS mental health staff promptly

evaluate him once he arrived to Rikers Island to ensure he received the most appropriate treatment while in custody. Bellevue Hospital staff's discharge diagnosis included antisocial personality disorder, malingering, Post-Traumatic Stress Disorder ("PTSD"), and suicidal thoughts.

On July 27, 2023, he arrived at the Eric M. Taylor Center ("EMTC") on Rikers Island as a new admission. During the intake screening, DOC correctional staff noted Mr. Powell spent time in a program for alcohol or drug abuse before his arrest. Although Mr. Powell reported to officers that he had used drugs in the past, he reported to health staff that he did not currently use drugs, denied active treatment for opioid use disorder or an overdose history, and his urine toxicology was negative. Health staff educated him about the availability of naloxone in housing areas. Mr. Powell reported a history of seizures and mental health treatment during a previous incarceration. He disclosed he was currently experiencing thoughts of wanting to kill himself, and, in 2007, he attempted to die by suicide. This prompted CHS staff to complete a mental health stat referral to expedite a psychiatric evaluation. On July 27, 2023, before receiving a housing assignment, a mental health clinician evaluated Mr. Powell. The clinician diagnosed him with major depressive disorder and placed him on suicide watch[6] in a mental observation housing area.[7]

From July 2023 through September 2023, a mental health clinician placed Mr. Powell on suicide watch multiple times for several days at a time before discontinuing it on September 14, 2025, after he no longer endorsed suicidal ideation. In addition to discontinuing watch, clinicians deemed mental observation housing was no longer required, and DOC transferred Mr. Powell to general population housing.[8] On September 21, 2023, seven days after transferring into general population housing, CHS initiated his readmission into mental observation housing after he endorsed suicidal ideation. On November 30, 2023, CHS determined general population was appropriate after he demonstrated he was able to advocate for his own needs, was fully oriented, and no longer expressed suicidal ideation.

DOC correctional staff transferred Mr. Powell into general population housing shortly after receiving a transfer notification request from CHS. According to DOC records, DOC served Mr. Powell four infractions while housed in general population for fighting (July and December 2024)

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

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

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

and assaulting staff and attempting to assault staff (January 2025). Mr. Powell was found guilty on all infractions. DOC staff intercepted mail that tested positive for "spice 6," intended for Mr. Powell. To reach these findings, DOC staff utilized their rapid scan machine (RaySecur), designed to detect and identify illicit substances instantly. Subsequently, he was designated as an intended contraband recipient ("ICR").[9]

According to DOC reports, on January 3, 2025, Mr. Powell had a medical emergency. DOC correctional staff discovered him on the bathroom floor of his assigned housing area, disoriented. DOC staff administered Narcan[10] and called a medical emergency. Medical staff assisted Mr. Powell to his feet and escorted him to the clinic. He was sent to Elmhurst Hospital via Emergency Medical Services ("EMS") due to suspicion of an overdose. Shortly after, Mr. Powell signed out from the hospital against medical advice. Paperwork provided at discharge advised him to follow up if he experienced another episode of loss of consciousness, disorientation, confusion, or weakness. Mr. Powell was transferred into a different housing area on February 1, 2025, shortly after returning from the hospital. Once he returned to the facility, CHS staff offered substance use counseling, including education on naloxone use and availability and other harm reduction strategies.

Records do not indicate that he was involved in any further incidents in the housing unit until February 18, 2025. On this day, surveillance footage shows the "B" post officer[11] did not check the cell doors to ensure they were secured at any time during tours. Therefore, cells remained unlocked, allowing individuals to enter and exit their cells without uniformed staff's assistance.[12] That evening, at 7:30 pm, video captures Mr. Powell following multiple individuals, one appearing to be in possession of a white rolled-up object, described by DOC as a joint, into a cell. As individuals occupied the cell, another individual sat on a table in the dayroom (common area),

[9] DOC designates an individual ICR if contraband such as weapons or drugs is found on their person, living quarters, visitor, or incoming or outgoing mail.

[10] Per DOC Directive #2/22, effective June 30, 2022, Naloxone (Narcan) is a life-saving medication in the form of a nasal spray that can reverse the effects of an opioids overdose. Trained staff members and incarcerated individuals can administer Narcan if an individual displays unresponsiveness, slow or no breathing, blue or grey lips and/or fingernails, or snoring or gurgling sounds.

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

[12] DOC Directive #4009R-C, "Lock-In/Lock-Out," states that individuals who are locked out during an optional lock-in/lock-out period may request to be locked-in or to retrieve personal items from the cells, only with the assistance of an officer.

smoking the object. The "B" post officer was on post, observing the activity in the unit without intervening.

At 7:34 pm, four minutes after Mr. Powell entered the cell, video footage shows Mr. Powell appearing to be unconscious while an individual carried him out of the cell and placed him in his own assigned cell. As this happened, footage shows the "B" officer standing in the middle of the dayroom and appearing to observe Mr. Powell being carried to his cell. At no time did the "B" officer intervene, check on him, or activate a medical emergency.[13] Board investigators confirmed via surveillance footage that the "B" officer conducted ten rounds after appearing to observe Mr. Powell unconscious.

