



**Commission of  
Correction**

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

**In the Matter of the Death of**

**Emmanuel Sullivan  
an incarcerated individual of the  
Robert N. Davoren Center**

**December 18, 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 Emmanuel Sullivan, who died on May 28, 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. Emmanuel Sullivan was a 20-year-old male who died on 5/28/22 from an Acute Methadone Intoxication while in the custody of the New York City Department of Corrections(NYC DOC) at the Robert N Davoren Center. The officer assigned to the housing unit failed to conduct proper supervisory tours as evidenced by the postmortem changes noted on the terminal event.
2. [REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED] In February 2022, Sullivan was arrested and charged with Murder, Robbery 1<sup>st</sup> Degree, two counts of Criminal Possession Weapon 2<sup>nd</sup> Degree, and Robbery 2<sup>nd</sup> Degree. Sullivan was arraigned on Murder, Murder 2<sup>nd</sup> Degree, Robbery 1<sup>st</sup> Degree, two counts of Burglary, three counts of Robbery 2<sup>nd</sup> Degree, Criminal Possession Weapon 2<sup>nd</sup> Degree, Burglary 2<sup>nd</sup> Degree, Robbery 3<sup>rd</sup> Degree, Burglary 3<sup>rd</sup> Degree, Criminal Possession Firearm, and Conspiracy 4<sup>th</sup> Degree. These charges were also abated by his death.
3. Sullivan had no reported chronic medical conditions. [REDACTED]  
[REDACTED]
4. On 2/8/22 at 5:40 p.m., Sullivan was received at the Eric M. Taylor Center. On the Suicide Prevention Screening Guidelines, Sullivan answered negative to all of the questions. A review of Sullivan's Arraignment and Classification Risk Screening form revealed that it was not completed by the receiving facility's supervisor. 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.*
5. [REDACTED]  
[REDACTED]

[REDACTED] py.

The Medical Review Board opines that Sullivan should have been referred to mental health and should have been placed on withdrawal monitoring or protocol.

6.

[REDACTED]

The Medical Review Board opines that Sullivan should have been on withdrawal monitoring and should have been scheduled for a follow-up.

7.

[REDACTED]

8.

[REDACTED]

9.

On 2/18/22, Sullivan was not seen for his [REDACTED] screen due to a court appearance.

10. [REDACTED]

11. [REDACTED]

12. On 2/26/22, Sullivan was not produced by DOC staff for his [REDACTED] screen.

13. [REDACTED]

14. On 3/4/22 and 3/8/22 at 12:11 a.m., Sullivan was not produced by DOC staff for his [REDACTED] screen.

15. [REDACTED]

16. [REDACTED]

17. [REDACTED]

18. [REDACTED]

19.

[REDACTED]

20. On 3/24/22, Sullivan called and requested sick call for constant aching pain and swelling to his knuckles and left ankle. Sullivan was not produced by DOC for sick call.

21.

[REDACTED]

The Medical Review Board finds it an unacceptable practice to discontinue a medical request for an incarcerated person due to the person not being produced by corrections staff on repeated occasions.

22.

[REDACTED]

23.

[REDACTED]

24.

[REDACTED]

25.

[REDACTED]

26.

[REDACTED]

27. [REDACTED]

28. [REDACTED]

29. [REDACTED]

30. [REDACTED]

31. [REDACTED]

32. [REDACTED]

The Medical Review Board opines that Sullivan had been prescribed a subtherapeutic level of Sertraline which should have titrated to a higher dose as part of the prescribed therapy for his depression disorder.

33. [REDACTED]

34. [REDACTED]

35. [REDACTED]

36. [REDACTED]

37. On 5/25/22, Sullivan was involved in a fight with a peer. [REDACTED] Per the reportable incident, this fight occurred on 5/24/22 at 12:45 p.m. The accident report signed by DOC and CHS staff

noted the incident occurred on 5/25/22. The inmate fight tracking logbook noted that the fight occurred on 5/26/22.

38.



