



**Commission of  
Correction**

**Final Report of the  
New York State Commission of Correction:**

**In the Matter of the Death of**

**Milton McNicholas,  
an incarcerated individual of the  
Westchester Department of Corrections**

**December 21, 2021**

**To: Commissioner Joseph Spano  
Westchester Department of Correction  
PO Box 389  
Valhalla, New York 10595**

**Allen Riley**  
*Chairman*

**Thomas J. Loughren**  
*Commissioner*

**Yolanda Canty**  
*Commissioner*

GREETINGS:

WHEREAS, the Medical Review Board has reported to the NYS Commission of Correction pursuant to Correction Law, section 47(1)(d), regarding the death of Milton McNicholas who died on July 30, 2019 , as a result of circumstances which occurred while an incarcerated individual in the custody of the Westchester County Department of Correction at the Westchester County Jail, the Commission has determined that the following final report be issued.

FINDINGS:

1. Milton McNicholas was a 55-year-old Caucasian male who died on 7/30/19 due to a suicidal hanging while in the custody of the Westchester County Department of Correction (DOC). A review of the case revealed that corrections staff failed to provide adequate supervisory inspections of McNicholas's housing area on the day of the terminal event in accordance with the Commission's Minimum Standards.

2. [REDACTED]

3. [REDACTED]

4. On 2/5/19, McNicholas was admitted to the Westchester DOC on a probation violation. [REDACTED]

5. [REDACTED]
6. [REDACTED]
7. [REDACTED]
8. [REDACTED]
9. [REDACTED]
10. [REDACTED]
11. [REDACTED]
12. [REDACTED]

13. [REDACTED]

14. [REDACTED]

15. [REDACTED]

16. [REDACTED]

17. [REDACTED]

18. On 4/2/19, McNicholas appeared in the Westchester County Court and was remanded back to the Westchester DOC with the next court appearance scheduled for 5/7/19.

19. [REDACTED]

20. On 4/8/19, McNicholas appeared in the Bronx Criminal Court for an unrelated criminal case but had no disposition documented.

21. [REDACTED]

22. [REDACTED]

23. [REDACTED]

24. [REDACTED]

25. [REDACTED]

26. On 5/7/19, McNicholas appeared in the Westchester County Court and was remanded back to the Westchester DOC with the next court appearance scheduled for 6/4/19.

27. [REDACTED]

28. On 5/20/19, McNicholas made an appearance in the Bronx Criminal Court with no disposition noted.

29. [REDACTED]

30. On 6/4/19, McNicholas appeared in the Westchester County Court was remanded back to the Westchester DOC with the next appearance scheduled for 9/10/19.

31. [REDACTED]

32. [REDACTED]

33. [REDACTED]

34. [REDACTED]

35. [REDACTED]

36. [REDACTED]

37. [REDACTED]

38. On 6/17/19, [REDACTED]  
McNicholas appeared in the Bronx Criminal Court with no disposition noted.

39. [REDACTED]

40. [REDACTED]

41. [REDACTED]

[REDACTED]

42.

[REDACTED]

43.

[REDACTED]

44.

[REDACTED]

45.

[REDACTED]

46.

[REDACTED]

47.

[REDACTED]

48.

[REDACTED]

49.

[REDACTED]

[REDACTED]

50. [REDACTED]

51. [REDACTED]

52. [REDACTED]

53. On 7/30/19 at 9:37 a.m. and 10:19 a.m., McNicholas made two phone calls. The first phone call McNicholas reported telling the judge that McNicholas would not be there for the next court appearance. This information was not relayed to the facility by the court nor by the person McNicholas called. The second phone call that was made to a friend was an in-depth conversation regarding court, charges, lawyers, and a possible sentence.

54. On 7/30/19 at 3:39 p.m., a medical code was called in Pen F1 block cell 11 and was changed to a code blue at 3:41 p.m. McNicholas was found on the floor to the right of the doorway with his head against the side of the wall and leaning forward with a piece of sheet tied around the neck. Westchester DOC staff noted that a ripped sheet was tied to a metal bar which was connected to the cell door frame and to the concrete wall.

