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Commission of Correction

Final Report of the New York State Commission of Correction:

In the Matter of the Death of

Ahliek Leonard
an incarcerated individual of the Albany County Jail

March 27, 2024

To: Sheriff Craig D. Apple
Albany County Sheriff's Office
Court House
Albany, New York 12207

Allen Riley
Chairman

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 Ahliek Leonard, who died on June 25, 2022, as a result of circumstances which occurred while an incarcerated individual in the custody of the Albany County Sheriff at the Albany County Jail, the Commission has determined that the following final report be issued.

FINDINGS:

1. Ahliek Leonard was a 20-year-old male who died on 6/25/2022 due to a Fentanyl overdose while in the custody of the Albany County Sheriff at the Albany County Jail (CJ).

2. Leonard's criminal history began with the instant offense. On 12/13/2021, Leonard was arrested and charged with Murder 2nd Degree and Criminal Possession of a Weapon 2nd Degree. On 5/11/2022, Leonard plead guilty to Manslaughter 1st Degree. On 7/8/2022, Leonard was scheduled to be sentenced to 24 years in prison.

3. [redacted] Leonard denied having any mental health history at intake. Leonard did not report any current prescriptions.

4. On 12/13/21 at 3:37 p.m., Leonard was booked into the Albany CJ. At 3:45 p.m., Leonard's suicide prevention screening was completed by Corrections Officer (CO) M. Leonard scored a 'two'. Documentation indicated that this was Leonard's first incarceration and he was angry. Leonard was referred to medical and mental health. Based on Leonard's charges, he was placed on constant observation. [redacted]

5. [redacted]

6. [redacted]

7. [redacted]

8. On 12/17/21 at 1:30 p.m., Leonard appeared in court for a preliminary hearing.

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24. On 4/28/22 at 8:08 a.m., Leonard assaulted another incarcerated individual (II).

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28. On 5/11/22, Leonard plead guilty to Manslaughter 1st Degree.

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30.

[redacted]

31. [redacted]

32. [redacted]

33. On 6/23/22 at 7:24 p.m., Leonard had a civilian visitor.

34. A review of housing unit logbooks from 6/23/22 at 10:53 p.m. through the terminal event indicated that there was no specific documentation concerning Leonard. Supervisory rounds were completed within every half hour at irregular intervals.

35. On 6/25/22 at approximately 9:42 a.m., CO D.G. was alerted by IIs from the right side of the housing unit that an II was in need of medical attention. At 9:42 a.m., CO D.G. called a medical emergency. CO J.M. entered the housing unit cell block. CO J.M. entered Leonard's cell and assessed Leonard who was unresponsive on his bunk. At 9:43 a.m., RN [redacted] and RN [redacted] arrived and assessed Leonard. CO J.M. and Sergeant L.W. moved Leonard to the floor just outside of his cell. [redacted] At 9:58 a.m., Colonie EMS arrived and assumed the care of Leonard. [redacted]

36. During an interview with Commission staff, CO D.G. stated that he was the only officer on the tier when he called the medical emergency, that he opened the gates to the responding staff and did not observe Leonard throughout this process. CO D.G. stated that on his prior supervisory watch tour, nothing seemed out of the ordinary. During an interview with Commission staff, CO J.M. stated that when he arrived at Leonard's cell, Leonard was on his bunk with his head towards the bars. CO J.M. stated that Leonard did have an unknown wet substance on him and that it was unknown if it was

perspiration or water from another II attempting to wake him up. CO J.M. stated that he did not notice any obvious injuries to Leonard. During an interview with Commission staff, Sergeant L.W. stated that when he performed CPR on Leonard, Leonard was not warm and his body was firm. Sergeant L.W. stated that there were no obvious signs of injury to Leonard from the neck up. During the medical emergency response, there was no documentation that Leonard received Narcan. The Medical Review Board opines that Narcan should have been administered to Leonard immediately when he was found unresponsive.

37. As per CO D.G.'s post tour incident report, on 6/25/22 at 6:50 a.m., when he came on post, he completed a security round of the housing unit and verified headcount both visually and physically. Supervisory watch tours were conducted again at 7:00 a.m. where CO G.D. documented tier clean and "in good order, count complete".

38. As per CO M.M.'s post tour incident report, on 6/25/22 at the 7:00 a.m. shift change, he and CO D.G. conducted an initial head count and all incarcerated individuals were sleeping and appeared to be alive at that time. The Medical Review Board opines that this was inaccurate given the postmortem changes identified by EMS. During an interview with Commission staff, CO M.M. stated that he did not see anything out of the ordinary regarding Leonard on this final watch tour or throughout the night.

ACTIONS REQUIRED:

TO THE ALBANY COUNTY SHERIFF:

The Sheriff shall take notice of the Medical Review Boards finding of the presence of postmortem changes as observed by the nursing staff as well as EMS. The Sheriff shall initiate an investigation into the conduct of the officer who was assigned to supervise the housing area. Administrative action should be taken if found to be in violation of department directives.

A report of the findings and any corrective actions taken shall be provided to the Medical Review Board upon completion.

In a response dated 2/1/24 to the Commission's preliminary report, the Sheriff's Office indicated that conducted an internal investigation and the officer was not found to be in violation of any department directives.

TO THE ALBANY COUNTY JAIL PHYSICIAN:

The Jail Physician shall conduct a comprehensive quality assurance review of the care provided to Leonard to include:

a. Why there was no notification made by medical staff to the provider regarding the multiple days that Leonard did not receive his [redacted] and why there was no clear documentation to indicate if the medication was refused.
b. Why Narcan was not administered immediately upon discovery of an unresponsive individual.

A report of the findings and any corrective actions taken shall be provided to the Medical Review Board upon completion.

The Commission did not receive a response from the jail physician. The open issues will be referred to the Commission for review during a health service evaluation.

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 27 h day of March 2024.

Allen Riley
Chairman
Commission of Correction

AR:MB:vc
2022-M-0074
March 27, 2024