



**Commission of  
Correction**

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

**In the Matter of the Death of**

**Elijah Muhammad,  
an incarcerated individual of the  
George R. Vierno 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*



*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]

6. [REDACTED]

7. On 6/14/22, Muhammad was not produced by DOC staff [REDACTED] [REDACTED] [REDACTED] Per the preliminary investigation report, Muhammad was at court. A review of the movement record for Muhammad by Commission staff, however, did not indicate that Muhammad was at court.

8. [REDACTED]

[REDACTED]

9. [REDACTED]

10. [REDACTED]

11. [REDACTED]

12. [REDACTED]

[REDACTED] The Medical Review Board questions the accuracy of Muhammad's psychiatric diagnosis. As Muhammad had an established history of schizophrenia, a diagnosis of inclusiveness, the Board questions why this major Axis I was not included.

13. [REDACTED]

14. [REDACTED]

15. [REDACTED]

16. [REDACTED]

17. On 6/22/22, Muhammad was transferred to GRVC. [REDACTED]

18. [REDACTED]

19. On 6/23/22, [REDACTED] Muhammad was not produced by DOC staff [REDACTED]

20. On 6/23/22 and 6/24/22, Muhammad not produced by DOC staff [REDACTED]

21. [REDACTED] The Medical Review Board opines that Muhammad should have been referred to KEEP sooner than 12 days after his admission. Additionally, the Board questions why Muhammad was placed on a Methadone taper without receiving a full assessment for opioid use disorder and also questions why management with suboxone was not considered.

22. On 6/26/22, Muhammad was not produced [REDACTED]

23. [REDACTED]

24. On 6/30/22, Muhammad was not produced by DOC staff [REDACTED]

25. On 6/30/22, [REDACTED] Muhammad was not produced by DOC staff [REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]

26. [REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]

27. On 7/1/22 at 12:08 p.m., [REDACTED] Muhammad was not produced by DOC staff [REDACTED]  
[REDACTED] During an interview with Commission staff, RN [REDACTED] stated that if the medication was not administered, a missed visit note must be entered and then the individual is rescheduled to the following tour and that the medication would have been given then. [REDACTED]  
[REDACTED]

28. [REDACTED]  
[REDACTED]  
[REDACTED]

29. [REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]

30. On 7/2/22 at 11:56 a.m., Muhammad was not produced by DOC staff [REDACTED] [REDACTED]  
[REDACTED] Per the [REDACTED] DOC escort record, house 5B was in locked-in status. [REDACTED]  
[REDACTED]  
[REDACTED]

31. On 7/3/22, Muhammad was not produced by DOC staff [REDACTED] [REDACTED]

32. On 7/5/22, Muhammad was not produced by DOC staff [REDACTED] [REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]

33. [REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]

[REDACTED]

34. [REDACTED]

35. [REDACTED]

36. On 7/7/22, Muhammad was not produced by DOC staff [REDACTED] [REDACTED] DOC noted that Muhammad refused the appointment.

37. On 7/7/22, [REDACTED] Muhammad was not produced by DOC staff [REDACTED] [REDACTED]  
[REDACTED]  
[REDACTED]

38. [REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]

39. On 7/9/22 at 12:53 p.m., Muhammad was not produced by DOC staff [REDACTED] [REDACTED]  
[REDACTED] Per the preliminary investigation report, Muhammad refused the appointment.  
At 11:24 p.m., an emergency was called for Muhammad [REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]

40. On 7/10/22, Corrections Officer (CO) E.L. was attempting to lock other incarcerated individuals in their cells as the individuals were manipulating the locks and exiting their cells. CO E.L. contacted the control room for assistance. At 9:46 p.m., CO E.L. noted that Muhammad had minimal movement. A medical response was called. [REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED] Urgicare Dr. A.L. arrived [REDACTED]  
[REDACTED] EMS arrived at 10:20 p.m. [REDACTED]  
[REDACTED] CO K.L. noted there was no AED on post and that the CPR mask was "compromised/used."

