**Commission of Correction**

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

## In the Matter of the Death of

## Ricardo Cruciani, an incarcerated individual of the Eric M. Taylor Center

**September 25, 2024**

**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*

**Elizabeth Gaynes**
*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 Ricardo Cruciani, who died on August 15, 2022, as result of circumstances which occurred while an incarcerated individual in the custody of the New York City Department of Correction, the Commission has determined that the following final report be issued.

FINDINGS:

1. Ricardo Cruciani was a 68-year-old male who died on 8/15/22 from a suicidal hanging while in the custody of the New York City Department of Correction (NYC DOC) at the Eric M. Taylor Center (EMTC). The Medical Review Board has found that a failure to supervise the facility in accordance with NYS Minimum Standards has jeopardized the safety of the incarcerated individuals in NYC DOC's custody and constitutes a violation of Correction Law §500-c(4) that requires the Department to keep incarcerated individuals safe. There was no officer assigned to supervise Cruciani's housing area at the time of his terminal event. Additionally, the Medical Review Board has found that there was a critical failure by NYC DOC staff to respond to communication from the committing court that Cruciani, a high profile defendant, was a suicide risk and in need of protective custody status  The Medical Review Board opines that had proper procedure been followed by immediately implementing suicide risk precautions, Cruciani's death may have been prevented.

2. On 2/20/18, Cruciani was arrested and charged with Rape 1st Degree, Criminal Sex Act 1st Degree, Attempted Rape 1st Degree, three counts of Sexual Abuse 1st Degree, and two counts of Rape 3rd Degree. On 2/21/18, Cruciani was arraigned on the following charges: Rape 1st Degree, Criminal Sex Act 1st Degree, Attempted Rape 1st Degree, three counts of Sexual Abuse 1st Degree, two counts of Rape 3rd Degree, Aggravated Sexual Abuse 4th Degree, and seven counts of Criminal Sex Act 3rd Degree. Cruciani was a practicing neurologist who reportedly committed predatory sexual acts against female patients under his care for years. On 7/29/22, Cruciani was convicted of Predatory Sexual Assault after a jury trial and was awaiting sentencing.

3.

4. On 7/29/22, Cruciani was committed to the custody of NYC DOC by the court after being found guilty at trial. The securing order from the judge committing Cruciani to the custody of NYC DOC noted, in the remarks section, that Protective Custody and Suicide Risk were ordered. At 11:45 a.m., a suicide screening was completed at Manhattan Courts and Corrections Officer (CO) E.H. documented that Cruciani . In the comment section, CO E.H. documented , CO E.H. responded "no" to question number one that the arresting or transporting officer believes or has received information that detainee may be a suicide risk. The Arraignment and Classification Form completed by CO E.H. noted that the

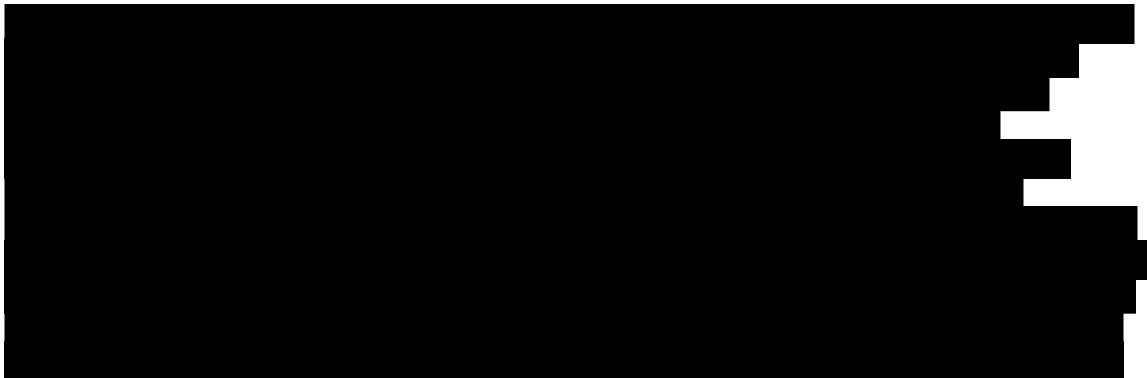
documents indicated that suicide watch and/or protective custody was ordered per the judge. During an interview with Commission staff, CO E.H. stated that the Arraignment and Classification Risk Screening Form with the Suicide Prevention Screen are given to the Control 4 bridge officers and that there was a form that would be attached to indicate that a suicide watch was initiated prior to an individual's arrival at the receiving facility. Upon Cruciani's arrival to EMTC, the supervisor failed to review the securing order from the court. The Arraignment and Classification receiving form was completed by Assistant Deputy Warden (ADW) M., who was the intake supervisor. ADW M. incorrectly noted that on the commitment form, protective custody/suicide watch were not indicated. ADW M. noted that medical staff cleared Cruciani for housing. ADW M. answered "no" to the question if special housing was required. There was no time or date documented by the supervisor on the Arraignment and Classification form to indicate when this form was completed. There was no documentation provided to indicate that Cruciani was placed on suicide watch or classified for protective custody as per the order of the judge. This was a violation of 9 NYCRR §7013.7(a) which states:
*Each inmate upon admission to a facility shall undergo an initial screening and risk assessment which shall consist of a screening interview, visual assessment and review of commitment documents. Such screening and risk assessment shall occur immediately upon an inmate's admission*.