DOC reports note that the following day (February 19), at 1:43 am, during the "B" officer's eleventh housing area tour, the area captain and "B" officer discovered Mr. Powell in his cell with foam discharging from his mouth. The captain activated a medical emergency and instructed the "B" officer to retrieve Narcan from the "A" station. The "B" officer retrieved Narcan, returned to the cell, administered one Narcan application, and performed chest compressions. Additional DOC staff arrived and administered a second Narcan application and continued chest compressions while awaiting medical staff.

According to medical records, upon their staff's arrival at 1:55 am, Mr. Powell was unresponsive, cold to the touch with vomit on his person, clothing, and bedding, and pupils fixed and dilated. He had no pulse or spontaneous respiration and there was an onset of rigor mortis. Medical staff attempted life-saving aid. Urgicare staff pronounced Mr. Powell deceased at 2:14 am.

DOC staff conducted a search of the unit following Mr. Powell's death. According to DOC records, while searching the cell Mr. Powell lost consciousness in, they confiscated a folder that appeared discolored and had a scent. Staff placed the folder in an evidence bag and surrendered it to the Department's Special Investigation Unit ("SIU") for testing. The documents inside the folder later tested positive for "spice 1," a synthetic cannabinoid, also known as K2. In addition, the search team recovered a rock-like substance from a shoe in Mr. Powell's cell. The substance was placed in an envelope and delivered to SIU for testing. The substance tested positive for Tramadol. Additionally, the search team recovered 121 pills (loose and packaged) from Mr. Powell's cell.

[13] DOC Directive #4517R, "Inmate Count Procedures," states that if an officer suspects that a person in custody is not exhibiting signs of life or may need medical attention, the officer shall immediately notify other officers on post, who will then request medical assistance. In addition, the officer shall render emergency first aid as appropriate.

OCME determined that Mr. Powell died from acute MDMB-4en-PINACA intoxication, a synthetic cannabinoid.

The Department's SIU investigated and authorized the suspension of the "B" post officer for violating the following DOC rules:

- 3.20.010: "Members of the Department shall present a professional demeanor and as employee of the City of New York shall act in a dignified manner."
- 3.20.030: "Conduct unbecoming of an officer or employee."
- 3.20.300: "Conduct of nature to bring discredit to the Department."
- 7.05.060: "The officer taking the count must observe "signs of life" in each inmate on the post."
- 7.05.090: "A correction officer shall be constantly alert, while on duty, observing everything that takes place on the post within sight or hearing and shall constantly patrol the post during the tour of duty."

DOC terminated the "B" officer before the conclusion of their suspension.

2. Terrence Moore

Age	55
Date of death	February 24, 2025
DOC admission date	January 26, 2023
Cause of death	5-Fluoro-MDMB-PINACA/5-Fluoro-EMB and PINACA and MDMB-4en-PINACA toxicity
Facility at time of death	NIC
Bail amount	Remand

On January 26, 2023, Terrence Moore entered EMTC as a new admission. During the intake screening, he informed uniformed correctional staff and medical staff of his medical history, including epilepsy. Furthermore, he informed medical staff that he smoked two packs of cigarettes a day and had a history of using crack cocaine and marijuana. Additionally, he shared that he participated in in-patient and outpatient correctional-based mental health treatment programs before his arrest. Medical staff submitted referrals for medication and a mental health assessment.

A mental health clinician evaluated Mr. Moore. During the evaluation, he informed the clinician that he spent time in inpatient and outpatient mental health programs and was hospitalized during previous incarcerations. The clinician diagnosed Mr. Moore with severe major depressive disorder with psychotic features, and prescribed medication accordingly.

Mr. Moore was assigned to general population housing after completing the new admission screening. Following his initial placement, DOC transferred him to various general population and

mental observation areas, in addition to housing him at the Bellevue Hospital Prison Ward ("BHPW") to receive treatment for chronic venous stasis ulcers. From August 2023 through October 2024, Mr. Moore was charged with assaulting staff twice and assaulting another individual in custody twice. Mr. Moore refused to participate in the hearings, and, in his absence, DOC found him guilty of all charges.

Mr. Moore filed several complaints with 311 and the Department's Office of Constituent and Grievance Services ("OCGS") while in custody. The most concerning complaint was received on December 25, 2024. Mr. Moore called 311 to report that he had a seizure in his cell at GRVC which caused him to lose a tooth, and no one was there to help him. He stated his classification score changed to medium from maximum, making him eligible for North Infirmary Command ("NIC") housing. He further stated a cell assignment is "no good" for his condition. OCGS staff referred the matter to CHS on December 27, 2024 and closed the complaint without confirming with its jail-based DOC staff that Mr. Moore had been brought to health services the previous day. On December 31, 2024, six days after making the complaint, DOC staff produced him to the clinic. Medical staff treated his injuries and prescribed him pain reliever, adjusted the doses of his seizure medication, and generated a dental care referral.

Medical records note that, on January 3, 2025, eight days after filing the 311 complaint, Mr. Moore called CHS's Health Triage Line[14] and requested to see a medical provider to discuss a treatment regimen for his seizures. He called the Health Triage Line at least seven times over the next month and a half. DOC staff produced him to the clinic to be seen by health care staff following each call. On January 7 and January 9, he called to inquire about what was holding up his transfer to NIC. On January 9, 2025, a CHS provider informed DOC that Mr. Powell met the criteria for NIC Main housing.