41. Per Captain J.P.'s statement, housing areas 3A and 5B were on lock down due to prior incidents on the housing area. It was discovered that many incarcerated individuals did not get their medications and medical reported that there was only one escort available. Captain J.P. escorted three individuals to the clinic and at 9:46 p.m., a medical response was heard. Captain J.P. responded and noted that CO L. was performing chest compressions on Muhammad. Captain J.P. administered Narcan. Medical arrived and during this event, another incarcerated individual in cell 22 was unresponsive. Assistance was called to assist with locking in the individuals in the housing unit. Additional EMS responded and went to cell 22.
42. Per the NYC DOC Investigation Division's closing report, the search of Muhammad's cell revealed:
  - Two rolled up pieces of paper with burn marks and an unknown substance inside the paper.
  - One piece of paper folded with an unknown white powdery substance.
  - One bag with an unknown green leafy substance.
  - One book soaked with an unknown substance.Per NYC DOC, the substances were sent for testing but testing was not completed.
43. A review of the GRVC 5B housing logbook noted that CO E.L. noted that active supervision tours were completed every 30 minutes from 1:00 p.m. until 6:30 p.m. CO E.L. noted that general supervision tours were completed every 30 minutes from 7:00 p.m. until 9:30 p.m. with nothing unusual to report. Per the logbook, the captain was on the unit at 6:40 p.m. and 7:30 p.m.
44. A Review of the Gentech video footage of the housing area on 7/10/22 revealed that Muhammad was using unauthorized substances and that there were multiple exchanges of unknown substances between Muhammad and other incarcerated individuals throughout the day. At approximately 3:00 p.m., Muhammad began to stumble and move in slow motion. Muhammad had his eyes closed and started to fall into the wall adjacent to his cell. CO E.L. opened Muhammad's cell while other incarcerated individuals assisted Muhammad into his cell. CO E.L. failed to address the obvious changes in Muhammad's behavior.
  - At 3:12 p.m., 3:18 p.m., and 3:20 p.m., CO E.L. looked into Muhammad's cell and opened the door.
  - At 3:21 p.m., CO E.L. completed a supervisory tour.
  - At 3:31 p.m., CO E.L. entered Muhammad's cell briefly.
  - At 3:40 p.m., two incarcerated individuals went to Muhammad's cell door and looked in.
  - At 3:43 p.m. and 3:55 p.m., CO E.L. checked on Muhammad.
  - At 4:07 p.m., four incarcerated individuals went in and out of Muhammad's cell.
  - At 4:12 p.m., there was a fight on the housing unit and an individual using crutches could be seen hitting another individual with the crutch. After the fight ended, the incarcerated individual with the crutches can be seen using one crutch and carrying the broken crutch around with the broken pieces of wood in his hands.
  - At 4:37 p.m., another incarcerated individual went to check Muhammad.
  - At 4:53 p.m., CO E.L. checked on Muhammad and two other incarcerated individuals entered Muhammad's cell for approximately four minutes.
  - At 5:02 p.m., another incarcerated individual looked into Muhammad's cell.
  - At 5:13 p.m., CO E.L. looked in Muhammad's cell and opened the door and another incarcerated individual entered the cell and CO E.L. walked away.

At 5:28 p.m. the Emergency Response Team (ERT) arrived, and all of the individuals were locked-in and one individual was sprayed with Oleoresin Capsicum.

The Medical Review Board finds that there was an unacceptable delay of approximately one hour and 16 minutes in the ERT response.

At 6:00 p.m., all individuals were locked in. The incarcerated individual workers were allowed out and at 6:35 p.m. and 6:54 p.m., an incarcerated individual looked into Muhammad's cell.

At 7:31 pm. some individuals were passing meal trays.

At 7:58 p.m., CO E.L. was assisting with meals.

At 8:23 p.m., an incarcerated individual was seen banging on Muhammad's cell door while delivering trays. Muhammad was never given a meal tray.

At 8:38 p.m., 8:45 pm., 9:11 p.m., and 9:20 p.m., other incarcerated individuals are seen banging on Muhammad's cell door.

