BOARD OF CORRECTION
CITY OF NEW YORK

Second 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. Special thanks to Deputy Executive Director and 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: Board Chair Dwayne C. Sampson 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 identifying criminality or individual shortcomings. Instead, BOC investigations identify areas of deficiency or failure to follow policies, with the aim of making recommendations to the Department of Correction ("DOC" or "Department") and Correctional Health Services ("CHS") to improve carceral conditions for individuals who live and work on Rikers Island.

The Board last published a report on its investigations of deaths in custody on May 3, 2024, covering the deaths of Chima Williams (date of death: January 4, 2024) and Manuel Luna (date of death: January 19, 2024).

This report details Board investigative staff's findings and recommendations related to the deaths of Charizma Jones and Anthony Jordan in 2024. Ms. Jones died on July 14 at New York Presbyterian Hospital, shortly after being discharged from DOC custody. Mr. Jordan died on August 20, while still in custody, at Mount Sinai Queens Hospital.

Upon learning of these deaths, Board investigative staff immediately responded to the correctional facilities where both individuals were housed prior to their deaths to collect documentation, interview people in custody and staff, and review DOC surveillance footage. The Office of the Chief Medical Examiner of the City of New York ("OCME") have not yet issued reports regarding the causes of deaths.

After carefully reviewing DOC and CHS records, the Board identified the following concerns:

- The camera inside Ms. Jones's cell in the Rose M. Singer Center ("RMSC") infirmary where she was housed from April 28, 2024 through May 3, 2024 and from May 5, 2024 through May 6, 2024, was inoperable across each of those dates.
- CHS records note DOC interfered in their ability to record Ms. Jones's vital signs by refusing to open her infirmary cell on May 5 and May 6, 2024.

[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.

- Inconsistent and inaccurate logbook entries by correctional uniformed staff.
- Uniformed staff failed to make 30-minute rounds in Anthony Jordan's housing area.

These concerns, and others, 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. Charizma Jones

Age	23
Date of death	July 14, 2024
DOC admission date	September 10, 2023
Cause of death	Pending (awaiting OCME report)
Facility at time of death	RMSC, before discharge from custody
Bail amount, if any	Remanded

Ms. Jones was admitted to correctional custody on September 10, 2023. As part of the admission process, RMSC correction officers reviewed court paperwork and gathered background information to determine the most appropriate custody level.[5] During CHS's evaluation of Ms. Jones,[6] she informed CHS staff that she had a mental health history and a history of substance and alcohol use. Records further indicate that Ms. Jones did not have any known drug allergies.

After completing the new admission screening on September 10, 2023, DOC assigned Ms. Jones to a medium classification general population housing area.[7] On September 16, 2023, CHS notes reflect that a correction officer completed a mental health referral for Ms. Jones after they noticed a radical and unusual change in her behavior, which included hallucinating. CHS staff evaluated her and recommended that she be transferred to a mental observation unit.[8]

[5] DOC performs initial and follow-up assessments on people in custody to determine the most appropriate form of housing (i.e. minimum classification, medium classification, and maximum classification).

[6] 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 and risks.

[7] DOC Operations Order #01/16, Department Housing Categories and Custody Management (effective date January 22, 2016), states that general population housing is designated by custody level (minimum, medium, and maximum) for people in custody who have completed the classification and new admission processing, including medical and mental health screening, and who do not require special housing.

[8] 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.

From September 16, 2023 through April 16, 2024, Ms. Jones was assigned various housing designations, such as protective custody,[9] general population housing, mental observation housing, and Program for Accelerating Clinical Effectiveness ("PACE")[10] housing. DOC records show that correction officers issued Ms. Jones seven infractions during this period. The most serious offense was for assaulting a correction officer in a general population unit on April 16, 2024. As a result, Ms. Jones was no longer considered for a reduction in her city sentence, recognized under the term "loss of good time," which is offered to people in custody serving a city sentence who do not commit disciplinary infractions while serving that sentence. In addition, she was rearrested and charged with assault, was placed on enhanced restraint status,[11] and received a new classification score[12] of 20.