Records show that, on January 9, 2025, Mr. Moore was transferred to a 50-and-older dormitory housing area in NIC. Medical staff followed up with him after he arrived to discuss his seizure regimen and address his other medical concerns. According to CHS records, since making the adjustment to his seizure medications, he did not have any further incidents. Records note that he started refusing his mental health medication, dropping his mental health medication compliance rates to 20 percent. A mental health referral order dated January 29, 2025 noted CHS Patient Relations flagged concerns received when Mr. Moore was seen for a 730 evaluation. According to the referral order, he seemed depressed and reported suicidal ideation. In addition, he reported that he had been refusing his medication and therapy.[15] In response, a clinician

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

[15] A court ordered mental health assessment to determine if an individual is mentally fit to stand trial.

evaluated him on January 30, 2025. During the evaluation, Mr. Moore informed the clinician that he received good news and had been offered less time in his sentence. He denied suicidal ideation. The clinician reported he presented well and engaged with others. In addition, the clinician scheduled him for weekly evaluations moving forward.

On February 24, 2025, DOC staff picked Mr. Moore up from his housing area, searched him, and escorted him to the facility receiving room to await transportation to a scheduled court appearance. Transportation staff arrived and performed a second search before placing him on the bus. The bus was occupied with individuals from various facilities across DOC. After arriving at the courthouse, DOC staff directed Mr. Moore to the metal detector, also referred to as a magnetometer. He passed through it without triggering the alarm. DOC staff then escorted him to a holding pen, which housed five other individuals.

Incarcerated individuals told Board investigators that, while waiting to be picked up to return to Rikers Island sometime around 3:00 pm or 3:30 pm, they witnessed Mr. Moore ingest a pill. However, OCME did not locate a yellow pill or pill-like substance in Mr. Moore's stomach or in vomitus located at the scene. Mr. Moore appeared sluggish and began to vomit. He fell from the bench and made "seizure-like movements." Those present called for uniformed staff, who responded immediately to the calls for help.

According to DOC reports, when uniformed correctional staff arrived at the pen at 4:05 pm, Mr. Moore was lying unresponsive on the floor. DOC staff called out to him and "shook" him, but did not get a response, prompting them to immediately begin cardiopulmonary resuscitation ("CPR") and activate a medical emergency. DOC staff administered three Narcan applications, provided rescue breaths, and turned Mr. Moore on his side in a recovery position to clear his airway, which was obstructed by vomit, before resuming CPR. They continued CPR until EMS arrived at 4:19 pm. Upon arrival, EMS took over the resuscitation efforts. After 30 minutes of performing aid and seeing no signs of improvement, they declared Mr. Moore deceased at 4:52 pm.

OCME searched Mr. Moore's clothing before performing an autopsy. They found a small, rolled, partially burnt piece of paper in his sock. The contents were preserved for evidence. OCME determined that the cause of death was an accident due to substance use, specifically 5-Fluoro-MDMB-PINACA/5-Fluoro-EMB and PINACA and MDMB-4en-PINACA toxicity.

3. Ariel Quidone

Age	20
Date of death	March 15, 2025
DOC admission date	March 7, 2025
Cause of death	Pending OCME confirmation
Facility at time of death	Released on own recognizance
Bail amount	$15, 000

Ariel Quidone entered custody on March 7, 2025 with an order from the court to undergo a psychiatric evaluation. As required by the court, a mental health clinician evaluated Mr. Quidone after DOC completed their screening. The examining clinician determined that he had a serious mental illness ("SMI")[16] and diagnosed him with intermittent explosive disorder, cannabis use disorder, and other specified neurodevelopmental disorder. He was also noted to have previously been diagnosed with an intellectual disability, schizophrenia, ADHD combined type, bipolar 1 disorder, oppositional defiant disorder, and unspecified trauma and stressor related disorder. Following the exam, the clinician determined that mental observation housing was most appropriate for him. He was seen for psychiatric assessment on March 10, 2025, and the mental health clinician prescribed him medication.

As part of the intake screening, medical staff examined Mr. Quidone. During the exam, he informed them that, in January 2025, he had four screws inserted in his back during surgery. He also informed them that before his arrest, he used Percocet, "lean," Xanax, and marijuana. Intake urinalysis results were positive only for marijuana. Following the exam, medical staff prescribed him pain reliever to alleviate the pain he experienced from his back surgery.

Mr. Quidone was assigned to a mental observation dormitory housing area in EMTC. On March 8, 2025, 24 hours after entering custody, CHS provided DOC with correspondence that stated Mr. Quidone may require civil psychiatric hospitalization once released from custody. On March 10, 2025, DOC transferred him to a mental observation cell housing area specifically for young adults at the Robert N. Davoren Center ("RNDC").

On March 13, 2025, NYC311 received a call from Mr. Quidone's family stating that he was experiencing withdrawals. That morning, at 9:27 am, surveillance video captures Mr. Quidone exiting his cell with a blanket over his shoulder, appearing to be unwell. He walked past the "B" officer, entered the dayroom, and vomited in the trash bin. He then sat at a dayroom table with a blanket over his head for a few minutes before returning to his cell. At 10:36 am, he exited his cell again, this time without a shirt on, showing signs of being unwell while passing the "B" officer. He reentered the dayroom and vomited in the trash bin. He exited the dayroom, appearing

[16] One or more mental, behavioral, or emotional disorders resulting in serious functional impairment, which interferes with or limits one or more major life activities.

sluggish, and reentered his cell. There was an enhanced suicide officer ("ESO") present, who was in the dayroom supervising another individual in custody when these events occurred. The "B" officer did not approach Mr. Quidone after appearing to notice he was unwell. Logbooks do not reflect that uniformed staff made any attempts to transport him to the clinic at that point.

