



**Commission of
Correction**

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

In the Matter of the Death of

**Ryan Wilson,
an incarcerated individual of the
Manhattan Detention Center**

December 20, 2023

**To: Commissioner Lynelle Maginley-Liddie
NYC Department of Correction
75-20 Astoria Blvd., Suite 100
East Elmhurst, NY 11370**

Allen Riley
Chairman

Yolanda Canty
Commissioner

[REDACTED]

5. [REDACTED]

6. [REDACTED]

7. [REDACTED]

8. [REDACTED]

9. [REDACTED]

10. [REDACTED]

11. [REDACTED]

12. [REDACTED]

13. [REDACTED]

[REDACTED]

14.

[REDACTED]

15.

[REDACTED]

16.

[REDACTED]

17.

[REDACTED]

18. [REDACTED]

19. [REDACTED]

20. [REDACTED]

21. [REDACTED]

22. [REDACTED]

23. [REDACTED]

[REDACTED] The Medical Review Board opines that Wilson did not have a proper mental health diagnosis. The Board opines that the diagnosis of Other Specified Disruptive Impulse-Control, and Conduct Disorder is an applicable diagnosis for juvenile behavior and not of an adult male to which Wilson did not meet clinical criteria for.

24. On 11/22/20, Correction Officer (CO) O.R. documented that he arrived on 6 North at 3:30 p.m. and was informed that Wilson had an incident with another incarcerated individual on the prior tour. CO O.R. documented that he notified the area supervisor of the incident.

25. A review of the Gentech video revealed:
At approximately 3:06 p.m., Wilson approached another incarcerated individual and put his hands up in a fighting stance and then kicked that individual and then walked away. That incarcerated individual entered cell 3 and closed the door. CO C. did not make any documentation regarding this incident in the logbook.

At approximately 3:13 p.m., Wilson again approached cell 3 and was seen at that door for a few seconds and then walked away. Per the Callout Report and Checklist, it appeared that Wilson spit in the cell. This cannot be seen in the video reviewed by Commission staff.

At approximately 3:15 p.m., Wilson was seen approaching cell 23 with a bouquet of flowers and a paper. Wilson was then seen pounding on cell 23 and yelling out to the housing area. Wilson then walked away without the cell door opening. Wilson then walked to his cell and CO C. closed his door. There was no documentation in the logbook to indicate any of this activity or any indication that a captain was notified of any incidents.

26. At 4:00 p.m., all incarcerated individuals were afforded lockout time except for Wilson. CO O.R. stated that he had been informed by other incarcerated individuals that if Wilson was let out of his cell, it would be "bad for him." Captain R.H. spoke to Wilson and notified CO O.R. that Wilson would be moved to a different housing area. At 4:30 p.m., CO O.R. conducted a tour and noted that Wilson had his window covered. Wilson was asked if he was okay, and his response was, "yes I am okay". Approximately 10 minutes later, another incarcerated individual approached and said that Wilson wanted to speak to CO O.R. CO O.R. reported to Wilson's cell. Wilson asked if he was being moved to another housing area and Wilson was told yes. Wilson then proceeded to "show" CO O.R. that he would harm himself with an institutional linen if the captain did not show up right away. As the captain arrived, CO O.R. radioed the A post officer to open cell 17 however, the transmission did not go through. Captain R.H. arrived at the cell and ordered CO Y.M. to open the cell. CO O.R. gave Wilson a direct order to remove the linen from around his neck. Captain R.H. then instructed CO O.R. to close the cell door due to the number of incarcerated individuals that were out in the housing unit and were gathering around the cell. At 4:57 p.m., per a review of the Gentech video, Captain R.H. returned to the desk and CO O.R. returned to the desk at which time he was advised to do a tour of the housing area with the captain. At 5:02 p.m., upon arrival to Wilson's cell, Captain R.H. and CO O.R. noted that Wilson had a sheet around his neck and was in a standing position. Captain R.H. instructed CO O.R. to open the cell door and Wilson was again given commands to take the sheet off his neck. Wilson did not comply or respond. CO O.R. was advised to use the 911 cut down tool to remove the sheet from the light fixture. Wilson was lowered to the floor. Wilson was checked for a pulse and chest compressions were initiated.

27. On 11/22/20 at 4:00 p.m., per the statement completed by Captain R.H., she arrived at 6 control to drop off paperwork. At that time, Captain R.H. was told by CO O.R. that Wilson requested to speak with a captain. Captain R.H. went to cell upper 17 to speak with