This was also a violation of 9 NYCRR §7013.7(b)(11) which states:
*A screening instrument(s) shall be utilized to elicit and record information on each inmate relating to the following: any other relevant information concerning the safety or welfare of the inmate*.

and a violation of 9 NYCRR §7013.7(c) which states:
*(c) An immediate decision concerning the disposition of each incarcerated individual shall be made on the basis of information gathered during initial screening and risk assessment. Such disposition may include, but is not limited to, referrals to outside medical and mental health service providers.*

During an interview with Commission staff, regarding the answers on the Arraignment and Classification form, ADW M. stated that the medical clearance is completed by the facility medical staff prior to the form being completed by DOC staff. ADW M. stated that the securing order noted the protective custody and suicide watch requested by the judge but stated that this was "a recommendation only". ADW M. stated that mental health would see the incarcerated individual and make the determination if suicide watch or protective custody was required and that the suicide watch would be initiated after ordered by mental health. ADW M. stated that DOC staff would "flag" the chart for suicide watch and notify mental health. ADW M. stated that the securing order remains with DOC and is not given to medical or mental health. The Medical Review Board finds that there was a critical failure by ADW M. to properly communicate a known suicide risk to Correctional Health Services staff and a failure to initiate a proper level of supervision in accordance with 9 NYCRR 7003.3(h) which states:
*The chief administrative officer and/or the facility physician shall determine whether a prisoner requires additional supervision based on the prisoner's condition, illness or injury, and the chief administrative officer shall order such supervision if warranted. Additional supervision may include:*
*(1) more frequent supervisory visits;*
*(2) active supervision when only general supervision is required; or*
*(3) constant supervision*.

5. Cruciani arrived at EMTC with an ankle monitoring device on the right ankle and this was not indicated on the admission paperwork. During an interview with Commission staff, ADW M. noted that the ankle monitoring device would have been documented on another form that was not in the records received by the Commission. During an interview with Commission staff, CO E.H. noted that a pat frisk is completed at the Manhattan Courts. CO E.H. stated that if a monitoring device is found, it is not noted on the Arraignment and Classification Form, but that CO E.H. would tell the receiving officer that it was present. CO E.H. noted that DOC staff does not remove monitoring devices and that a special department would be brought in to remove the device. Individuals can be brought into NYC DOC with monitoring devices in place. This was a violation of 9 NYCRR §7002.2 Authority for Admission (d)(3) which states:
*The admissions process shall include the recording of: an itemization of all documents and property received with the prisoner*.

6. 
. The Medical Review Board finds that this was a critical failure to maintain Cruiciani's safety as he should have been an immediate referral to mental health.

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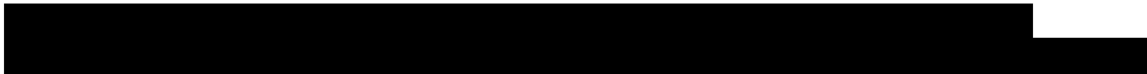
9. 