According to CHS records, on April 28, 2024, Ms. Jones started to feel unwell and developed a rash on her skin. To expedite a clinic visit, on April 28, 2024, Ms. Jones called 311 from her housing area to report that she could not eat, experienced throat swelling, and had hives and welts all over her body. 311 forwarded the complaint to the Office of Constituent and Grievance Services ("OCGS"). Staff assigned to the OCGS unit forwarded the complaint to CHS medical staff. According to CHS records, Ms. Jones was seen in the clinic after submitting the 311 complaint. CHS clinic staff examined her and collected nasal and throat specimens to send to the lab to rule out COVID-19, influenza A/B, and rapid strep. The cultures sent to the lab tested negative.

[9] Protective custody housing is a housing unit designated for those people in custody whom the Department has determined to be at risk from other persons in custody and, for safety and security reasons, cannot reasonably be housed in a less restrictive assignment in the general population.

[10] CHS PACE Operations Manual (dated September 23, 2015) states that the purpose of the PACE program is to provide a robust, evidence-based treatment environment by offering a continuum of care to meet the diverse clinical needs of specific groups of mentally ill patients in the New York City jail system.

[11] DOC Operations Order #06/10, Red ID and Enhanced Restraint Status Inmates (effective May 25, 2010), states that people are placed on enhanced restraint status if they "exhibit violent behavior either during his/her current incarceration or exhibited violent behavior during a prior incarceration within the last five years."

[12] DOC Directive 4100R-C (dated January 19, 2007) states that the "inmate classification system" is a tool for facility managers and supervisors to ensure the safe and proper housing and management of all persons committed to DOC custody. The "inmate classification system" is designed to minimize the potential for violence, escape, and institutional misconduct based upon objective criteria predictive of behavior. Classification includes establishment of a custody score and a custody level, and the identification of people in custody who have special housing and other needs or require special status designation.

CHS recommended DOC transfer Ms. Jones to the medical isolation[13] infirmary due to the new onset of skin rash, itching, coughing, chills, and high temperature. They also requested isolation continue until the symptoms were resolved. CHS records note that, before leaving the clinic for isolation, staff gave Ms. Jones a Benadryl injection and prescribed Tylenol to be taken three times a day or as needed.

On April 28, 2024, DOC placed Ms. Jones in a cell in the RMSC infirmary.[14] CHS staff checked on her shortly after she arrived. According to staff notes, Ms. Jones had "no complaints and was stable in bed in isolation."

According to CHS chart notes, the following morning on April 29, 2024, a clinician checked on Ms. Jones while performing routine rounds in the area. During the cell-side encounter, the clinician reported that Ms. Jones had no known drug allergies or evidence of Stevens Johnson Syndrome.[15] The only concern noted by clinicians after seeing Ms. Jones was that she developed a non-specific rash or skin eruption.

On May 3, 2024, CHS reported in Ms. Jones's records that she began to show improvement after receiving prednisone, antibiotics, and Tylenol. They also noted she requested to leave isolation, saying, "I feel good… I'm ready to get out of here."

On May 3, 2024, CHS discharged Ms. Jones from the infirmary, and she was transferred to a general population housing unit. According to CHS notes, Ms. Jones was discharged from the infirmary because she did not report pain or discomfort or appear to exhibit signs of acute distress during an encounter the previous day. Less than 24 hours later, on May 4, 2024, Ms. Jones called 311 to report she developed another rash on her skin. Ms. Jones stated the following in her 311 complaint:

[13] 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.

[14] BOC Minimum Standard § 3-02(e)(1), Access to Health Care Services, states: Infirmaries shall be utilized to provide overnight accommodations and health care services of limited duration to persons in custody in need of close observation or treatment of health conditions which do not require hospitalization.

[15] The Mayo Clinic describes Stevens-Johnson syndrome ("SJS") as a rare, serious disorder of the skin and mucous membranes. It is usually a reaction to medication that starts with flu-like symptoms, followed by a painful rash that spreads and blisters.

> "First, it was my wipes and vitamins for my acne. Now, I have a swollen throat, redness, irritation, itchiness, and a hive breakout. My skin is turning orange and getting dark and peeling. I requested they take me to an actual hospital because they did an EKG, and I couldn't stay still because of my skin. They keep giving me medications, and they don't know what is wrong with me. Today, I got back from the infirmary, and they are refusing to give me antibiotics. My throat is closing. This is an emergency, and they said they have no doctors available."

According to CHS records, Ms. Jones first received antibiotics for a skin condition she complained about on October 24, 2023. This treatment continued until October 28, 2023. Beginning on May 1, 2024, CHS prescribed a second antibiotic. She received this antibiotic twice daily from May 1 through May 3, 2024. On May 4, 2024, the day Ms. Jones called 311, CHS records do not indicate she received the second newly prescribed antibiotic. However, records show she received both antibiotics on May 5, 2024.

