



**Commission of
Correction**

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

In the Matter of the Death of

**Marvin Pines,
an incarcerated individual of the
North Infirmery Command**

March 26, 2025

**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

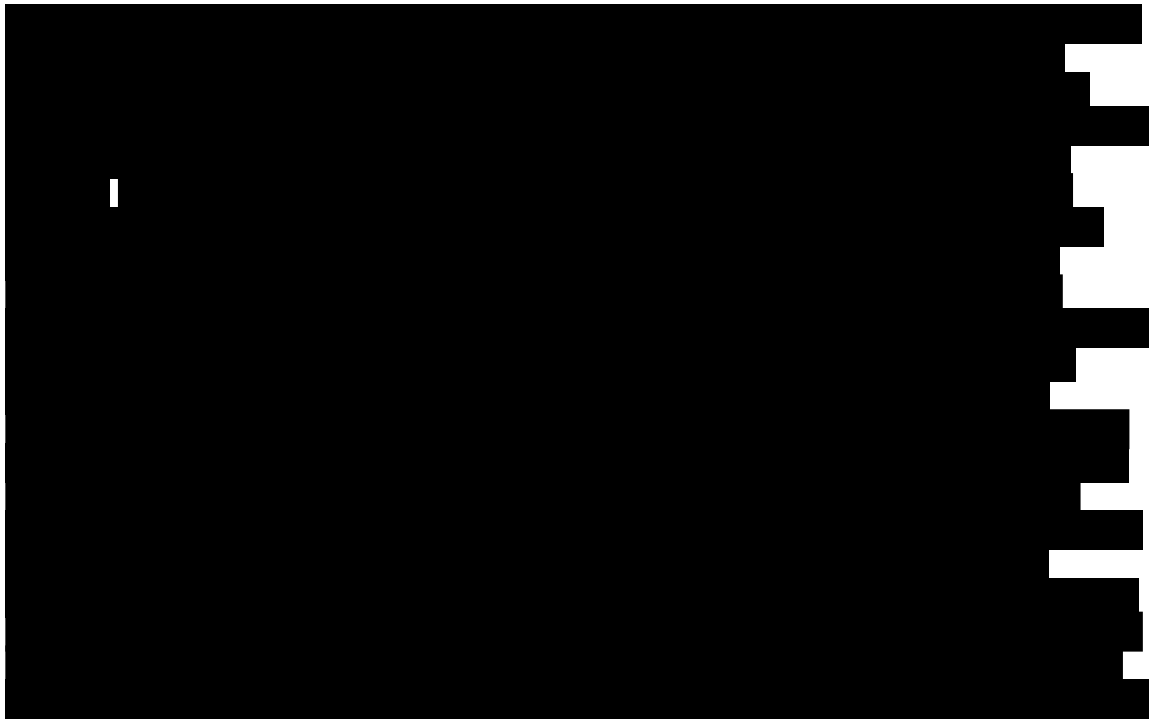
GREETINGS:

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 Marvin Pines, who died on February 4, 2023, 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. Marvin Pines was a 65-year-old male who died on 2/4/23 from a Seizure Disorder of unknown etiology while in the custody of the New York City Department of Corrections (NYC DOC) at the North Infirmity Command (NIC). The Medical Review Board has found that supervision by NYC DOC staff was not in compliance with minimum standards and that there were failures by Correctional Health Services (CHS) to perform the required assessments and follow-ups on Pines.

2.



On two occasions in March 2022, Pines was arrested for CSCS 3rd Degree and Reckless Endangerment 1st Degree. In November 2022, Pines was convicted of CSCS 3rd Degree and CPCS 3rd Degree and was awaiting sentencing. Pines' conviction was vacated, and the charges were abated by his death. In May 2022, Pines was arraigned on charges of CSCS 3rd Degree and CPCS 3rd Degree. In November 2022, Pines was convicted of CSCS 3rd Degree and CPCS 3rd Degree and was awaiting sentencing. The conviction was vacated, and the charges were abated by his death. In July 2022, Pines was arraigned on a charge of CPCS 3rd Degree. In November 2022, Pines was convicted of CPCS 3rd Degree and was awaiting sentencing. This charge was abated by his death.