[REDACTED]

55. A review of the logbook for F1 on 7/30/19 from 7:00 a.m. to 3:00 p.m. revealed the following documentation: At 7:00 a.m., CO M.G. was on post and performed a security tour and documented all appeared secure. Active supervision was in effect. All



equipment was checked and operable and the count was confirmed with the CO in booking. Per the housing logbook documentation, security tours were made and all appeared secure at 8:30 a.m., 9:00 a.m., 9:30 a.m., 10:30 a.m., 11:00 a.m., 11:25 a.m., 12:00 p.m., 12:30 p.m., 1:00 p.m., 1:30 p.m., 2:00 p.m., and 2:30 p.m., at which time a live body count was completed. At 10:26 a.m., the Captain and the Sergeant completed rounds. At 2:00 p.m., the sergeant completed rounds.

56. A review of the housing unit camera recording revealed the following:
- At 7:04 a.m., CO J.S. arrived on the housing unit and looked into all of the cells on the even side.
  - At 7:05 a.m., probationary CO M.G. completed rounds and looked into all the cells on the odd side.
  - At 7:30 a.m., CO J.S. performed an inadequate security inspection and did not look into any cells.
  - At 7:43 a.m., McNicholas was seen getting a breakfast tray and entering the dayroom.
  - At 7:46 a.m., McNicholas returned to the cell.
  - At 8:00 a.m., probationary CO J.S. conducted inadequate security inspections without looking in any of the cells.
  - At 8:23 a.m., CO J.R. conducted inadequate security inspection without looking in any cells.
  - At 8:26 a.m., CO M.G. conducted inadequate security inspection without looking into any cells.
  - At 8:54 a.m., probationary CO J.S. conducted inadequate security inspection without looking into any cells.
  - At 8:55 a.m., probationary CO J.S. conducted inadequate security inspection without looking into any cells.
  - At 9:05 a.m., McNicholas exited the cell and went into the day room.
  - At 9:31 a.m., CO M.G. conducted inadequate security inspection without looking into any cells.
  - At 9:37 a.m., McNicholas made a phone call that lasted nine minutes and nine seconds.
  - At 9:47 a.m., McNicholas wandered on the tier until 9:56 a.m. when McNicholas locked into the cell.
  - At 10:00 a.m., CO M.G. should have made a security round, however, no such tour was made on the north side. CO M.G. was noted to be letting the medication nurse off the block and then making a telephone call.
  - At 10:16 a.m., McNicholas left the cell and entered the day room.
  - At 10:19 a.m., McNicholas made a phone call to a friend.
  - At 10:26 a.m., Captain K.K. and Sergeant K.M. completed rounds on the housing unit and looked in every cell.
  - At 10:31 a.m., probationary CO J.S. conducted inadequate security inspection without looking into any cells.
  - At 10:42 a.m., McNicholas exited the day room.
  - At 10:45 a.m., McNicholas left the housing unit to go to medical.
  - At 10:55 a.m., CO M.G. conducted inadequate security inspection without looking into any cells.
  - At 11:04 a.m., McNicholas was seen by the nurse practitioner.
  - At 11:10 a.m., McNicholas returned to the housing unit and locked into the cell.
  - At 11:10 a.m., CO J.J. conducted a security inspection and appeared to look in every cell.