People in custody housed in the same general population unit as Ms. Jones recalled the moment, she first started to feel unwell on May 4, 2024. Shortly after 4:00 pm, Ms. Jones used the phone in the dayroom to call 311, then walked over to the housing area door that leads to the vestibule area and leaned against it for balance. Another person in custody who stood near her held her up to prevent her from falling to the floor. This individual informed BOC staff that, while holding Ms. Jones up, "her eyes rolled behind her head." Another person in the unit noticed they needed assistance and ran over to help hold Ms. Jones upright. Board staff reviewed Genetec footage after speaking with people in custody to independently verify their accounts of these events. Genetec surveillance shows the incident occurred as they stated. Additionally, video footage showed the correction officer in the unit utilizing the DOC phone after observing Ms. Jones struggle to maintain her balance.

According to people in custody, the correction officer seated near the front of the housing area noticed Ms. Jones was not well and advised the correction officer assigned to the housing area control post[16] to call a medical emergency. According to people in custody present during this incident, the correction officer on the control post called the clinic multiple times to report a medical emergency, but each time the officer was informed that "there was no staff to respond." The control post officer did not record this in the housing area logbook. However, the clinic

[16] DOC Operations Order #10/08 (effective November 19, 2008) states that a control post officer supervises people in custody activities, feedings, and inspects assigned areas and people in custody for conditions that threaten safety and security.

logbook reflects that the control post correction officer did call the clinic. The clinic logbook noted: "Medical emergency generated for PIC Jones, Charisma [sic]. Movement in the clinic paused due to two full enhanced PCs in the area."

Although DOC records indicate that a medical emergency was called into the clinic, CHS reports that they have no record of DOC informing them of a medical emergency. Additionally, CHS reports there are no visual indications that the correction officer at the clinic's front desk or any other DOC personnel informed the clinic staff of a medical emergency involving Ms. Jones.

People in custody stated that, after the housing area control post called the clinic to request medical assistance, the correction officer in the unit offered Ms. Jones the chair reserved for staff on the floor post and allowed people in custody to push Ms. Jones into the vestibule (BOC staff confirmed this statement via video review). While in the vestibule, people in custody rubbed ice on Ms. Jones's skin to cool her off because she was hot. People in custody reported to Board staff that they became frustrated with the lack of response by clinical staff, so they became disruptive and refused to comply with staff orders to reenter the housing area, prompting the control post correction officer to activate a level "A" alarm.[17] Board staff confirmed this through DOC records. Surveillance footage captured one captain and one officer responding to the level "A" alarm less than five minutes after it was activated. The response did not align with policy, in that level "A" responses should include four to seven predetermined officers, one captain, and a camera operator.

According to people in custody, DOC staff advised they were going to escort Ms. Jones to the clinic but, first, they had to retrieve a wheelchair for her use. DOC staff located a wheelchair within minutes, and assisted Ms. Jones to sit on it, then transported her to the clinic. After Ms. Jones departed the area with DOC, people in custody returned to the housing area.

CHS records show staff examined Ms. Jones once she was taken to the clinic. During the exam, staff identified new problems – nausea and vomiting, spiked fever, and chills. After the exam, staff recommended isolation in an infirmary cell pending the outcome of tests. In addition, they prescribed antibiotics for the rash, vomiting, and possibility of scarlet fever, and Tylenol for the fever and sore throat.

[17] DOC Operations Order #25/19 (effective August 22, 2019) states that a level "A" alarm is "any situation in a department facility where a member of service activates his/her personal body alarm, a radio alarm, or calls for assistance in any way." The level "A" response team is a trained team of four to seven predetermined officers and one captain, including one camera operator responsible for responding to level "A" disruptions.

At 11:50 pm that same day, DOC transferred Ms. Jones to a cell in the infirmary as directed by CHS staff. CHS records note that, after DOC housed Ms. Jones in the infirmary, correction officers did not open her cell when requested to allow medical staff to check her vital signs. According to CHS records, infirmary correction officers refused to open Ms. Jones's cell five times on May 5 and once on May 6. Ms. Jones was also not produced to a nursing appointment for vital sign monitoring at 1:52 pm on May 5, 2024.

