Final Report of the New York State Commission of Correction:

In the Matter of the Death of

Michael Nieves, 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

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 Michael Nieves, who died on August 30, 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. Michael Nieves was a 40-year-old male who died on 8/30/22 from an incised wound of the neck while in the custody of the New York City Department of Correction (NYC DOC) at the Anna M. Kross Center (AMKC). The Medical Review Board has found that Correctional Health Services (CHS) failed to recognize Nieves' profound psychiatric decomposition and failed to refer him for forensic hospitalization which eventually led to his suicide. The Board found that the NYC DOC staff failed to protect Nieves from self-harm and failed to institute constant supervision when the razor issued to him was not returned or located. Additionally, the Board found that NYC DOC failed to intercede and respond timely when Nieves was fatally hemorrhaging from a self-inflicted wound. The Board opines that had Nieves been properly forensically hospitalized and had proper intervention, his death could have been prevented.

2. On 4/9/19, Nieves was charged with Burglary, Arson 2nd Degree, Reckless Endangerment 1st Degree, and Unlawful Imprisonment 1st Degree. On 10/24/22, Nieves's charges of Burglary 1st and 2nd Degrees, Arson 2nd Degree, Reckless Endangerment 1st Degree, and Unlawful Imprisonment 1st Degree were abated by his death. Nieves's charges remained unadjudicated through 2022

3. Nieves was returned to NYC DOC on 6/8/22.

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5. On 6/8/22, Nieves's Arraignment and Classification Risk Screening form was not completed by the receiving facility or the receiving facility supervisor. Correction Officer (CO) J. completed the Suicide Prevention Screening Guidelines, and all responses were "no" except to having support in the community. CO J. failed to note that Nieves had a history of There was no indication on the form that Nieves . 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)(4) & (11) which states:
   A screening instrument(s) shall be utilized to elicit and record information on each inmate relating to the following:
   (4) history of mental illness or treatment
   (11) any other relevant information concerning the safety or welfare of the inmate.

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8. Nieves was to be housed in AMKC Mod 1Upper A.

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11. There was no documentation provided which indicated that a supervisor was notified that Nieves did not have an officer assigned to him to provide the required constant supervision nor was there any action taken to protect Nieves from self-harm with no ESO assigned. The lack

of an officer assigned to Nieves's suicide watch was a violation of 9 NYCRR §7003.3(h) which states:

(h) The chief administrative officer and/or the facility physician shall determine whether a prisoner requires additional supervision based on the prisoner's condition, illness or injury, and the chief administrative officer shall order such supervision if warranted. Additional supervision may include:
(1) more frequent supervisory visits.
(2) active supervision when only general supervision is required; or
(3) constant supervision.

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29. A court order was signed by Honorable L.W. Honorable L.W. ordered that New York City Health and Hospitals (HHC) deliver all medical and mental health records to the Forensic Psychiatric Evaluation Court Clinic of New York County .

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39. On 7/7/22 and 7/11/22, Nieves was not produced by DOC staff

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42 On 7/15/22 and 7/16/22, Nieves was not produced by DOC staff

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The Medical Review Board opines that Nieves had persistent psychosis that was not stabilized and was not clinically appropriate for discharge to NYC DOC from OMH on 6/8/22. The Board opines that CHS psychiatric and mental health providers failed to recognize Nieves' profound psychosis and that he did not have the capacity to advocate for his care and needed forensic hospitalization.

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60. Nieves was not produced by DOC staff

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NYC DOC had no documentation to support that Nieves had spoken to investigators. During an interview with Commission staff, DL . stated that she was told to leave the unit for safety reasons .

62. On 8/25/22, CO J.T. noted in the logbook that Nieves was issued a razor at 8:56 a.m. At 10:40 a.m., CO J.T. noted in the B logbook that Nieves still had a razor and that the Captain was notified. Nieves reported that he did not know where the razor was. At 11:10 a.m., by order of Captain M.T., CO B.J. entered Nieves's cell and searched the cell with negative results. Per the NYC DOC callout and checklist report, once the cell was searched, Captain M.T. advised CO B.J. to take Nieves to main intake for a search with the body scanner. Nieves refused to exit his cell. Captain M.T. instructed CO B.J. to close the cell door and stated that she "don't have time for this." Captain M.T. stated that she would come back after. At 11:29 a.m., the cell door was closed. The individual in cell #5 was also in the shower around that time. At 11:33 a.m., CO B.J. searched cell #5 with negative results. Captain M.T. ordered CO B.J. to take Nieves to the intake area to have a scan by the Body Orifice Scanning System (BOSS) chair. The Medical Review Board finds that Captain M.T. failed to properly intervene and have Nieves, a known high risk person for self-harm, secured and removed from his cell to properly search him.