10. On 8/15/22 at 4:26 a.m., per the callout and checklist report from NYC DOC, Cruciani entered the bathroom of the 5 Main housing area with a bundle of linen. At approximately 5:35 a.m., CO A.B. was notified that there was someone in the bathroom that needed assistance. Cruciani was observed to be sitting in a grey chair in the shower area with a rope and sheet tied around his neck. CO A.B. utilized a 911 knife to remove the sheet. CO A.B. then returned to the control post and called a medical response. CO A.B. was the only DOC staff on the housing unit at that time. At 5:42 a.m., medical staff arrived. . Emergency Medical Services (EMS) was activated EMS arrived

11. A review of 5 B Main logbook revealed:
On 8/11/22 at 10:00 p.m., CO L. was off post to relieve "A" officer. There was no officer assigned to the B post.
On 8/12/22 at 12:10 p.m., CO S. assumed the B post. Rounds were completed every 30 minutes until 3:30 p.m. There was no officer assigned to the B post after 3:30 p.m.
On 8/12/22 at 6:25 p.m., CO G. assumed the B post and rounds were made every 15 minutes until 11:20 p.m. There was no officer assigned to B post again until after the terminal event.

12. On 8/15/22, Captain T.D.-C. did not make a supervisory tour during the shift.

13. The Medical Review Board finds that the abandonment of security staffing posts for the housing areas is a violation of 9 NYCRR §7003.3(a) and had fostered unsafe conditions of confinement in violation Correction Law §500-c(4).

The Medical Review Board also find that the facility failed to ensure that proper population counts were conducted. This a violation of 9 NYCRR §7003.5(a) and (b) which states:

*(a) Prisoner population counts shall:*
*(1) be conducted at the completion and commencement of each regularly scheduled shift;*
*(2) be conducted by the facility staff member completing such regularly scheduled shift;*
*(3) be conducted by the facility staff member beginning the next regularly scheduled shift; and*

*(4) include an accounting of all prisoners housed in or otherwise assigned to the facility area in which such count is conducted.*

*(b) The results of each prisoner population count conducted pursuant to paragraphs (a)(2) and (3) of this section shall be recorded in writing. Such written records shall include the:*
*(1) date and time of the count;*
*(2) facility area in which the count was conducted;*
*(3) number of prisoners accounted for; and*
*(4) name of facility staff member conducting the count.*

Additionally, the Medical Review Board finds that the facility failed to comport with 9 NYCRR §7003.2(c) which states:
*Active supervision shall mean the immediate availability to prisoners of facility staff responsible for the care and custody of such prisoners which shall include:*
*(1) uninterrupted ability to communicate orally with and respond to each prisoner unaided by any electronic or other artificial amplifying device; and*
*(2) the conducting of supervisory visits at 30-minute intervals;*
*(3) the ability of staff to immediately respond to emergency situations; and*
*(4) in any facility housing area in which more than 20 inmates are housed, the continuous occupation of a security post within such housing area.*

ACTIONS REQUIRED:

TO THE COMMISSIONER OF THE NEW YORK CITY DEPARTMENT OF CORRECTION:

1. The Commissioner shall conduct an investigation as to why the housing unit was not properly staffed and supervised in comportment with 9 NYCRR §7003.3(a),(b),(c), & (j), and 9 NYCRR §7003.2(c) and why population counts were not properly completed in accordance with 9 NYCRR §7003.5. Administrative action should be taken if staff are found to be in violation of department directives.

2. The Commissioner shall inform the Commission on the measures being taken by DOC to address the chronic staffing issues and safety conditions effecting EMTC.

3. The Commissioner shall conduct an investigation into the failure of staff to properly communicate the committing courts information that Cruciani was a suicide risk and in need of protective custody and failed to immediately notify correctional health staff and initiate constant supervision until Cruciani could be evaluated. Administrative action should be taken if staff are found to be in violation of department directives.

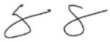
4. The Commissioner shall conduct an investigation into the staff that failed to properly complete the Classification of Cruciani in comportment with 9 NYCRR §7013.7(a), 9 NYCRR §7013.7(b)(11) and 9 NYCRR §7013.7(c). Administrative action should be taken if staff are found to be in violation of department directives.

5. The Commissioner shall conduct an investigation into the staff that failed to identify the ankle monitoring device on Cruciani in comportment with 9 NYCRR §7002.2. Administrative action should be taken if staff are found to be in violation of department directives.

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

*In a response dated 6/25/24 to the Commission's preliminary report NYC DOC indicated that the requested reviews were completed with corrective action plans detailed. The Medical Review Board found the response to be mostly acceptable however noted that explanations regarded why cited staff failures, particularly the review of committing court documents and ankle monitoring device, occurred.*

WITNESS, HONORABLE YOLANDA CANTY, Commissioner, 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 25th day of September 2024.



Yolanda Canty
Commissioner
Commission of Correction

YC:DC:vc
2022-M-0090
September 25, 2024

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
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