3. On 8/3/22 at 12:38 p.m., Pines was received in NYC DOC at the Eric M. Taylor Center (EMTC). Pines charges were listed as three counts of CPCS 3rd Degree.

4. [REDACTED]

5. [REDACTED]

6. [REDACTED]

7. [REDACTED]

8. [REDACTED]

9. On 8/7/22 at 10:57 a.m., Pines was not produced by DOC staff [REDACTED].
[REDACTED]

10. On 8/8/22, Pines was not produced by DOC staff [REDACTED].

11. [REDACTED]

12. On 8/10/22, Pines was not produced by DOC staff [REDACTED].

13. [REDACTED]

[REDACTED]

14.

[REDACTED]

15.

[REDACTED]

16.

[REDACTED]

17.

[REDACTED]

- 18. [REDACTED]
- 19. [REDACTED]
- 20. [REDACTED]
- 21. [REDACTED]
- 22. [REDACTED]
- 23. [REDACTED]
- 24. [REDACTED]
- 25. [REDACTED]
- 26. [REDACTED]
- 27. [REDACTED]

28. On 8/29/22, Pines was admitted to North Infirmery Command. [REDACTED]

29. [REDACTED]

30. [REDACTED]

31. [REDACTED]

32. [REDACTED]

33. [REDACTED]

34. [REDACTED]

35. [REDACTED]

36. [REDACTED]

37. [REDACTED]

38. On 9/14/22, [REDACTED]. Pines was not produced by DOC staff [REDACTED]

39. [REDACTED]

40. [REDACTED]

41. [REDACTED]

42. [REDACTED]

43. [REDACTED]

44. [REDACTED]

45. [REDACTED]

46. [REDACTED]

47. [REDACTED]

48. [REDACTED]

49. [REDACTED]

50. [REDACTED]

51. [REDACTED]

52. [REDACTED]

53. [REDACTED]

54. [REDACTED]

55. [REDACTED]

56. [REDACTED]

57. On 10/24/22, Pines was not produced by DOC staff [REDACTED].

58. On 10/25/22, Pines was not produced by DOC staff [REDACTED]
[REDACTED]

59. [REDACTED]

60. [REDACTED]

61. [REDACTED]

62. [REDACTED]

63. [REDACTED]

64. [REDACTED]

65. [REDACTED]

66. [REDACTED]

67. [REDACTED]

68. [REDACTED]

69. [REDACTED]

70. [REDACTED]

71. On 12/28/22 at 3:43 p.m., Pines was not produced by DOC staff [REDACTED]

72. [REDACTED]

73. On 1/4/23 and 1/6/23, Pines was not produced by DOC staff [REDACTED].

74. [REDACTED]

75. [REDACTED]

76. [REDACTED]

77. [REDACTED]. The Medical Review Board opines that this diagnostic finding would not have been detectable on a standard CT of the brain but would have been identifiable had an MRI been ordered. The Board opines that Pines' unresolved neurologic complaints warranted further study by an MRI which could have identified his underlying condition.

78. [REDACTED]

79. [REDACTED]

80. [REDACTED]

81. On 2/4/23 at 5:15 a.m., a medical emergency was called for Pines. Pines was found on the floor, lying on his left side, breathing heavily and he was lethargic. As per the DOC officer, Pines had been given two Nasal Narcan without the desired effect. [REDACTED]

. DOC staff were asked to call Urgicare and to activate EMS at 5:25 a.m.

EMS was activated at 5:47 a.m. EMS arrived in the clinic at 6:00 am.

The Medical Review Board has found per a review of Pines' medical record that there was a 22 minute delay in activating EMS to his medical emergency.

82. A Review of the Gentech video footage of Pines' housing area revealed:

On 2/3/23 at 9:32 p.m., CO N.H. left the housing area and went to the A station.

From 10:00 p.m. until 11:30 p.m., there was no officer on the housing area.

At 11:38 p.m., CO T. left the area and CO A.A. assumed the A post. CO N.H. remained in the A station.

At 11:59 p.m., Pines went to the bathroom, exited and returned to his bunk at 12:03 a.m.

At 12:12 a.m., Captain J.F. and CO N.H. completed a supervisory tour on the housing area and exited the housing area.

At 12:30 a.m., there was no officer on post. CO E.P. had assumed the post from CO N.H. CO E.P. and CO A.A. were in the A station.

