NEW YORK CITY BOARD OF CORRECTION RELEASES REPORT ON THE DEATH OF LAYLEEN XTRAVAGANZA CUBILETTE-POLANCO

Report makes 25 recommendations to address systemic issues and prevent future deaths.

FOR IMMEDIATE RELEASE: June 23, 2020

New York, NY – The New York City Board of Correction (BOC), the independent oversight Board for the City's jail system, released a report today presenting findings and recommendations in connection with its investigation concerning the death of Layleen Xtravaganza Cubilette-Polanco. Ms. Polanco died in the Restrictive Housing Unit (a form of punitive segregation) on Rikers Island on June 7, 2019. She was a 27-year-old Afro-Latinx transgender woman. The Board's report includes a summary of events (pp. 4-11), key findings (pp. 11-12), and recommendations to NYC Hospitals' Correctional Health Services (CHS) and the Department of Correction (DOC) (pp. 12-13).

"The Board's investigation into the death of Layleen Xtravaganza Cubilette-Polanco identifies a number of underlying systemic issues that must be addressed by the Department and CHS to help ensure the safety and well-being of all persons in custody," said Board Chair Jennifer Jones Austin. "We urge the City to immediately implement all 25 report recommendations."

The Board's investigation is distinct from those conducted by other City and State agencies. BOC investigations do not focus on criminal wrong-doing or individual fault. Rather, the Board's investigations focus on the circumstances of deaths in custody and identifying where lessons can be learned to prevent future deaths. The Board's report makes 25 recommendations concerning DOC and CHS policies and practices. These include recommendations to: transform the processes the agencies use to exclude from punitive segregation people with medical or mental health issues; increase and improve information sharing between NYPD, DOC, and CHS while protecting sensitive patient information; enhance and retrain on DOC and CHS policies for housing area rounds to ensure staff identify people at-risk; and institute new oversight of medication provision to encourage proper access and compliance.

The Board's public report summarizes major events in the time leading up to Ms. Polanco's death: from her arrest and subsequent transfer to Bellevue Hospital on April 13, 2019 to her death in custody at the Rose M. Singer Center on Rikers Island on June 7, 2019. Key findings include, among others, a failure to follow up on collateral medical information at intake; an insufficient and inconsistent process that is also susceptible to undue pressure from DOC, for identifying people for medical and/or mental health exclusion from PSEG/RHU; and inadequate rounding practices by CHS and DOC.

"As Ms. Polanco's family and friends continue to mourn her death and thousands of members of her community protest in the streets, the Board's report presents a path forward for the City to make significant changes to protect the safety and care of people in custody," said Jackie Sherman, Chair of the Board's Prison Death Review Board

Dr. Bobby Cohen, Board member and member of the Prison Death Review Board said, "The Board mourns the death of Layleen Polanco. The Department of Correction must honor its commitment to house incarcerated individuals consistent with their gender identity. I am also eager to work with the Board and the City to implement the reforms outlined in the report."

In addition to the 25 recommendations to DOC and CHS, the Board has proposed a new, comprehensive rule to reform restrictive housing (including punitive segregation) in the City's jails. After receiving extensive written comment and holding two public hearings on the proposal, the Board continues to work on amending the rules and aims to finalize the new rules this fall.

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