CHS records note correctional staff's basis for refusing direct access to Ms. Jones was for safety or security reasons, as follows:

Date/time encounter created	**Reason for not accessing cell**
May 5 - 9:52 am	"Pt can not [sic] be out from her cell for safety reason as per DOC report"[18]
May 5 - 1:08 pm	"RN said DOC do not open door to check vitals. But RN was able to medicaid [sic] through slot in the door"
May 5 - 2:03 pm	"several attempts were made to do vitals.. DOC officer on duty refused to opn [sic] cell"
May 5- 3:35 pm	"due to security issue as per DOC report"
May 5 - 6:04 pm	"For security reason, pt cell can't be opened as per CO officer"
May 6 – 7:19 am	"[p]atient is Medlock"

According to CHS records, at 7:19 am on May 6, 2024, Ms. Jones "was seen hovering over tiolet [sic]. Patient stated she vomited several times. DOC stated patient is medlock and can not [sic] leave cell for vital signs… Patient was periodically checked on throughout the morning. No further issues noted or voiced."

Board staff reviewed DOC surveillance video in each instance CHS reported DOC refused to open Ms. Jones's cell on May 5 and May 6, though CHS records do not note whether these encounters with correctional staff happened inside or outside the housing area or telephonically. Surveillance footage from multiple camera angles in the housing area did not capture CHS staff on the floor or engaging with DOC staff in front of Ms. Jones's cell or near the housing area officer's desk. DOC has not produced any records to the Board that reflect that uniformed staff granted or refused to grant CHS staff access to Ms. Jones. However, surveillance footage does

[18] The Board has not received any DOC report reflecting that Ms. Jones cannot be out of her cell for safety reasons.

confirm that DOC did not open Ms. Jones's cell at any point from the first time she was admitted to the infirmary on May 4 through 8:58 am on May 6. Additionally, notes in Ms. Jones's medical chart reflect that when correctional staff refused to open Ms. Jones's cell at 9:52 am, 3:35 pm and 6:04 pm on May 5, CHS staff notified a DOC captain, charge nurse, medical director, or CHS operations. Although surveillance footage confirmed DOC did not open Ms. Jones's cell, it did show correctional staff provided her three meals a day through the food slot.

Video surveillance footage shows that at 8:58 am on May 6, 2024, correctional staff opened Ms. Jones's cell for CHS staff to enter. CHS staff exited the cell four minutes later, at 9:02 am. Board staff did not observe medical staff's response within the cell because the stationary camera inside the cell was inoperable. However, CHS records note that staff performed a triage exam and during the exam and discovered that Ms. Jones had a sore throat, high fever, rash, chills, and elevated liver function tests of 1,000 (a sign of inflamed or damaged cells in the liver), which prompted them to activate an Emergency Medical Services ("EMS") run through a 911 call. EMS entered the infirmary shortly after receiving the call, at 9:08 am. At 9:52 am, over 30 minutes after EMS arrived, correctional staff opened Ms. Jones's cell. She exited without assistance and walked toward EMS, eating an orange. At 9:55 am, Ms. Jones exited the infirmary on a gurney, seated upright and conscious, escorted by EMS. EMS transported her to Elmhurst Hospital Center.

Ms. Jones was admitted to Elmhurst Hospital Center on May 6, 2024. Following admission, hospital staff collected bloodwork for testing. According to Elmhurst records, the bloodwork uncovered she had a condition known as transaminitis (a condition where there are elevated transaminases or liver enzymes in the blood) and unconjugated hyperbilirubinemia (a condition where there are high levels of unconjugated bilirubin in the blood). In addition, her liver function test ("LFT") indicated she had an antibiotic-induced liver injury. Elmhurst staff attempted to perform a liver biopsy to determine the cause of the liver injury, but Ms. Jones refused the exam.

On May 9 and May 10, 2024, hospital staff prescribed Ms. Jones medication to treat the antibiotic-induced liver injury. After learning Ms. Jones was allergic to one of the medications prescribed, a new prescription was filled as an alternative. Despite receiving new medication, Ms. Jones's LFT scores continued to increase. She also developed a new rash.

On May 19, 2024, medical staff performed a computed tomography ("CT") scan that showed Ms. Jones had axillary and mediastinal lymphadenopathy (enlarged lymph nodes in the armpit and chest) and a 6.2 mm pulmonary nodule. Elmhurst Hospital Center processed Ms. Jones for transfer to Mount Sinai Hospital after reviewing the CT scan results. The referral paperwork

included a note for Mount Sinai Hospital to perform a liver biopsy on Ms. Jones. On May 21, 2024, Ms. Jones was discharged from Elmhurst Hospital and transferred to Mount Sinai Hospital.