At 1:00 a.m., there was no officer on post.

At 1:48 a.m., Pines went to the bathroom and returned to his bunk at 2:12 a.m.

At 1:55 a.m., Captain J.F. entered the A station and did not complete a supervisory tour of the housing area.

At 2:00 a.m., CO E.P. left building 6 without touring 6 south.

At 3:17 a.m., CO N.H. assumed the A post. CO A.A. assumed the B post, entered the housing area and completed a supervisory tour.

At 3:43 a.m., CO A.A. completed a supervisory tour.

At 4:12 a.m., Pines went to the shower area.

At 5:02 a.m., CO A.A. completed a supervisory tour but did not go into bathroom. CO A.A. then left the post. Another incarcerated individual (II) entered the bathroom and left the bathroom at 5:08 a.m.

At 5:12 a.m., CO A.A. returned to post and another II entered the bathroom and exited the bathroom.

At 5:17 a.m., another II entered the bathroom. CO A.A. quickly walked to the bathroom area. CO A.A. motioned to the A station. Two other II's walked to the shower area.

At 5:19 a.m., another II walked to the shower and CO A.A. was standing by.

At 5:21 a.m., CO A.A. was looking toward Pines then walked away and returned.

At 5:23 a.m., medical staff arrived.

At 5:30 a.m., medical staff moved Pines to a stretcher, left the housing area and brought Pines to the 6th floor clinic and began care.

The lack of completed proper supervisory tours and the failure of the officers to conduct a personal observation of each incarcerated individual in the housing area is a violation 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.

In response to an internal review of this incident, NYC DOC administration issued five Memorandum of Complaints (MOC) for ADW S., ADW G., Captain F., CO A.A. and CO P as follows:

To ADW S, the reasons were not stated.

To ADW G. for failing to conduct tours and failing to assure the supervisor conducted tours.

To Captain F for failing to conduct tours of inspections, failing to enter the housing area, and making a false entry that he completed a supervisory tour.

To CO A.A. for not conducting irregular tours of the housing area including the bathroom.

To CO P. for not conducting irregular tours and for signing off post without being properly relieved.

83. An autopsy report completed by the NYC Medical Examiners Office concluded that



ACTIONS REQUIRED:

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

1. Correctional Health Services shall conduct a quality assurance review regarding why the medical provider was not notified of Pines' return with elevated blood pressure on 8/12/22 and why there was not a follow-up appointment scheduled.
2. Correctional Health Services shall conduct a quality assurance review regarding why Pines was not referred to a medical provider from 8/25/22 through 8/30/22 for uncontrolled blood pressure.
3. Correctional Health Services shall conduct a quality assurance review regarding why Pines' 10/5/22 urine toxicology that was positive for Methamphetamines and negative for Methadone was not addressed.
4. Correctional Health Services shall conduct a quality assurance review regarding the treatment and monitoring of Pines' blood pressure.
5. Correctional Health Services shall co-coordinate a quality assurance review with the attending Neurologist as to why an MRI for Pines was not considered.
6. Correctional Health Services shall conduct a quality assurance review regarding the delay in activating EMS.

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

completion.

In a response dated 1/31/25 to the Commission's preliminary report, Correctional Health Services indicated that the requested quality assurance reviews were completed but disagreed with the Medical Review Board's findings. The Medical Review Board remains opined that there was inadequate monitoring and follow up of Pines' blood pressure and should have been referred for an MRI of his brain. The Commission will follow up on the quality assurance reviews at a health services evaluation at a later scheduled date.

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

1. 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 minimum standards for security and supervision standards including: 9 NYCRR §7003.2(c)(1)-(4) Active supervision.
2. The Commissioner shall conduct a review of the incident investigation to ascertain why an inventory of medications confiscated from Pines' property was not completed.

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

In a response dated 2/18/25 to the Commission's preliminary report NYC DOC indicated that corrective actions were taken including, hiring of new correction officer staff, redeployment of existing staff, and monitoring of sick leave use. The Special Investigation Unit going forward will be required to catalogue any medications found at a scene of deceased individual.

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 26th day of March 2025.



Yolanda Canty
Commissioner
Commission of Correction

YC:DC:vc
2023-M-0013
March 26, 2025

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