39. Correction Officer (CO) T.L. documented in the 6 Upper South C logbook the following:

At 6:31 a.m., CO T.L. assumed the C post with 17 live breathing individuals.  
At 7:00 a.m., 7:30 a.m., and 8:00 a.m., a general supervision tour was completed and there was nothing unusual to report.  
At 8:20 a.m., Institutional lock out was afforded.  
At 8:30 a.m., an active supervision tour was completed with nothing unusual to report.

The Watch Tour Pipe was inoperable due to paint on the buttons on the wall. This was noted at 12:50 a.m. This was initially noted on 5/27/22 at 7:50 p.m. and a work order was submitted.

At 9:00 a.m., 9:30 a.m., and 10:00 a.m., an active supervision tour was completed with nothing unusual to report.  
At 10:03 a.m., the captain signed on the post.  
At 10:30 a.m., an active supervision tour was completed with nothing unusual to report.  
At 10:40 a.m., the food wagon was on post and at 10:50 a.m., the institutional feeding was in progress.  
At 11:00 a.m., an active supervision tour was completed with nothing unusual to report. There was a note that the cell doors were closed but the light remained red. There was no indication that a work order was submitted.  
At 11:25 a.m., the institutional feeding was completed and sanitation was in progress.  
At 11:30 a.m., 12:00 p.m., 12:30 p.m., 1:00 p.m., 1:30 p.m., an active supervision tour was completed with nothing unusual to report.  
At 1:36 p.m., the captain was on post.  
At 1:55 p.m., one individual was out for medications.  
At 2:00 p.m., an active supervision tour was completed with nothing unusual to report.  
At 2:06 p.m., an individual returned from medications.  
At 2:30 p.m., an active supervision tour was completed with nothing unusual to report.  
At 2:55 p.m. the institutional lock-in was in progress  
At 2:58 p.m., the lock n was completed and sanitation was in progress.  
At 3:00 p.m., 3:30 p.m., and 4:00 p.m., an active supervision tour was completed with nothing unusual to report.

40. A review of the Gentech video from 5/28/22 on unit 6 Upper South revealed:

At 1:05 p.m., CO T.L. walked on the housing unit but did not look into cell 22 (Sullivan's

cell). Another incarcerated individual hands something into cell 22 and was talking to Sullivan. Multiple incarcerated individuals are seen passing a water bottle around and drinking from the bottle.

At 1:10 p.m., multiple incarcerated individuals were around cell 22.

At 1:15 p.m. multiple incarcerated individuals enter the cell next to cell 22 which was Sullivan's cell.

At 1:28 p.m., CO T.L walked on the housing unit but did not look into cell 22.

At 1:34 p.m., two DOC staff walked on the housing unit but did not look into cell 22. One DOC staff removed two incarcerated individuals from cell 9.

At 1:43 p.m. the same two incarcerated individuals re-entered cell 9.

At 1:47 p.m. a third incarcerated individual entered cell 9.

At 2:07p.m., another incarcerated individual looks into cell 22.

At 2:15 p.m., CO T.L. glanced into cell 22.

At 2:17 p.m., an incarcerated individual was seen "talking" to Sullivan in cell 22. Another incarcerated individual looked into the cell. The first incarcerated individual removed a full meal tray from the cell through the feed up flap and gave that meal to another incarcerated individual.

At 2:25 p.m., the same incarcerated individual returned to cell 22 and was looking into the cell.

At 2:32 p.m., another incarcerated individual looked into cell 22.

At 2:35 p.m., multiple incarcerated individuals are at cell 22 and one closed the feed up flap.

At 2:51 p.m., another incarcerated individual looked into cell 22.

At 2: 53 p.m. CO T.L walked on the housing unit but did not look in cell 22.

At 3:00 p.m., incarcerated individuals began locking in their cells.

Between 3:28 p.m. and 3:43 p.m., an incarcerated individual was seen sweeping and mopping.

At 4:00 p.m., incarcerated individuals were coming out of cells.