Ms. Jones arrived at Mount Sinai Hospital on May 21, 2024. Records note that she arrived with a fever exceeding 104 degrees and a rash that covered her entire body. On May 28, 2024, Mount Sinai staff performed a liver biopsy on Ms. Jones, as Elmhurst recommended. The biopsy showed Ms. Jones had cholestatic hepatitis (coughing up a small amount of blood mixed with sputum) and occasional hemophagocytosis (a rare life-threatening disease that occurs when the immune system is activated), which is consistent with drug-induced liver injury.

Although Ms. Jones consented to the liver biopsy exam, records note that she refused daily treatment, lab tests, checks of vital signs and telemonitoring, certain medications and antibiotics, and exams. The records also note hospital staff observed Ms. Jones removing the intravenous injection from her right arm and refused to allow them to resecure it. Mount Sinai staff reported multiple instances of verbal aggression toward them when attempting to educate Ms. Jones on the importance of cooperating with their plan of care and medication compliance.

On June 3, 2024, two weeks after arriving at Mount Sinai Hospital and one month after departing RMSC, Ms. Jones developed jaundice and yellow sclera to both eyes. Ms. Jones continued to refuse some of the medications and recommended skin assessment. The continuous refusals to submit to lab tests, and accept medication, checks of vital signs and telemonitoring possibly contributed to her physical decline, according to records. Mount Sinai staff described the decline in Ms. Jones's health due to "patient triggered sepsis." Records reflect that Ms. Jones suddenly lost the strength to walk to the bathroom, and experienced fatigue, loss of appetite, nausea and vomiting, itching, and yellow of the skin and eyes. Additionally, she experienced a high fever, throat swelling and pain, lip pain and swelling, yellow discharge from nose and eyes, erythematous (abnormally red or inflamed skin or mucus membranes and slight bleeding), and elevated LFTs, potentially contributing to Ms. Jones requiring intubation after going into septic shock and respiratory failure on June 4, 2024.

On June 23, 2024, Mount Sinai records note that Ms. Jones developed Steven Johnson Syndrome, likely due to certain medications and/or antibiotics prescribed. This prompted staff to review the list of medications she received, ultimately leading to immediately discontinuing two antibiotics.

On June 25, 2024, Mount Sinai transferred Ms. Jones to New York Presbyterian Cornell Medical Center. According to New York Presbyterian notes, Ms. Jones arrived requiring treatment for Steven Johnson Syndrome, adult-onset Still's Disease, hemophagocytic lymphohistocytosis, drug-induced liver injury, DRESS syndrome, acute pain due to injury, anxiety, other specified anemias,

hypoalbuminemia, and hypernatremia. Ms. Jones also required enteral nutrition (a feeding tube). Ms. Jones was admitted to New York Presbyterian's Burn unit.

As at Elmhurst Hospital and Mount Sinai Hospital, Ms. Jones continued to refuse care. According to records, Ms. Jones's condition gradually worsened. Records note there were visible burns to her face, scattered open areas to her head, face and neck, and blood discharging from her mouth. On July 4, 2024, Ms. Jones was placed on a ventilator.

New York Presbyterian attempted to obtain contact information for a family member or friend before Ms. Jones's health declined further but she refused to provide information. New York Presbyterian then contacted CHS. CHS got in touch with Ms. Jones's attorney and informed them about Ms. Jones's poor prognosis. CHS petitioned the court to advocate for Ms. Jones's release from custody. The court granted the request and Ms. Jones was released from DOC custody on July 11, 2024. According to New York Presbyterian records, at 11:30 pm on July 14, 2024, Ms. Jones was pronounced deceased. Records indicate the preliminary cause of death was "multi-organ failure."