63. At approximately 11:40 a.m., CO B.J. returned to Nieves's cell and found Nieves standing in the back of the cell bleeding. CO B.J. turned on his body camera and a review of the body camera recording showed Nieves standing at back of his cell. Nieves was stating that the state and federal government forced him to commit suicide over his inventions and patents. Nieves remained standing in the back of cell. CO B.J. repeatedly told Nieves to sit down. Three minutes and 30 seconds later another officer arrived with a white object and told Nieves to put that on his wound. After four minutes and 17 seconds, CO B.J. asked Nieves where the blood was coming from and Nieves responded that it was from his neck. After five minutes and 27 seconds, Captain M.T. came to the cell and stated, "you don't want us to help you?" Nieves replied "no." After six minutes and 40 seconds, Nieves sat on the floor. After nine minutes and 36 seconds, the medical staff arrived. Medical staff could be heard stating that no one told them what the emergency was and that they had nothing with them to treat Nieves. Captain M.T. responded that she told the clinic what had happened. Medical staff could be heard requesting Urgicare, Emergency Medical Services (EMS), and all medical staff to respond to the clinic. The Medical Review Board finds that there was a substantial failure by NYC DOC to properly supervise and intervene with a known dangerous contraband situation. The Medical Review Board also finds that there was a substantial delay in obtaining emergency medical treatment for Nieves who had an obvious life-threatening hemorrhage occurring.

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The Medical Review Board opines that there was a significant delay in transporting Nieves to the hospital for a life-threatening injury that required immediate surgical intervention.

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66. There was no documentation from NYC DOC that indicated that Nieves met with investigators.

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68. During an interview with Commission staff, CO J.T. stated that he had assumed the control desk, was responsible to call medical for the response and that the source of the medical response was relayed on that call. CO J.T. called medical a second time to determine time until arrival.

69. During an interview with Commission staff, CO J.S. stated that he was assigned as an escort on that day. CO J.S. reported that he searched the other incarcerated individuals' cell with nothing located. They had planned to take Nieves to intake for the body scan and when they arrived at the cell, Nieves had cut himself. CO J.S. offered Nieves a shirt to place on his neck and Nieves refused. CO J.S. reported that no one was assigned to watch Nieves when he was placed in his cell.

70. During an interview with Commission staff, CO B.J. CO B.J. reported that he pat frisked both individuals and that he searched Nieves's cell without the razor located. CO B.J. stated that once in the cell Nieves reported that he had to use the bathroom and sat on the toilet. CO B.J. reported that he did intermittently check on Nieves and when Nieves was off the toilet, he went to back of his cell and had his back to the door. At that time, when the cell door was opened and Nieves turned around, he was bleeding. CO B.J. stayed with Nieves. Nieves refused assistance and stated that it was due to the government that he cut himself. CO B.J. reported that there is a nurse assigned to that housing area, but the nurse did not respond, and he did not recall seeing the nurse after the morning medication pass. CO B.J. stated that the control officer would call the medical emergency and that the control officer would then notify the medical staff assigned to the unit.

71. A review of the body cam worn by CO B.J. revealed that CO B.J. stood at the door and offered Nieves assistance which he declined. The other officer on the unit came to offer Nieves a shirt to put around his neck and threw it on the bed. The Captain offered Nieves assistance which he declined. The review of the video revealed that there was no apparent urgency or repeated attempts to offer any assistance nor was there any offer to get mental health staff to talk to Nieves.

72. A review of the housing logbook by Commission staff did not notate that any of the civilian staff seen on camera were assigned to the housing unit or were present in the housing area. This is a violation of NYC DOC Directive 4514R-C Housing Area Logbooks IV.A.1(M) which states:

once identification is verified the following information shall be entered into the logbook. The name, rank/title, and ID/shield number of all persons entering the housing area

including the time of arrival/departure and reason for presence in the housing area. The uniformed staff member on the post shall verify the identification of all non-uniformed staff and visitors seeking to enter the housing area prior to granting entry. Such verification shall include a face to photo identification and if warranted communication with the facility front entrance to establish the identity of the pass holder.