Mr. Quidone did not exit his cell again until the pharmacy technician arrived at the unit to dispense medication. CHS confirmed that the pharmacy technician distributed medication to Mr. Quidone from the "A" station slot on the morning of March 13. CHS mental health staff conducted rounds and spoke to Mr. Quidone for approximately five minutes, from 12:19 pm to 12:24 pm. Health records reflect that Mr. Quidone was moderately engaged during the encounter but appeared to be going through withdrawal symptoms and requested medical care. Following CHS rounds, the "B" officer toured the housing area at 1:13 pm and 1:58 pm.

Later in the day, at 2:30 pm, video footage shows a CHS social worker in the unit. The social worker stopped at Mr. Quidone's cell and spoke with him through the door. One hour after the social worker spoke with Mr. Quidone, at 3:33 pm, the "B" officer commenced another tour of the area (approximately one hour and 35 minutes between tours). Shortly after, at 3:37 pm, a suicide prevention aide ("SPA") conducted rounds.[17] The SPA stopped at Mr. Quidone's cell. After a couple of failed attempts to get his attention, the SPA called out for the "B" officer. The "B" officer observed Mr. Quidone unresponsive inside the cell, which prompted them to advise the "A" post officer to open the cell and activate a medical emergency. Multiple DOC staff responded to the request for medical assistance. While awaiting medical staff, DOC staff administered two doses of Narcan and performed chest compressions.

Medical staff entered the unit at 3:45 pm. Chart notes reflect that when they arrived, Mr. Quidone was unresponsive, had no pulse, no spontaneous breathing, his skin was cold and clammy, and his pupils were dilated. They took over continued resuscitation efforts from DOC staff, administering a third dose of Narcan and three epinephrine doses. Additionally, they continued CPR with a Lund University Cardiopulmonary Assist System ("LUCAS"). Medical staff also utilized an AED device and placed him under intubation. Medical staff obtained return of

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

circulation at 4:15 pm, then placed Mr. Quidone on a stretcher and departed the area for the clinic. Before they arrived at the clinic, they were met by EMS in the corridor. EMS transferred Mr. Quidone to their stretcher and departed the facility with him. They transported him to Elmhurst Hospital. Based on facility surveillance footage, Mr. Quidone did not appear to regain consciousness. EMS records also note that he never regained consciousness.

DOC established a crime scene following Mr. Quidone's departure from the housing area. Shortly after getting the instructions to establish a crime scene, the facility received instructions to dismantle it. RNDC officers and DOC's K-9 unit searched the area. According to a facility report, staff did not recover contraband during the search.

The judge assigned to Mr. Quidone's criminal matter released him from custody on his own recognizance ("ROR") on March 14, 2025. Elmhurst Hospital medical staff pronounced him deceased on March 15, 2025DOC informed BOC that no action has been taken against staff assigned to the housing area at the time of Mr. Quidone's death.[18]

OCME has not provided the Board with information on Mr. Quidone's cause of death.

4. Sonia Reyes

Age	55
Date of death	March 20, 2025
DOC admission date	February 25, 2025
Cause of death	Hanging
Facility at time of death	West Facility
Bail amount	N/A

Sonia Reyes, sentenced to serve 364 days in DOC custody, arrived at the Rose M. Singer Center (RMSC) on Rikers Island as a new admission on February 25, 2025. Court records show that the court requested that Ms. Reyes receive a medical and mental health exam upon arrival and be placed in protective custody. DOC staff did not note any concerns during their screening. During the medical screening, CHS staff learned Ms. Reyes used illicit drugs when her urine tested positive for amphetamines,[19] methamphetamines,[20] and phencyclidine.[21] Ms. Reyes reported smoking one pack of cigarettes a day and having asthma. Medical staff prescribed her

[18] DOC informed the Board that a formal investigation into the circumstances surrounding the death of Ariel Quidone is pending external investigations. These active investigations impose legal and procedural restrictions that prevent DOC from interfering or duplicating investigative efforts at this time. As such, any internal fact-finding or disciplinary reviews are temporarily paused pending the outcome of these external inquiries.

[19] A stimulant that speeds up the body's system.

[20] Methamphetamine, also known as meth, is a powerful and highly addictive stimulant that affects the central nervous system.

[21] Phencyclidine also known as PCP or angel dust, is a hallucinogenic drug sold in powder form.

medication to treat asthma. They also advised her on the dangers of using drugs and encouraged her to quit. Ms. Reyes refused to provide a blood sample for communicable disease testing at intake; therefore, CHS advised DOC to place her in medical isolation[22] until communicable illness could be ruled out.