2. Anthony Jordan

Age	63
Date of death	August 20, 2024
DOC admission date	March 20, 2024
Cause of death	Pending (awaiting OCME report)
Facility at time of death	North Infirmary Command ("NIC")
Bail amount, if any	Remanded

On March 20, 2024, Mr. Jordan was admitted to custody at the Eric M. Taylor Center ("EMTC"). During the new admission screening, correction officers did not flag any medical or mental health concerns. During his medical screening, Mr. Jordan informed CHS that he had a mental health history. Mr. Jordan also informed CHS that he used crack/cocaine and smoked three cigarettes a day for years. CHS confirmed his drug use after the urine sample provided at intake tested positive for cocaine. He denied using alcohol at intake, but after CHS gained access to his medical records, it showed that he was admitted to the emergency room at Harlem Hospital for alcohol intoxication on September 17 and September 18, 2023. After learning of Mr. Jordan's alcohol use history, CHS scheduled him for therapy to learn appropriate coping mechanisms to maintain his sobriety.

On March 22, 2024, DOC assigned Mr. Jordan to a new admission general population housing area in EMTC. On March 28, 2024, DOC transferred him to a 50-and-over general population housing area in NIC. According to DOC records, Mr. Jordan lived in this unit without incident until August 19, 2024.

DOC records reflect that, on August 19, 2024, correctional uniformed staff assigned to Mr. Jordan's housing area conducted tours per policy every 30 minutes from 12:00 pm to 3:30 pm.[19] Board staff's independent video review discovered otherwise: uniformed staff toured the housing area four times from 12:00 pm through 3:30 pm. According to policy, correctional staff should have conducted seven tours. When not touring, correctional staff was observed seated at the correction officer's desk at the front of the housing area.

Surveillance footage captured Mr. Jordan entering the bathroom at 3:35 pm on August 19. At 3:36 pm, he exited the bathroom to return to his bed. He collapsed, landing on another individual's bed before falling to the floor. Correctional uniformed staff seated near the front of the housing area observed Mr. Jordan fall to the floor and activated a medical emergency, at 3:37 pm. CHS staff responded shortly thereafter, entering the unit with a wheelchair at 3:41 pm. At 3:42 pm, CHS escorted Mr. Jordan to the clinic in a wheelchair. By 4:12 pm, Mr. Jordan returned to the housing area without the wheelchair.

Individuals in the unit reported to Board staff that Mr. Jordan made multiple attempts to get to the clinic before his medical emergency on August 19, 2024. They stated he asked the correction officers to take him to the clinic and called the CHS Health Triage Hotline, but "his requests were ignored." DOC records do not indicate the correction officer escorted Mr. Jordan to the clinic on August 19, 2024. However, CHS records show that Mr. Jordan called the Triage Hotline at 8:31 am on August 19, seven hours before the medical emergency, to report he was experiencing severe left arm pain from his left shoulder down to his left arm. He stated that he had lifted a heavy bag and had been experiencing pain since. According to CHS records, medical staff examined Mr. Jordan after receiving the complaint and prescribed medication to alleviate the pain.

DOC records show Mr. Jordan had another medical emergency on August 20, 2024. Individuals in the unit shared with Board staff that, before the medical emergency at around 3:15 am, Mr. Jordan had some trouble breathing, which caused him to fall out of bed. People nearby helped him rise from the floor and back onto the bed. They then notified the correction officer seated at the desk near the front of the housing area. Surveillance video shows the correction officer last toured the housing area at 3:22 am, just over 45 minutes before learning Mr. Jordan needed medical assistance. Before that tour, video shows the correction officer touring the unit three times from 12:00 am through 4:05 am.

[19] Per DOC Teletype Order #HQ-02438-0, correction officers shall 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, day rooms) including their cells or tiers.

Board staff's video review substantiated the events reported by people in custody present during the incident. At 3:26 am on April 20, 2024, Mr. Jordan sat on the edge of his bed, rocking back and forth, appearing to be in pain. At 4:02 am, he fell off the bed. Individuals nearby assisted him get back onto the bed. At 4:05 am, one individual walked to the front of the housing area and appeared to inform the correction officer assigned to the floor post that Mr. Jordan was having difficulty breathing. At 4:06 am, the correction officer appeared to make a call from the DOC phone on post. After making the call, the correction officer went to check on Mr. Jordan. From 4:06 am to 4:16 am, the correction officer stood by Mr. Jordan and closely monitored him until medical staff arrived. Surveillance video captured CHS staff entering the unit with a wheelchair at 4:16 am. With assistance from some individuals in the unit, Mr. Jordan sat in the wheelchair. CHS staff supplied oxygen using a nasal cannula because he had trouble breathing, utilized the vital sign machine, and escorted him to the clinic. After entering the clinic treatment room at 4:20 am, CHS attached a cardiac monitor. In addition to administering oxygen, CHS staff performed cardiac and blood glucose monitoring while awaiting EMS.