73. Per the NYC DOC Closing Report, CO B.J., Captain M.T. and CO J.S. were suspended for 30 days. When they returned to work, they were placed on modified duty prohibiting contact with any incarcerated individual.
CO B.J. and CO J.S. also had a Memorandum of Complaint (MOC) issued for the following policies:
Policy 2.30.010: Correction Officer shall be held responsible for the safety, sanitation, and security of their posts, for the proper care, custody, control and treatment of inmates, and the enforcement of the Rules and Regulations of the Department and the command.
Policy 3.05.120: Members of the Department are responsible for the efficient performance of their duties and for the proper supervision of any inmates under their direction.
Policy 3.20.030: Members of the Department found guilty of any of the following offenses may be dismissed from the Department or suffer such punishment as the Commissioner may direct: 1. Violation of the rules and regulations, 4. Conduct unbecoming of an officer or employee.
Policy 3.20.300: Though not specifically mentioned in these rules and regulations, all behavior which threatens the good order and discipline and all conduct of a nature to bring discredit upon the Department shall be acted upon by the Department according to the nature and degree of the offense and punished at the discretion of the Commissioner.
Policy 7.05.010: It shall be the duty of members of the Department supervising inmates to look after the inmate's welfare and to ensure that the inmates receive proper food, clothing, and medical treatment.

On August 31, 2023, formal charges and specifications were filed against CO B.J. and CO J.S. Both officers were charged with violating the Rules and Regulations listed in the MOC, as well as Directive 4521R-A, Suicide Prevention and Intervention.

Captain M.T. retired from the NYC DOC on 12/2/22. If the Captain had remained with the department, she would have been charged with failure to supervise.

74. Per the report issued by the NYC Board of Corrections, there was not a psychiatric nurse in the unit. Correctional Health Services (CHS) assigns nursing staff to PACE units, but they are not required to remain on the unit at all times. A psychiatric nurse was not observed responding to the incident on the recorded video.

75. Per the NYC DOC Investigation Division report, there was no camera footage that showed a pat frisk being completed on Nieves. Radio transmissions were reviewed and indicated that a medical emergency was called at 11:42 a.m. and again at 11:49 a.m. requesting a time of arrival. Phone records were also reviewed which revealed calls to Hart's Island Clinic at 11:40 a.m., 11:44 a.m. and 11:45 a.m. Per the NYC DOC records, Captain M.T. last received CPR, AED, and First Aide Training in 2018. CO B.J. last received the training in 2022, and CO J.S. last received the training in 2019. Pursuant to 9 NYCRR §7010.2 (f):

Facility personnel shall receive training and maintain certification in approved first aid and emergency life saving techniques including the use of emergency equipment

NYC DOC ID found conflicting information pertaining to the first aide training provided and, in the treatment, required by DOC staff. Therefore, DOC ID recommended "That DOC amend its rules and regulations to make clear that correction officers are required to treat severe bleeding without waiting for the arrival of medical staff, as the rules and regulations already make clear with respect to other life-threatening situations (use of ligatures, cessation of breathing).That DOC train all officers on care of severe bleeding and provide them with the equipment needed for the job, such as personal protective equipment (PPE) and gauze and bandages, as DOC now does for other life-threatening situations."

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 staff failed to address Nieves's positive urine test for Buprenorphine.

2. Correctional Health Services shall conduct a quality assurance review to determine why the nurse assigned to PACE did not respond to the medical emergency.

3. Correctional Health Services shall conduct a quality assurance review to determine why Nieves's Medication Administration Records were incomplete.

4. Correctional Health Services shall in conjunction with NYC DOC conduct a systemic review pertaining to medical emergency responses and the communication of vital information regarding the emergency and any resources that are needed for the emergency.

5. Correctional Health Services shall review Nieves psychiatric treatment and management with a review as to why forensic hospitalization was not considered for a patient who lacked capacity to engage his psychosis therapies.

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 that the requested reviews were completed. Correctional Health Services indicated that an updated version of the medication administration record was provided. The Medical Review Board did not find the remaining actions required satisfactorily addressed and will have them forwarded to the Commission for follow up at a later scheduled health services evaluation.

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 Nieves in compliance 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 the failure of the Department to assign an ESO staff to Nieves when he was placed on constant supervision for suicidal ideations.

3. The Commissioner shall conduct an investigation into the failure of the officer assigned to complete the 330ADM Suicide Prevention Screening Guidelines to properly complete the screen.

4. The Commissioner shall conduct an investigation into the failure of the officers assigned to the housing area to follow NYC DOC Directive 4514R-C Housing Area Logbooks IV.A.1(M).

5. The Commissioner shall conduct an investigation into the failure of the Department to be in compliance with 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 Office of Policy Compliance will be developing facility memorandums to be issued to ensure that ESO are assigned to all individuals placed on suicide watch.
-The Office of Policy Compliance will be developing facility memorandums to be issued to ensure that the Suicide Prevention Screening Guidelines form is properly completed.
- The Office of Policy Compliance will be developing facility memorandums to be issued to ensure that staff are complying with NYC DOC directive on logbook entries.
-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 schedule facility 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, 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-0093
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