



**Commission of
Correction**

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

In the Matter of the Death of

**Michael Lopez,
an incarcerated individual of the
Anna M. Kross Center**

June 25, 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

[REDACTED]

6.

[REDACTED] Lopez was released from NYC DOC on 12/9/21. [REDACTED]

7.

[REDACTED]

8.

[REDACTED]

9.

[REDACTED]

10.

[REDACTED]

[REDACTED]

11. [REDACTED]

12. [REDACTED]

13. [REDACTED]

14. [REDACTED]

15. [REDACTED]

16. On 6/4/22 at 3:06 p.m. and at 10:58 p.m., Lopez was not produced by DOC staff for a [REDACTED]

17. [REDACTED]

[REDACTED]

18. [REDACTED]

19. On 6/12/22 at 3:21 p.m. and at 9:12 p.m., Lopez was not produced by DOC staff for his [REDACTED]

20. [REDACTED]

21. [REDACTED]

22. On 6/19/22, 6/22/22, and on 6/23/22 at 2:38 p.m. and 9:55 p.m., Lopez was not produced by DOC staff for his [REDACTED]

23. [REDACTED]

24. [REDACTED]

25. On 6/24/22., [REDACTED] Lopez was not produced by DOC staff for his [REDACTED]

26. On 6/26/22, Lopez was not produced by DOC staff for his [REDACTED]

27. [REDACTED]

35. [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
36. [REDACTED]
[REDACTED] On 7/14/22 at 4:52 p.m., Lopez was not produced by DOC staff for [REDACTED]
37. Per the NYC DOC Callout Report and Checklist, a review of the Gentech video footage revealed that on 7/14/22 from 7:39 p.m. until 8:16 p.m., Lopez was observed doing drugs on Mod 9B. No further descriptive information was available to the Commission regarding what was observed or where the assigned housing area officers were at the time.
38. On 7/15/22 at 9:15 a.m., pharmacy staff started administering medications on MOD 9B. [REDACTED] Corrections Officer (CO) V.A. was conducting a supervisory tour and noted that Lopez was unresponsive on his bunk. A medical response was activated. CO A. and CO G. initiated Cardiopulmonary Resuscitation (CPR). At 9:34 a.m., medical staff arrived on the housing unit [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] Dr. [REDACTED], Dr. [REDACTED], and Dr. [REDACTED] arrived. [REDACTED]
[REDACTED]
[REDACTED] Urgicare Dr. [REDACTED] arrived at 9:48 a.m. [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
39. Per the NYC DOC closing report, multiple loose pills were found under Lopez's mattress to include Haldol, Benztropine, and one unidentified pill.
40. [REDACTED]
41. A review of the 7/15/22 Gentech video by Commission staff revealed:
At 12:00 a.m., CO M. was on the post and no tour was conducted.
At 12:21 a.m., CO M. looked in the bathroom.
At 12:22 a.m., Captain L. and CO M. conducted a tour.
At 12:32 a.m., CO M. rested his head against the wall sitting in the officer's chair.
At 1:55 a.m., CO M. conducted a tour.
At 2:17 a.m., CO M. conducted a tour. Captain L. signed the officer's book and exited the housing area without making a supervisory tour.
At 4:45 a.m., Assistant Deputy Warden M. conducted a tour with CO M.
At 5:00 a.m., feeding began.

At 5:08 a.m., CO M. conducted a tour.
 At 6:29 a.m., CO R. conducted a tour and an institutional count.
 At 6:33 a.m., Captain L. signed the officer's book and did not complete a supervisory tour.
 At 6:35 a.m., CO M. conducted a tour.
 At 6:45 a.m., CO M. exited the housing area.
 At 6:56 a.m., CO P. entered the housing area and left with another individual.
 At 7:03 a.m., CO R. entered the housing area and conducted a tour.
 At 7:25 a.m., CO R. left the housing area and returned at 7:42 a.m. to retrieve the logbook and left the housing area.
 At 8:33 a.m., CO A. entered the housing area.
 At 8:43 a.m., CO A. conducted a tour.
 At 9:18 a.m., Lopez's body made a quick motion every 20 seconds for several minutes.
 At 9:23 a.m., CO G. entered the housing area with medications. Lopez remained in bed.
 At 9:24 a.m., Lopez's upper body moved.
 At 9:27 a.m., CO A. attempted to wake individuals for medications.
 At 9:28 a.m., CO A. attempted to wake Lopez without success and signaled for CO G. to respond. CO G. was unable to wake Lopez.
 At 9:30 a.m., CO G. ran to A post and advised of the medical emergency.
 At 9:35 a.m., CO G. and CO A. moved Lopez to the floor and started chest compressions. The compressions were intermittent and were stopped and started repeatedly in an inconsistent pattern.
 At 9:38 a.m., medical arrived.

CO M. noted that he completed supervisory tours every 30 minutes from 11:30 p.m. until 1:30 a.m., and then every 30 minutes from 2:30 a.m. until 6:00 a.m. which was false. CO M. was observed to be unalert while on post from 3:00 a.m. until 4:30 a.m. The lack of completed proper supervisory tours and the 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.

42. Per the NYC DOC closing report, CO S. and CO M. had an unobstructed view of the housing area and failed to stop individuals from smoking.

43. Captain L. made false logbook entries at 2:20 a.m. and 6:35 a.m. As per the video review, no tours were completed.
44. Training records revealed that CO V.A. received CPR training on 6/28/18, 6/9/21, and 7/22/22. CO A.G. received CPR training on 5/22/17. This is a violation of 9 NYCRR §7010.2(f) which states that *facility personnel shall receive training and maintain certification in approved first aid and emergency life saving techniques including the use of emergency equipment.*
45. Based upon the NYC DOC closing report and actions of CO M., CO S. and Captain L. were found to be in violation of Departmental Rules and Regulation. A Memorandum of Complaint was generated recommending formal disciplinary charges.

ACTIONS REQUIRED:

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

1. The Commissioner shall conduct an investigation into the staff that failed to properly complete the Classification of Lopez 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.
2. The Commissioner shall verify that all staff are properly trained in CPR in accordance with the requirements of 9 NYCRR §7010.2(f).

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

In a response dated 6/17/25, NYC DOC indicated the following corrective actions taken:

-Facility memorandums were issued to staff regarding the proper completion and processing of the Arraignment and Classification Risk Screening Form.

-The Correction Academy has been working with the Administration Division to schedule training deficient staff for a full week of refresher training that includes CPR.

These corrective actions will be subject to review by the Commission at a later scheduled facility evaluation.

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 June 2025.



Yolanda Canty
Commissioner
Commission of Correction

YC:DC:vc
2022-M-0079
June 25, 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