According to CHS records, the nurse on shift called EMS at 4:32 am to request a hospital transport from NIC. The dispatcher received the call and sent a team to respond to the facility. EMS officers reported to the Otis Bantum Correction Center ("OBCC") instead of NIC. The facility mix-up delayed the response, prompting the doctor on shift to call EMS a second time at 4:51 am. EMS eventually arrived at 5:18 am. At 5:30 am, they departed the clinic for Mount Sinai Queens Hospital with Mr. Jordan in stable condition.

EMS records note that Mr. Jordan went into cardiac arrest on the way to the hospital and EMS attempted to resuscitate him. According to the FDNY prehospital report, EMS performed CPR, used an endotracheal tube to provide oxygen, utilized a nasal cannula, administered three epinephrine injections and intravenously administered atropine, calcium chloride and normal saline. Mr. Jordan's condition remained the same: "asystole" or without a heartbeat.

EMS arrived at Mount Sinai Queens Hospital at 6:03 am. Medical staff intubated Mr. Jordan at 6:04 am. Medical staff ended their assessment at 6:19 am after showing no progress. At 6:19 am, a doctor at Mount Sinai Hospital pronounced Mr. Jordan deceased. Their records do not include a preliminary cause of death.

Key Findings

Access to Medical Care

Minimum Standard § 3-02 on Access to Health Care Services states:

> § 3-02(b)(3): "Under no circumstances shall an inmate's access to any heath care service, including but not limited to those services described in these standards, be denied, or postponed as punishment."
>
> § 3-02(b)(4): "Correctional personnel shall never prohibit, delay, or cause to prohibit or delay an inmate's access to care or appropriate treatment. All decisions regarding the need for medical attention shall be made by the health care personnel."
> § 3-02(b)(6): "Any correctional personnel who knows or has reasons to believe that an inmate may be in need of health services shall promptly notify the medical staff and a uniformed supervisor."

CHS staff alleged correction officers impeded their ability to care for Ms. Jones while isolated in the infirmary. CHS records note that on six or more occasions on May 5 and May 6, 2024, correction officers in the unit refused to open Ms. Jones's cell so medical staff could check her vital signs.

Video Surveillance

DOC Operations Order #12/18 (effective 11/21/18) establishes guidelines and procedures for the assessment and maintenance of stationary, wall-mounted cameras as required by the 2018 *Nunez* consent judgment. Section 2(B) of Operations Order 12/18 requires DOC to repair malfunctioning or damaged cameras expeditiously.

During the Board's independent review of Charizma Jones's death, Board staff discovered that the camera in her infirmary cell was inoperable during her time in the area. Further review revealed that the camera malfunctioned and suddenly stopped working on February 14, 2024. Board staff flagged this as a concern for DOC. On September 19, 2024, six months after the camera became inoperable, DOC made the appropriate repairs, and the camera went live and is currently viewable on DOC's video surveillance system.

Inaccurate and inconsistent logbook entries by uniformed staff

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."

According to multiple people in custody housed in RMSC, on May 4, 2024, the correction officer in Ms. Jones's unit called the clinic numerous times to request assistance for Ms. Jones. According to people in custody, each time the correction officer called the clinic to request assistance, they were told there was no clinical staff available to respond. There are no entries in the housing area logbook to support this claim. However, there is an entry in the clinic logbook that shows the housing area correction officer called the clinic to report a medical emergency. Per the clinic logbook, movement was on pause because there was a patient in enhanced restraints in the area. On the day of Mr. Jordan's medical emergency at NIC, the correction officer assigned to the unit recorded 30-minute touring entries in the housing area logbook. After reviewing surveillance footage, Board staff confirmed that the entries were inaccurate. The correction officer instead completed tours of the area at 1:32 am, 1:46 am, and 3:22 am.

Insufficient housing area tours by uniformed staff

DOC Teletype Order No. HQ-2438-0, dated October 20, 2023, requires correction officers to 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.

Surveillance video reviewed by Board staff captured the correction officer touring Mr. Jordan's housing area three times between 12:00 am and 4:05 am on the day of Mr. Jordan's medical emergency. Per policy, the correction officer should have recorded nine tours between 12:00 am and 4:05 am.