The disposition of a health assessment dated February 25, 2025 was "Medical Isolation Pending MH Evaluation." Another medical note dated that same day indicated that CHS ordered an assistive walking device for Ms. Reyes, which necessitated placement in the medical infirmary. Mental health staff scheduled Ms. Reyes for a psychiatric evaluation on February 26, 2025. Due to a conflicting court date, Ms. Reyes missed her evaluation but was seen the next morning. While in isolation, mental health staff regularly checked in on her wellbeing during rounds. At no time did Ms. Reyes report a medical or mental health concern to the clinician during their rounds.

On February 27, 2025, a mental health clinician evaluated Ms. Reyes. After the evaluation, the clinician determined she met the criteria for mental observation level of care. On March 4, 2025, during a follow-up visit, the clinician noted Ms. Reyes had a history of psychiatric hospitalizations and diagnosed her with schizoaffective disorder depressive type and amphetamine abuse. On March 6, 2025, a medical doctor met with her in the unit. The doctor determined infirmary level of care was no longer necessary. The doctor then cleared her for mental observation housing.

On March 7, 2025, DOC transferred Ms. Reyes to a mental observation dormitory. On March 19, 2025, CHS modified her housing disposition from mental observation to the communicable disease unit ("CDU"), a medical therapeutic housing unit, because Ms. Reyes tested positive for COVID-19. At the request of CHS, DOC transferred her to a single-occupancy CDU cell at West Facility. Nursing staff met with her shortly after transferring into the area. According to CHS records, Ms. Reyes was alert and oriented and voiced no complaints during the encounter.

Footage shows the "B" post officer talking to Ms. Reyes through the cell door from 2:12 am to 2:14 am on March 20, 2025. According to DOC reports, Ms. Reyes stated to the "B" officer that she was hungry. The officer had no food to give her but advised that when breakfast arrived, she would receive double portions. Video surveillance captures the officer conducting five rounds after speaking to Ms. Reyes. Rounding times were 2:57 am, 3:09 am, 3:13 am, 3:57 am, and 4:25 am. As the CDU is not a mental health therapeutic housing unit, DOC staff conduct rounds every 30 minutes instead of every 15 minutes (in the absence of an SPA).

[22] CHS's Medical Isolation policy (revised June 30, 2014) states that persons in custody with a potentially communicable illness will be isolated from other persons in custody to prevent possible transmission of disease within the institution.

At 4:45 am, the food cart arrived with breakfast. The "B" officer, along with the officer who delivered the food, went to each cell offering individuals breakfast. When the "B" officer reached Ms. Reyes' cell, multiple attempts were made to get her attention. Ms. Reyes did not respond. The "B" officer unlocked the cell door and entered. Once inside, the officer found Ms. Reyes sitting on the floor, leaning against the bed, with an electric wire from the medical bed around her neck. The "B" officer removed the cord, activated a medical emergency and began CPR while awaiting medical staff's arrival.

Medical staff entered the unit at 4:50 am. According to medical records, upon their arrival, Ms. Reyes was unresponsive, on the floor in supine position, pulseless and apneic. In addition, her body was cool to the touch. The medical team took over CPR efforts from DOC staff, administered two doses of Narcan and three doses of epinephrine, utilized an AED device, and provided ventilation with an Ambu Bag. While medical staff attempted to resuscitate Ms. Reyes, the charge nurse requested EMS. EMS responded at 5:15 am and assisted medical staff in performing CPR. After showing no signs of improvement, staff discontinued resuscitation efforts. Urgicare staff declared Ms. Reyes deceased at 5:23 am.

DOC's SIU assigned investigators to review the events that led to Ms. Reyes' death. Investigators determined the "B" officer failed to conduct meaningful tours and, as a result, the officer received a command discipline. DOC informed the Board that no further disciplinary actions or findings can be made on this case pending the conclusion of external investigations.

OCME determined that Ms. Reyes' cause of death was suicide by hanging.

5. Dashawn Jenkins

Age	27
Date of death	March 31, 2025
DOC admission date	July 18, 2024
Cause of death	Pending OCME confirmation
Facility at time of death	GRVC
Bail amount	Remand

On July 16, 2024, Dashawn Jenkins was arrested in Manhattan. On July 18, 2024, he was admitted to DOC custody. New admission screening forms completed by DOC staff noted he appeared "fine" and vocalized he is "okay." Court staff reported otherwise, flagging the need for medical attention once in DOC custody. Medical staff examined Mr. Jenkins on July 19, 2024, as part of the routine intake process. He informed the examiner that he only smoked cigarettes – anywhere from one to two packs a day. The urine sample he provided to medical staff tested negative, showing no signs of any substance. Mr. Jenkins was assigned to a general population dormitory.

DOC housed Mr. Jenkins in several general population units at EMTC, West Facility, OBCC, and GRVC. Records show that, while at West Facility, he was involved in one incident that led to an infraction for refusing to obey a direct order. Consequently, DOC restricted his commissary privileges for seven consecutive days. On March 27, 2025, one week after being found guilty of the infraction, DOC reassigned him to a general population cell area in another facility.

Surveillance video and area logbooks uncovered that, on March 31, 2025, Mr. Jenkins' unit did not have a "B" post officer from 2:30 pm through 6:08 pm. An officer assumed the post at 6:09 pm. After taking the post, the officer exited the unit three times to enter the "A" station, in violation of DOC policy.[23] The officer was off post from five minutes to 23 minutes each time. In absence of a "B" post officer, Mr. Jenkins continuously entered and exited his cell without assistance from uniformed staff. In addition, other individuals accessed their cells and other cells without assistance. Amid the constant cell activity, Board investigators observed two groups of individuals appearing to be in possession of rolled-up white paper, which is commonly used in the jails as drug paraphernalia. When the "B" officer was on post, he did not appear to attempt to secure the cell doors.