- At 11:28 a.m., CO J.J. made another in security inspection and appeared to look into every cell.
- At 12:01 p.m., McNicholas exited the cell for a lunch tray and returned back to the cell.
- At 12:03 p.m. and 12:24 p.m., CO M.G. conducted inadequate security inspection without looking into any cells.
- At 12:29 p.m., CO M.G. let medical staff into the housing unit and walked down the tier without looking at any cells.
- At 1:35 p.m., during the movement of F1 individuals are returning from recreation, CO M.G. can be seen moving the individuals along in an effort to clear the tier.
- At 1:40 p.m., probationary CO J.S. conducted inadequate security inspection without looking into any cells.
- At 1:56 p.m., CO M.G. conducted inadequate security inspection without looking into any cells.
- At 2:01 p.m., Sergeant A.M. conducted a security inspection and looked into every cell on both sides of F1
- At 2:11 p.m., CO M.G. secured another incarcerated individual into a cell and then conducted inadequate security inspection without looking into any cells.
- At 2:12 p.m., F1 N was locked down for the cross complex count.
- At 2:23 p.m., CO M.G. conducted inadequate security inspection without looking into any cells.
- At 2:31 p.m., probationary CO J.S. conducted inadequate security inspection without looking into any cells.
- At 2:33 p.m., probationary CO J.S. escorted maintenance workers off the block and did not look into any cells
- At 2:43 p.m., probationary CO J.S. secured the door and cleared all the incarcerated individuals off the FN tier.
- At 2:47 p.m., CO M.G. opened the housing unit door to let an individual on the unit. CO M.G. appeared to be looking in the odd side cells in the vicinity of McNicholas's cell. CO M.G. walked past the cell and then went back to the vicinity of the cell and looked in appearing to step closer to the cell so as to look in the cell through the window and its door. CO M.G then resumed the inspection of the odd side cells only.
- At 2:49 p.m., probationary CO J.S. walked down the middle of the tier without looking at any cells.
- At 2:53 p.m., CO M.G. went to the north side and looked into the first five or six even numbered cells then went to the outside and looked in the vicinity of cells 11 and 13. CO M.G. then returned to the staff office.
- At 2:59 p.m., CO S.B. and CO J.B arrived. CO J.B. conducted a security inspection on the even side looking into all cells. CO S.B. conducted a tour on the odd side looking into all cells. CO S.B. stopped in the vicinity of cell 19 at 3:01 p.m. CO SB with a clipboard arrived in vicinity of cell 13 looked into the cell and then went toward McNicholas and looked into the cell. CO S.B. then began to walk towards the staff office at the same time that CO J.S. was walking to the housing unit exit door. CO J.S. stopped in the vicinity of McNicholas' cell. CO S.B. turned around and went back to CO J.S. who was closely looking into McNicholas's cell. CO J.S. extended the right arm and pointed into the cell.
- At 3:02 p.m., probationary CO J.S. exited the housing unit,
- At 3:04 p.m., probationary CO J.S. reentered the housing unit and went to the office.
- At 3:05 p.m., CO M.G. exited the housing unit.
- At 3:06 p.m., probationary CO J.S. exited the housing unit.
- At 3:08 p.m., the Aramark worker arrived in the housing unit with the meal trays.
- At 3:09 p.m., CO J.B. opened cell 3 for the meal tray.

- At 3:11 p.m., the Aramark worker exited the housing unit.
- At 3:29 p.m., the Aramark commissary employee arrived on the housing unit to distribute commissary.
- At 3:30 p.m., CO J.B. made a security inspection walking down the middle of the tier and did not appear to look into the cells.
- At 3:37 p.m., CO J.B. opened McNicholas's cell for commissary. CO J.B. partially entered the cell and appeared to check on McNicholas. CO J.B. then closed the cell door and ran toward the dayroom to alert CO S.B.
- At 3:38 p.m., CO J.B. ran back to cell 11 with CO S.B. Officer J.B. then ran to the phone and called a signal 3 and then reentered cell 11 and removed the blue bed sheet from the cell door support bracket at 3:39 p.m.

57. Based upon the review of the housing area logbooks and a review of the recorded housing area video, the Medical Review Board finds that there was a failure of the security staff to perform adequate security inspections in compartment with the requirements of 9 NYCRR §7003.3(a) which state:  
*Active supervision shall be maintained in all facility housing areas, including multiple occupancy housing units, when any prisoners are confined in such areas but not secured in their individual housing units.*
58. In the case of McNicholas's death, CO M.G., CO J.S., CO J.B., CO S.B., Sergeant M.C., Sergeant K.M., and CO J.R. were all subject of an internal investigation by Westchester County DOC regarding the supervision conducted on the day of McNicholas' death. Officer M.G. is no longer employed with the Westchester County DOC. Officer J.S. was initially given a 30-day suspension and after arbitration, it was determined that appropriate sanctions were to be a total suspension of 65 days. Officer J.S. was put on notice that if culpability in another case involving the same or similar misconduct was reported that the penalty will be dismissal from service. The remaining staff were not found culpable in the matter.
59. A suicide note was left by McNicholas to the family which stated that McNicholas was sorry to put them through all of this and McNicholas hoped that they would be forgiving.


ACTIONS REQUIRED:

TO THE COMMISSIONER OF WESTCHESTER COUNTY DEPARTMENT OF CORRECTION:

The Commissioner shall conduct a review with assigned housing area staff to assure compliance that active supervision as per 9 NYCRR §7003.3(a) is maintained in all applicable housing areas.

*In a response to the Commission's preliminary report dated 10/28/21, WDOC Commissioner indicated that the requested review was completed with corrective action taken.*

WITNESS, HONORABLE THOMAS J. LOUGHREN, Commissioner, NYS Commission of Correction, Alfred E. Smith State Office Building, 80 South Swan Street, 12<sup>th</sup> Floor, in the City of Albany, New York 12210 on this 21<sup>st</sup> day of December, 2021.

  
Thomas J. Loughren  
Commissioner & Chair  
Medical Review Board

TJL:DC:jdb  
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