From 3:21 p.m. until 9:20 p.m., CO E.L. was not observed making any supervisory tours. There was no documentation in the logbook to indicate that the fight that occurred or any mention of the ERT response. This is a violation of 9 NYCRR §7003.3(j)(6), Supervision of Prisoner in Facility Housing Areas, which states that all written records pertaining to facility housing supervision shall be recorded in a bound ledger and shall include any significant events and activities occurring during supervision, including:

- (i) the date and time of such event or problem;
- (ii) the names of all prisoners and/or staff involved;
- (iii) facility staff response to such event or problem, including a summary of what occurred;
- (iv) a description of the condition of any prisoners involved

Per the NYC DOC closing report, CO E.L. was noted to be in the control post for an extended period of time and failed to conduct adequate supervisory tours or notify medical or a supervisor of Muhammad's change in behavior. On 7/11/22, CO E.L. was terminated from duty due to failing to perform his duties during this incident which resulted in him not passing the two-year probation timeframe. CO C. was assigned to the control post and had full visual access to the housing area. CO C. failed to intervene when the substance use occurred and the exchanges were made between incarcerated individuals. CO C. also allowed CO E.L. to remain in the control post for extended periods. CO C. received a Memorandum of Complaint (MOC) for inefficient performance of duties.

45. [REDACTED]

46. [REDACTED]

ACTIONS REQUIRED:TO THE COMMISSIONER OF THE NEW YORK CITY DEPARTMENT OF CORRECTIONS:

1. The Commissioner shall conduct an investigation into the staff that failed to properly complete the Classification of Muhammed 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 conduct an investigation into why the preliminary investigation noted that Muhammad was at court on 6/14/22 and Muhammed's movement record did not indicate that he was at court on this date.
3. The Commissioner shall conduct an investigation into why the CPR mask was "compromised." The Commissioner shall assure that all housing areas have access to emergency medical equipment.
4. The Commissioner shall assure that all staff are in compliance and follow the requirements of 9 NYCRR §7003.3.
5. The Commissioner shall review the SERT response to the incident on 7/10/22 to determine why the response was delayed.

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 were taken:*

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

*-The discrepancy of Muhammad's court appearance and facility movement was attributed to a clerical error.*

*-The Office of Policy Compliance will be developing facility memorandums to be issued regarding the issuance of disposable CPR masks and the use location of AED's.*

*- The GRVC administration issued a memorandum to staff regarding compliance with NYC DOC Directive 4514R Housing Area Logbooks and the requirement(s) to document significant events.*

*-The Office of Policy Compliance is conducting a review of the amount of time it took for SERT to respond to the fight incident on 7/10/22.*

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

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

1. Correctional Health Services shall conduct a quality assurance review to determine why Muhammad's reported [REDACTED] status was not addressed with testing or follow-up.
2. Correctional Health Services shall conduct a quality assurance review to determine why nursing staff documented that Muhammad was not produced for his Methadone and the

medication administration record noted that the medication was given.

3. Correctional Health Services shall develop an action plan in conjunction with NYC DOC to assure that individuals prescribed Methadone are produced and given their medication as prescribed.
4. Correctional Health Services shall conduct a quality assurance review regarding Muhammad's psychiatric diagnosis and treatment as to why his known established diagnosis of schizophrenia was not continued.
5. Correctional Health Services shall conduct a quality assurance review to determine why Muhammad was not referred to KEEP until 12 days after his admission and why Muhammad was not seen by KEEP. Additionally the Board requests a review of Muhammad's opioid use disorder management as to whether he was fully assessed to have opioid use disorder, why he was ordered a Methadone taper, and was suboxone considered as a treatment option.

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

*In a response dated 5/14/25 to the Commission's preliminary report, Correctional Health Services indicated the requested reviews were conducted and corrective actions were taken. The Commission will review the corrective actions taken at a later scheduled health services evaluation.*

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 25<sup>th</sup> day of June 2025.



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Yolanda Canty  
Commissioner  
Commission of Correction

YC:DC:vc  
2022-M-0078  
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