



**Commission of  
Correction**

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

**In the Matter of the Death of**

**Rubu Zhao,  
an incarcerated individual of the  
George R. Vierno Center**

**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 Rubu Zhao, who died on May 16, 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. Rubu Zhao was a 52-year-old male who died on 5/16/23 from blunt force trauma to his head due to a suicidal fall down a stairwell that occurred on 5/14/23 while in the custody of the New York City Department of Correction (NYC DOC) at the George R. Vierno Center (GRVC). The Medical Review Board has found that there were inadequacies in the psychiatric and mental health care provided to Zhao by Correctional Health Services (CHS) providers.
2. On 12/13/22, Zhao was arrested for Murder and Criminal Possession of a Weapon 4<sup>th</sup> Degree and remanded without bail. Zhao reportedly stabbed his girlfriend to death after a verbal argument. This was Zhao's first criminal contact.
3. Zhao had no chronic medical conditions and was not prescribed any medications. Zhao had no history of mental health treatment in the community.
4. On 12/14/22, Zhao had a Suicide Prevention Screening Guideline completed at DOC admission and answered 'no' to all questions except that this was his first incarceration. The officer comment noted that a 730 exam was ordered by the arraignment court part. A review of Zhao's documentation by Commission staff revealed that the Arraignment and Classification Risk Screening Form was not completed by the receiving supervisor. This is 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 is 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. On 12/15/22, Zhao was received in the Eric M. Taylor Center (EMTC). 

6.

[REDACTED]

7.

On 12/16/22, Zhao was at court [REDACTED].

8.

[REDACTED]

9.

[REDACTED]

10.

[REDACTED]

[REDACTED]

11. On 1/9/23, Zhao was [REDACTED] at court.

12. [REDACTED]

13. [REDACTED]

14. On 1/12/23, 1/16/23, 1/17/23, and 1/18/23, Zhao was not produced [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.

[REDACTED]

29.

[REDACTED]

30.

[REDACTED]

31.

[REDACTED]

32.

[REDACTED]

33.

[REDACTED]

34.

[REDACTED]

35.

[REDACTED]

36.

[REDACTED]

37.

[REDACTED]

38.

[REDACTED]

39. [REDACTED]

The Medical Review Board opines that Zhao's diagnosis of Adjustment Disorder with Mixed Anxiety and Depressed Mood was clinically incorrect as it fails to capture the psychotic nature of his condition. Given Zhao's prominence of psychotic and paranoid thoughts, a form of Psychotic Disorder should have remained in Zhao's primary diagnosis.

40. On 5/9/23, Zhao was not produced by DOC staff for his [REDACTED] appointment.

41. On 5/14/23 at 2:20 p.m. as recorded on housing area video, Zhao threw himself down a stairwell. Zhao was found on the ground level in front of the stairs next to the DOC control room. [REDACTED]

[REDACTED] . DOC officers responded and called for an immediate medical emergency. [REDACTED]

[REDACTED] , a note was found in Zhao's pocket written in Chinese. [REDACTED]

[REDACTED] . EMS arrived at 3:00 p.m. [REDACTED]

42. [REDACTED]

43. [REDACTED] .

ACTIONS REQUIRED:

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

The Commissioner shall conduct an investigation into the staff that failed to properly complete the Classification of Zhao 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 Board upon completion.

*In a response dated 2/18/25 to the Commission's preliminary report NYC DOC indicated that corrective action training was completed with staff to assure compliance with the cited minimum standard. Commission staff will verify the corrective actions taken during 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 with NPP O.A. regarding diagnostic criteria for psychotic disorders and making changes with patient diagnoses.

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 a quality assurance review was completed and that no corrective action was needed as the psychiatric NP was conducting a medication re-evaluation and a medication re-evaluation note does not determine the status of disorders. The Medical Review Board disagrees with this position and opines that any psychiatric encounter should have an accurate diagnosis established for a patient and the diagnosis provided to Zhao by the cited NPP on 5/8/23 was not clinically correct and requires further review.*

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 26<sup>th</sup> day of March 2025.



Yolanda Canty  
Commissioner  
Commission of Correction

YC:DC:vc  
2023-M-0054  
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