At 4:02 p.m., another incarcerated individual entered cell 22 and exited calling for the officer. CO T.L. entered the cell and came out yelling down the housing unit for a medical emergency to be called.

At 4:04 p.m., CO T.L. re-entered cell 22 while other incarcerated individuals stood outside cell and others entered the cell.

At 4:07 p.m., additional DOC staff arrived at cell 22.

At 4:10 p.m., medical staff arrived at cell 22.

At 9:50 a.m. and 1:40 p.m., the Captain conducted a supervisory tour but did not look into cell 22.

41. A review of both the logbook and recorded video of 6 Upper South revealed that at 1:00 p.m. and 1:30 p.m., CO T.L. completed a supervisory tour but did not look into cell 22 during the tours. At 2:00 p.m. and 2:30 p.m., CO T.L. noted that a supervisory tour was completed however, a review of the video revealed that the supervisory tour was only completed at 2:15 p.m. At 3:00 p.m., CO T.L. documented and completed a supervisory tour but did not look in cell 22. CO T.L. documented completing supervisory tours at 3:30 p.m. and 4:00 p.m. however, no tours were completed as per the review of the video. The lack of completed proper supervisory tours and failure of the officers to look into the cells on the housing area is a violation of 9 NYCRR §7003.2(b) which states:  
*General supervision shall mean the availability to prisoners of facility staff responsible for the care and custody of such prisoners which shall include supervisory visits conducted at 30-minute intervals.*

and of 9 NYCRR §7003.2(c)(1)-(4) which states:

*Active supervision shall mean the immediate availability to prisoners of a 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.*

41. The body camera worn by CO T.L. showed her doing CPR and calling out for Urgi Care to be called. On the body cam, someone can be heard saying that Sullivan was foaming at the mouth. CO T.L. repeatedly stated that Sullivan got his food but was locked in all day.
42. Per the NYC DOC closing report, CO T.L. was charged for inefficiently performing her duties and making false logbook entries.

ACTIONS REQUIRED:

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

1. The Commissioner shall conduct an investigation into the staff assigned to supervise Sullivan and take administrative action if found to be in violation of department directives.
2. The Commissioner shall note the findings of the Commission's report as official notice that facility staff were found to be repeatedly out of compliance with basic fundamental security and supervision standards including:  
9 NYCRR §7003.2(b) General supervision.  
9 NYCRR §7003.2(c)(1)-(4) Active supervision.
3. The Commissioner shall review the incident of 5/25/22 involving Sullivan and ensure that an accurate Reportable Incident is completed.
4. The Commissioner shall conduct an investigation into the staff that failed to properly complete the Classification of Sullivan in comportment with 9 NYCRR §7013.7(a) and 9 NYCRR §7013.7(b)(11). 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 the Medical Review Board upon completion.

*In a response dated 12/3/24 to the Commission's preliminary report, NYC DOC indicated that administrative action was taken regarding the cited staff and a revised reportable incident was submitted. The cited minimum standard compliance issues will be forwarded to the Commission for further review at a later scheduled facility evaluation.*

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

Correctional Health Services shall conduct a quality assurance review to determine why Sullivan was not referred to mental health on his admission and why monitoring for withdrawal and follow-up were not ordered.

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

*In a response dated 11/14/24 to the Commission's preliminary report, Correctional Health Services acknowledged the Board's findings and indicated the requested reviews with corrective actions were completed.*

TO THE OFFICE OF THE NYC COUNCIL SPEAKER:

As the appointing authority for the delivery of correctional health services pursuant to Correction Law section 501, the City Council shall review the above findings and conduct an inquiry into the fitness of the currently designated provider.

WITNESS, HONORABLE YOLANDA CANTY, 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 18<sup>th</sup> day of December 2024.



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Yolanda Canty  
Commissioner  
Commission of Correction

YC:DC:vc  
2022-M-0061  
December 18, 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  
Correctional Health Services  
Chief Medical Officer  
Correctional Health Services  
Executive Director  
NYC Board of Correction