Wilson. Wilson reported that he could no longer stay on the housing unit due to an issue on the prior shift. Officer O.R. reported that he was informed by their prior tour that Wilson had spit on another incarcerated individual in the housing unit. Captain R.H. informed Wilson that she would rehouse him. At 4:45 p.m., Captain R.H. returned to the housing unit, signed the logbook, and began conducting a tour on the bottom tier. Captain R.H. proceeded to the top tier and met CO O.R. who was standing in front of cell 17. There were numerous incarcerated individuals around the cell. The cell door was opened and Captain R.H. noted that Wilson was standing on the ground in an upright position with what appeared to be a white sheet around his neck tied to the fixture. The cell door was closed and Captain R.H. spoke with CO O.R. to tell him what they needed to do. Due to the number of incarcerated individuals out in the housing area, Captain R.H. called for a de-escalation unit. At approximately 5:05 p.m., Captain R.H. and CO O.R. reentered the cell and CO O.R. cut the sheet around Wilson's neck and Wilson was placed on the floor. A medical emergency was called. Officer O.R. initiated CPR until medical arrived. Due to the number of incarcerated individuals on the housing unit, medical staff would not enter the scene. Captain K. and Assistant Deputy Warden (ADW) M. assisted in moving the individuals into their cells and approximately five to seven minutes later, the medical team entered. The doctor told the captain to go get the AED machine. Captain R.H. stated that she went to 6 control however, the AED was not located there. North tower was contacted, and clinic staff were advised to bring the AED to the area.

28. On 11/22/20, per the statement completed by CO R.R., at approximately 5:03 p.m., he responded to a level A de-escalation on 6 North. When CO R.R. arrived, Captain R.H. and CO O.R. were standing in front of cell 17. CO R.R. asked Captain R.H. what the de-escalation was however she did not respond. Captain R.H. was giving Wilson verbal commands to take the sheet down. CO O.R. and CO R.R. made a radio transmissions to have the cell door opened. When it was opened, Wilson was seen hanging with the linen around his neck and CO O.R. cut the linen from Wilson's neck.
29. On 11/22/20, per the statement completed by CO Y.M., CO Y.M. was on meal relief on 6 Control at 4:32 p.m. and was informed by CO O.R. that due to a prior incident with Wilson and another incarcerated individual, Wilson's cell door was not to be opened. CO O.R. reported that Captain R.H. was coming to assist with the situation as there were threats against Wilson. At 4:40 p.m., Captain R.H. arrived and was writing in the logbook while other incarcerated individuals were yelling and banging for cell 17 to be opened. CO Y.M. could not see CO O.R. and would not open the cell per previous direction given. At approximately 4:45 p.m., Captain R.H. entered the housing area while other incarcerated individuals stated that Wilson was hanging. Captain R.H. located CO O.R. at the cell door and ordered the door opened. Captain R.H. and CO O.R. entered the cell and other incarcerated individuals were coming to the top tier and Captain R.H. ordered the cell door be closed. At approximately 5:05 p.m., Captain R.H. then completed a tour and then signaled CO Y.M. to open the cell door and a medical emergency was called. The Medical Review Board affirms the findings of the investigation and concurs that Wilson was actively hanging at approximately 4:45 p.m. but was deliberately ignored by Captain R.H. who failed to respond and direct staff to respond to the emergency until approximately 5:05 p.m., some 20 minutes later. The Medical Review Board opines that had immediate intervention occurred, Wilson's death may have been prevented. The Medical Review Board concurs with actions taken by the Manhattan District Attorney's Office in this matter and serve a reminder to all correction staff the requirements of

Correction Law §500-c(4) to safely keep individuals in their custody necessitates response to and preventing individuals from committing acts of self-harm.

30. On 11/22/20 at 5:08 p.m., a medical response was called for Wilson on MDC 6N. [REDACTED]
[REDACTED]
[REDACTED] At 5:19 p.m., EMS was activated. [REDACTED]
[REDACTED]
[REDACTED] EMS arrived at 5:40 p.m. [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

- 31. A review of the 6 Control logbook revealed:
At 4:40 p.m., Captain R.H. was on post for a tour of the unit and medical response was called. This time was inaccurate based on camera review.
- 32. A review of the 6 North logbook revealed that from 8:00 a.m. until 3:30 p.m., active supervision tours were completed every 30 minutes and there was no documentation in the logbook of any incidents involving Wilson.

ACTIONS REQUIRED:


TO THE SENIOR VICE PRESIDENT OF CORRECTIONAL HEALTH SERVICES, NYC HEALTH AND HOSPITALS:

Correctional Health Services shall conduct a quality assurance review with the attending mental health providers for Wilson regarding the accuracy of his mental health diagnosis and whether proper clinical criteria for said diagnoses was properly met.

A report of findings and corrective actions taken shall be forwarded to the Commission upon completion.

In a response dated 11/14/23, CHS indicated that the requested quality assurance review was completed.

WITNESS, HONORABLE ALLEN RILEY, Chairman, NYS Commission of Correction, Alfred E. Smith State Office Building, 80 South Swan Street, 12th Floor, in the City of Albany, New York 12210 on this 20th day of December, 2023.


Allen Riley
Chairman
Commission of Correction

AR:DC:vc
2020-M-0125
December 20, 2023

cc: Deputy Commissioner of Legal Matters/General Counsel
Deputy Commissioner of Security Operations
Deputy Commissioner of Health Affairs
Director of Compliance
Patricia Yang, DrPH, Senior Vice President
Correctional Health Services
Bipin Subedi, MD, Chief Medical Officer
Correctional Health Services
Executive Director
NYC Board of Correction