Video footage recorded Mr. Jenkins entering his cell for the final time at 8:33 pm on March 31, 2025. Nine individuals followed him inside and remained there for 15 minutes. Board investigators are unable to confirm what happened inside the cell. All the individuals exited the cell at 8:48 pm and the last person turned off the cell lights while exiting. DOC staff did not commence their next tour until 9:10 pm, when a captain entered the unit. The captain and the "B" post officer toured the unit together. At 9:18 pm, they stopped at Mr. Jenkins' cell to address the obstruction covering his window. The "B" officer entered the cell with intentions to remove the window obstruction but, once inside, observed Mr. Jenkins in distress on the bed with his head tilted to the side and spitting up. The captain activated a medical emergency and instructed the "B" officer to retrieve Narcan from the "A" station. The captain also instructed the SPA assigned to the unit to turn Mr. Jenkins on his side in a recovery position. The "B" officer returned with Narcan and administered two applications while awaiting the arrival of medical staff.

Medical staff arrived at the unit at 9:27 pm, five minutes after being notified by DOC staff. The team noted that Mr. Jenkins was unresponsive when they arrived, without a pulse, breathless, and his pupils were fixed and dilated. Medical staff administered additional doses of Narcan and epinephrine, placed ammonia under his nose, attached a LUCAS device to perform automated chest compressions, and provided oxygen. CHS staff continued CPR, but Mr. Jenkins remained in asystole throughout the medical response. Urgicare staff pronounced him deceased at 9:56 pm.

[23] Correction officers shall not permit any unauthorized person or employee on their post.

OCME investigators performed a toxicology test on Mr. Jenkins. Synthetic cannabinoids were found to be in his system. Additionally, investigators discovered wick and ash residue in his cell.

Following the incident, DOC staff searched Mr. Jenkins' housing area. According to DOC reports, the search team recovered a vape pen, a bottle containing an unknown liquid substance, and a white chalky substance in other cells. CIB reported that the chalky substance tested as "no detection." In addition, on April 1, 2025, an SIU supervisor searched Mr. Jenkins' cell. The supervisor discovered two rolled burnt pieces of paper, two tea bags, and one ripped piece of paper. DOC sent the recovered items to the NYPD forensic laboratory for testing, which returned negative for narcotics.

Per protocol, the Department's SIU investigated the incident. Staff findings led SIU to authorize the suspension of the "A" and "B" post officers for 30 days each for violating the following rules and regulations:

- 7.05.060: "The officer taking the count must observe "signs of life" in each inmate on post."
- 7.05.090: "A correction officer shall be constantly alert while on duty, observing everything that takes place on the post within sight or hearing and shall constantly patrol the post during the tour of duty."
- 3.20.010: "Members of the Department shall present a professional demeanor and as an employee of the City of New York shall act in a dignified manner."
- 3.20.030: "Conduct unbecoming of an officer or employee."
- 3.20.300: "Conduct of a nature to bring discredit to the Department."
- 4.30.020: "False entries."
- 2.30.030: "Correction officers shall not permit any unauthorized person or employee on their post."

DOC terminated one of the officers while serving out their 30-day suspension. SIU also submitted a recommendation to DOC to extend the area supervisor's probationary period by six months for failing to take corrective action during each tour of the housing area, specifically for failing to address obstructed cell window visibility and unsecured cell activity.

OCME has not provided the Board with Mr. Jenkins' official cause of death as of the date of this report's publishing.

Key Findings

Delays in requests for medical services

DOC rules and regulations require uniformed correctional staff to promptly notify medical personnel when an individual appears to be injured or sick. Staff assigned to Mr. Powell's and Mr. Quidone's housing areas did not take immediate action, even though they were in the respective areas and appeared to observe they were both unwell.

Staff in Mr. Powell's unit appeared to observe him unwell at 7:34 pm on February 18. The same staff member later discovered him unconscious in his cell the next morning at 1:43 am on February 19.

DOC staff informed the Board that Mr. Quidone was produced to the clinic on March 12 because he appeared unwell. Medical records do not indicate that Mr. Quidone was seen by health care staff on March 12. CHS mental health staff spoke with Mr. Quidone on March 13, noting he appeared to be going through withdrawal symptoms and requested medical care. That same day, DOC staff in Mr. Quidone's unit appeared to observe him unwell at 9:27 am and 10:36 am; however, they did not notify medical staff until later in the day at 3:37 pm after finding him unconscious in his cell.

Inconsistent tours and inaccurate logbook entries

On March 31, 2025, Mr. Jenkins' housing area was without a "B" post officer from 2:30 pm through 6:08 pm. After staff signed onto the post at 6:09 pm, they did not conduct their first tour of the area until 7:36 pm. At 9:11 pm, staff conducted their second tour. In addition to the sporadic tours, staff walked off post to enter the "A" station three times, leaving the unit without supervision. Video surveillance shows tours were not conducted in accordance with policy; however, staff recorded logbook entries in the "B" post logbook that reflect regular 30-minute tours were conducted.