Recommendations for DOC

1. Prepare and distribute memorandum reminding uniformed correctional staff not to interrupt, interfere, or deny a person in custody access to medical care. The memorandum must remind correctional staff that all decisions involving a person in custody's health must come from CHS staff.

2. 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.[20]

3. To avoid delays or miscommunication between correctional staff in the housing unit and medical staff in the clinic, CHS and DOC should set up a dedicated direct phone line for medical emergencies that does not rely on information being relayed through multiple staff to reach the medical response team. Currently, the "A" post officer contacts the clinic officer, who then notifies the medical team. CHS and DOC should actively track response time to identify undue delays and take corrective action. The direct line phone number should be posted in a visible area within the "A" station.[21]

4. 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, accurately, and legibly document personal breaks, meals, tours, and incidents in logbooks, and tour units as required by Directive #4514R-C and rules and regulations 2.30.010 and 7.05.090.[22]

5. Ensure all deaths in custody are reported to the Board's Executive Director within 30 minutes of their occurrence by phone or via email.

6. 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

[20] A variation of this recommendation is in the *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,* and *Third Report and Recommendations on 2022 Deaths in New York City Department of Correction Custody.*

[21] As recommended in *February & March 2022 Deaths in DOC Custody Report and Recommendations* and *Report and Recommendations on 2021 Suicides and Drug-Related Deaths in the New York City Department of Custody*.

[22] As recommended in *Second Report and Recommendations on 2023 Death in New York City Department of Correction Custody* published February 9, 2024.

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.[23]

7. VMU must immediately submit a work order to repair inoperable cameras as soon as they are no longer operable and must follow up with maintenance staff consistently until the repair is completed.

Recommendations for CHS

1. Establish a mechanism for CHS staff to report observations and concerns regarding DOC staff interference when it impacts their ability to care for a person in custody in violation of Minimum Standards §§ 3-02(b)(3), 3-02(b)(4), and 3-02(b)(6). Any interference in care must be reported to, at least, a CHS supervisor and the highest-ranking uniformed staff member in the specific facility. Both agencies should develop procedures and policies on how to address these deficiencies in access to care, including training or discipline.

2. Prompt medical attention and transportation to a hospital is essential when responding to a potentially fatal emergency. CHS and DOC must collaborate to examine why EMS reported to the wrong facility when responding to Mr. Jordan's medical emergency and ensure that similar errors do not reoccur.

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

December 2024

NYC Department of Correction Response to Board of Correction's "Second Report and Recommendations on 2024 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 death of Charizma Jones remains under investigation by the NYS Attorney General and 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 the Board would afford the Department the opportunity to submit and publish a response to address any inaccuracies and omissions in this report.

NYC HEALTH + HOSPITALS/CORRECTIONAL HEALTH SERVICES RESPONSE TO RECOMMENDATIONS IN THE NYC BOARD OF CORRECTION'S "SECOND REPORT AND RECOMMENDATIONS ON 2024 DEATHS IN NEW YORK CITY DEPARTMENT OF CORRECTION CUSTODY"

Recommendations for CHS

1. **Establish a mechanism for CHS staff to report observations and concerns regarding DOC staff interference when it impacts their ability to care for a person in custody in violation of Minimum Standards §§ 3-02(b)(3), 3-02(b)(4), and 3-02(b)(6). Any interference in care must be reported to, at least, a CHS supervisor and the highest-ranking uniformed staff member in the specific facility. Both agencies should develop procedures and policies on how to address these deficiencies in access to care, including training or discipline.**

Per CHS' long-standing practice, staff are expected to make their direct supervisors aware when they encounter barriers to delivering services to patients. CHS' clinical and operations staff work with DOC at the facility level to address on-site access-to-care issues. If further assistance is required, clinical supervisors can escalate to CHS Central Operations which then may notify DOC Facility Operations Leadership.

2. **Prompt medical attention and transportation to a hospital is essential when responding to a potentially fatal emergency. CHS and DOC must collaborate to examine why EMS reported to the wrong facility when responding to Mr. Jordan's medical emergency and ensure that similar errors do not reoccur.**

CHS agrees that the timely transport of patients to hospital is essential. CHS will continue to escalate delayed responses and transfers in real-time and will work with DOC and FDNY leadership to address the issue. CHS agrees that the timely transport of patients to hospital is essential. CHS continues to escalate delayed responses and transfers in real-time and continues to work with DOC and FDNY leadership to address the issue.