In Mr. Quidone's housing area, the "B" officer did not tour the unit for approximately one hour and 35 minutes on the day of his death, when tours were supposed to take place every 30 minutes. The "B" officer assigned to Ms. Reyes' unit also failed to conduct meaningful tours. Abandoning the post, inconsistent touring, and inaccurate logbook entries violate DOC Directive #4514R-C.

Presence of contraband in the jails

During a search immediately following the deaths of Mr. Powell and Mr. Jenkins, a search team recovered contraband in the two units. In Mr. Powell's unit, staff recovered synthetic marijuana, also known as K2, from a cell he occupied shortly before losing consciousness. In Mr. Jenkins'

unit, an SIU supervisor recovered wick and ash residue which tested negative for narcotics, and a vape pen concealed in a roll of toilet paper.

At the time of his death in the Manhattan Court holding pen, Mr. Powell had a small, rolled, partially burnt piece of paper in his sock. It is unknown if he departed his assigned facility with it, obtained it from another individual on the bus while on route to court, or received it from someone after arriving at the courthouse. OCME findings do not indicate how Mr. Powell ingested the synthetic cannabinoid that led to his death. The fact remains that contraband is widespread and available in DOC jails, and that the security protocols in place to recover the contraband failed to discover the rolled piece of paper during the numerous searches that individuals must clear before arriving at court.

Mental observation housing disposition

While her level of mental health care did not change, Ms. Reyes' housing disposition was modified on March 19, 2025, when CHS determined she would be moved to the CDU, a medical therapeutic housing unit, given a positive COVID-19 test. Mental health services follow persons in custody at a modified mental observation level of care when they require housing in CDU for medical isolation. This includes more frequent clinical encounters by mental health staff but does not include daily mental health rounding. This is of concern because, in the CDU, DOC staff conduct rounds every 30 minutes instead of every 15 minutes in the absence of an SPA, as required in mental observation housing.

Unsecured cell doors

Per DOC Directive # 4009R-C, "optional lock-in/lock-out periods shall be afforded in accordance with the Lock-in and Lock-Out Schedule. Individuals may be locked in their cells during optional lock-in/lock-out periods. Individuals choosing to remain locked in during an optional lock-in/lock-out period may request to lock out of their cells at the hourly optional lock-in/lock-out period. Individuals who are locked out during this period may request to be locked in their cell at any time during the optional lock-in/lock-out period."

As policy notes, individuals must rely on an officer to enter and exit their cells. DOC's video surveillance footage shows that staff assigned to Mr. Powell's and Mr. Jenkins' housing areas did not secure the cell doors, allowing individuals in the unit to freely maneuver and access their cells and other cells without their assistance.

Delayed COD notifications

DOC policy requires facility tour commanders to notify the COD[24] within 15 minutes or as soon as it becomes apparent that a death has occurred, as a death in custody is considered an "unusual incident." That ensures a response team or appropriate assistance can be dispatched if necessary. Facility tour commanders delayed notifying COD outside the prescribed times in four instances.

- CHS declared Mr. Powell deceased at 2:14 am. DOC staff reported the incident to COD at 3:50 am.
- DOC records note that EMS staff pronounced Mr. Moore deceased at 4:05 pm. DOC staff reported the incident to COD at 5:20 pm.
- CHS pronounced Ms. Reyes deceased at 5:23 am. The DOC staff reported the incident to COD at 6:30 am.
- CHS declared Mr. Jenkins deceased at 9:56 pm. DOC staff reported the incident to COD at 10:39 pm.

Suspensions

Uniformed correctional staff assigned to Mr. Powell's and Mr. Jenkins' housing areas were suspended following their deaths. DOC determined that staff assigned to both areas violated several rules and regulations, ranging from conduct unbecoming of an officer to failure to remain alert while on duty and observing everything that takes place on the post within sight or hearing. DOC terminated one officer following the charges. DOC also issued a command discipline to the "B" officer assigned to Ms. Reyes' unit for failure to conduct meaningful tours.

Mental health history

Records show that four of the five individuals who died had a mental health history and received treatment while incarcerated. According to CHS records, at the time of each death, the individuals were prescribed medication to treat their mental health diagnoses.

In September 2025, the Mayor's Management Report showed an upward trend in the number of individuals in DOC custody eligible for specialized mental health discharge procedures (54% in FY24 to 57% in FY25).[25] Additionally, the report showed an upward trend of individuals in custody with a serious mental health diagnosis from FY24 (20.3%) to FY25 (20.7%), continuing the upward trend noted in FY23.

[24] COD, also known as the Central Operations Desk, is a unit whose primary mission is to accept notification and information specific to an unusual incident occurrence and disseminate that information to the appropriate authorities within DOC.

[25] https://www.nyc.gov/assets/operations/downloads/pdf/mmr2025/2025_mmr.pdf

Recommendations to CHS

1. When individuals housed in mental observation test positive for communicable diseases that require isolation, CHS must ensure that those individuals continue to receive mental observation levels of care when they are transferred to the CDU. If the individual is not deemed fit enough for discharge from mental observation care, CHS and DOC must coordinate to place the individual in an isolated area where DOC staff can round every 15 minutes, as required in mental observation housing.

Recommendations to DOC

1. Housing area correctional staff must immediately notify their immediate supervisor when they observe the presence or use of contraband and intervene to confiscate it. DOC staff must arrange an unscheduled search of the unit immediately after such notification is received and drug test the individuals in custody assigned to that unit.[26]

2. Per DOC protocol, housing area correctional staff must instruct individuals to remove all cell window obstructions. If verbal commands to remove all coverings does not take its desired effect, staff must immediately notify a supervisor and document the encounter in their logbook. Upon receiving notification, a DOC supervisor must physically remove the coverings. Uniformed supervisory staff must regularly monitor housing areas and audit logbooks to ensure staff follow protocol.[27]

3. DOC's Video Monitoring Unit ("VMU") is charged with the responsibility to "remotely monitor all facility inmate activity in real-time, promptly identify security concerns, and when necessary, make immediate notifications to the appropriate personnel so action can be taken to avoid potential incidents, whenever possible[.]" VMU could be a crucial tool in identifying poor touring practices, deficient supervision, unsecured and covered cell doors, as well as other incidents that pose a risk to individuals in custody and staff alike. DOC must immediately increase the number of staff assigned to VMU to expand

[26] Similar recommendations featured in *First Report and Recommendations on 2023 Deaths in [NYC DOC] Custody, Third Report and Recommendations on 2022 Deaths in [NYC DOC] Custody,* and *Second Report and Recommendations on 2022 Deaths in [NYC DOC] Custody.*

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

this additional layer of supervision and support facility supervisors tasked with ensuring that tours are conducted pursuant to policy.[28]

4. DOC should distribute memoranda and conduct updated trainings on providing prompt medical aid to an individual who is sick, impaired, unconscious, or injured. The memoranda and training should emphasize when to immediately call for medical assistance.[29]

5. Reinforce and retrain staff on basic supervision, touring, and logbook entry practices, including but not limited to, correction officers' responsibility to remain on post and remain vigilant. Training should also focus on accurately and legibly documenting personal breaks, meals, tours, and incidents in logbooks, and tour units as required by Directive #4514R-C and rules and regulations 2.30.010 and 7.05.0904.[30]

6. DOC should discontinue using paper-based logbooks and transition to a computerized, electronic record-keeping system. Paper-based logbooks can be damaged, lost, more easily forged, and difficult to read due to poor handwriting. A computerized record-keeping system offers the centralization of records that is easily accessible, efficient and legible.[31]

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

[29] Similar recommendation featured in *Second Report and Recommendations on 2022 Deaths in [NYC DOC] Custody.*

[30] As recommended in *Second Report and Recommendations on 2024 Deaths in [NYC DOC] Custody* and *Second Report and Recommendations on 2023 Deaths in [NYC DOC] Custody.*

[31] Similar recommendations were made in *Second Report and Recommendations on 2024 Deaths in [NYC DOC] Custody* published December 30, 2024; *Updated First Report and Recommendations on 2023 Deaths in [NYC DOC] Custody* published March 29, 2024; *Second Report and Recommendations on 2023 Death in [NYC DOC] Custody* published February 9, 2024; *Third Report and Recommendations on 2022 Deaths in [NYC DOC] Custody* published April 21, 2023; *Report and Recommendations on 2021 Suicides and Drug-Related Deaths in [NYC DOC] Custody* published September 12, 2022; *February & March 2022 Deaths in DOC Custody Report and Recommendations* dated May 9, 2022; and BOC's report on the death of Layleen Cubilette-Polanco dated June 23, 2020.

7. DOC should track and report the names of staff who habitually report unusual incidents to COD outside the prescribed times. DOC should encourage facility leadership to notify COD of unusual incidents within the allotted time frame.[32]

8. 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.[33]

[32] Partly recommended in *First Report and Recommendations on 2024 Deaths in [NYC DOC] Custody* and *Second Report and Recommendations on 2023 Deaths in [NYC DOC] Custody.*
[33] As Recommended in *First Report and Recommendations on 2023 Deaths in [NYC DOC] Custody* and *Second Report and Recommendations on 2022 Deaths in [NYC DOC] Custody*.

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

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

NYC HEALTH + HOSPITALS/CORRECTIONAL HEALTH SERVICES RESPONSE TO RECOMMENDATIONS IN THE NYC BOARD OF CORRECTION'S "FIRST REPORT AND RECOMMENDATIONS ON 2025 DEATHS IN NEW YORK CITY DEPARTMENT OF CORRECTION CUSTODY"

Recommendations to CHS

1. **When individuals housed in mental observation test positive for communicable diseases that require isolation, CHS must ensure that those individuals continue to receive mental observation levels of care when they are transferred to the CDU. If the individual is not deemed fit enough for discharge from mental observation care, CHS and DOC must coordinate to place the individual in an isolated area where DOC staff can round every 15 minutes, as required in mental observation housing.**

Patients with active communicable illness, including those who require a higher level of mental health care, need to be isolated in the Communicable Disease Unit in order to protect the health of the population. CHS' Mental Health service continues to follow these patients at a modified MO level of care, which includes more frequent clinical encounters with Mental Health staff. However, CHS cannot provide MO-level care – which includes group work and daily rounds – on the CDU. Moving forward, we will better communicate to DOC that any patient on CDU who would have otherwise been housed on an MO or PACE unit needs to be rounded on every 15 minutes because of their mental health designation.