



**Commission of
Correction**

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

In the Matter of the Death of

**Jose Mejia,
an incarcerated individual of the
George R. Vierno Center**

September 24, 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 Jose Mejia, who died on June 10, 2021, 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. Jose Mejia was a 34-year-old male who died on 6/10/21 from Acute Methadone Intoxication 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 was a failure by NYC DOC officers to maintain active supervision in accordance with NYS Minimum Standards.
2. Mejia was committed to NYC DOC on charges of Petit Larceny, Criminal Possession Stolen Property, Criminal Possession Controlled Substance with a court return date of 5/29/21 and on a New York State Department of Corrections and Community Supervision (NYS DOCCS) parole violation warrant.
3. [REDACTED]
4. On 5/13/21, Mejia was received into NYC DOC custody. A review of the Arraignment and Classification form by Commission staff revealed that the receiving supervisor section was not completed along with the date and time the form was completed. 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.
5. On 5/15/21 at 10:58 a.m., Mejia was received at the Eric M. Taylor Center (EMTC).
[REDACTED]
6. [REDACTED]

[REDACTED]

7.

[REDACTED]

8.

[REDACTED]

9.

[REDACTED]

10.

On 5/25/21, Mejia transferred from EMTC to Otis Bantum Correction Center (OBCC). On 5/26/21, Mejia was transferred to GRVC 5B.

11.

[REDACTED]

18. A review of recorded Gentech video of unit 9B for 6/10/25 by Commission staff revealed:

At 10:02 a.m., Mejia steps out of the housing area with an officer and other individuals and returned at 10:06 a.m. Another incarcerated individual poured the contents of his cup into a cup Mejia was holding and Mejia drank the liquid.

At 10:37 a.m., Mejia used his inhaler.

At 11:30 a.m., Mejia was walking around the housing area looking increasingly sluggish and rubbing his eyes.

At 11:56 a.m., CO J.P. responded to what appeared to be Mejia having some physical difficulty as he leaned against a set of rails on top of the stairs. CO J.P. gestured to Mejia, but he did not respond or move. CO J.P. went back downstairs. There was medical staff on the unit who were leaving the unit at that time.

At 12:10 p.m., Mejia was sitting at the dayroom table. Mejia appeared unconscious with his head leaning on table. Two other incarcerated individuals lifted Mejia up and assisted him to his cell. CO J.P. and CO S.S. were observed standing at the housing desk area.

At 12:23 p.m., CO J.P. looked in Mejia's cell for approximately three seconds.

At 1:16 p.m., CO J.P. looked into cell 1 for approximately 10 seconds.

At 2:30 p.m., another incarcerated individual walked past Mejia's cell and looked in. That incarcerated individual approached CO J.P. at the desk and CO J.P. followed him to Mejia's cell and opened the cell door allowing the incarcerated individual to go into the cell. After approximately one minute, the incarcerated individual left and CO J.P. appeared to lock the cell door.

At 2:34 p.m., CO J.P. looked into Mejia's cell for approximately 3 seconds.

At 2:53 p.m., CO J.P. completed a tour and looked into Mejia's cell for approximately 10 seconds then continued his tour.

At 3:05 p.m., CO J.P. looked into Mejia's cell for approximately 15 seconds.

At 3:38 p.m., another incarcerated individual entered Mejia's cell and came out at 3:40 p.m. That incarcerated individual notified several other incarcerated individuals and two of them entered Mejia's cell.

At 3:42 p.m., CO J.P. responded to Mejia's cell after an incarcerated individual told him that Mejia needed assistance.

The Medical Review Board opines that there was a failure by the assigned DOC officers to maintain proper supervision of the housing area and a failure to intervene when Mejia showed signs of obvious incapacitation. The Medical Review Board opines that during supervisory visits, the officers failed to follow agency policy as required to be established per 9 NYCRR §7003.1 which states:

Consistent with the requirements of this Part, each local correctional facility shall develop and employ policies and procedures designed to ensure that proper facility safety, security and supervision is maintained.

And that active supervision was not properly conducted as required by 9 NYCRR §7003.3(a) which states:

Active supervision shall be maintained in all facility housing areas, including multiple occupancy housing units, when any prisoners are confined in such areas but not secured in their individual housing units.

19. A review of the 9B logbook by Commission staff revealed:

The first page of the received logbook noted "Tuesday June 6th, 2021." June 6th was a Sunday.

On 6/6/21 at 10:30 p.m., housing area not secure, cell doors inoperable and unable to close.

The next shift entry noted "Wednesday June 7th 2021" which was a Monday 11:00 p.m. to 7:05 a.m.

On 6/7/21 at 1:20 a.m., CO was told to leave their post to go to level B. At 4:01 a.m., the CO returned to the post from level B.

The next shift was noted to be "Wednesday June 9th, 2021," at 7:31 a.m. which was the correct date.

On 6/9/21 at 1:25 p.m., multiple cell door unsecured. At 3:30 p.m., multiple doors open and inmates refusing to close doors, level B activated.

Change of tour June 10, 2021, at 11:30 p.m., the CO noted: "notified central control that housing area is not secured and multiple inmates remain in dayroom." At 11:45 p.m., the officer noted that all doors, gates, windows, and cells were not secure and the Alpha Captain was notified.

On 6/10/21:

At 8:10 a.m., "all doors, exits, gates, windows and cells appear secure."

At 9:00 a.m., "active supervision and all doors unsecure."

At 9:30 a.m., "active supervision tour and nothing unusual."

At 10:00 a.m., "active supervision tour and all doors obstructed."

At 10:30 a.m., "active supervision nothing unusual and all doors unsecure."

At 11:02 a.m. and 11:30 a.m., "active supervision and all doors unsecure."

At 12:00 p.m., "Officer S. on post affording medical services, Mejia refused."

At 12:00 p.m., 12:30 p.m., 1:00 p.m., 1:30 p.m., and 2:00 p.m., "active supervision tour and all door obstructed."

At 2:30 p.m., "active supervision, nothing unusual and all doors unsecure."

At 3:00 p.m., "active supervision tour and all doors are not secure at this time."

At 3:37 p.m., "Medical emergency activated at this time. Medical enroute."

At 3:45 p.m., "medical staff arrived."

20. On July 11, 2021, according to NYC DOC's investigation of the incident, CO J.P. was placed on modified duty prohibiting inmate contact and the possession of a personal firearm.

On August 2, 2022, NYC DOC filed a memorandum of complaint (MOC) against CO J.P. alleging that he "failed to efficiently perform [his] duties and provide care, custody, and control to Mejia."

On November 16, 2022, NYC DOC filed formal charges and specifications against CO J.P. charging that he violated department rules.

On June 16, 2023, in satisfaction of all disciplinary charges, CO J.P. resigned from his position as a correction officer with the NYC DOC pursuant to a negotiated agreement.

21. On August 2, 2022, NYC DOC filed disciplinary charges against CO S.S. alleging that CO S.S. provided false and misleading statements in the incident report when she claimed that she offered Mejia a sick call service and that he refused. According to the charges, CO S.S. did not interact with Mejia. The writeup also alleged that CO S.S. "failed to efficiently perform her duties and provide care to Mejia" when he was slumped over a table and escorted to his cell by other people.

On January 3, 2023, NYC DOC filed formal charges and specifications against CO S.S.

charging violations of Rules and Regulations. As of the date of this report, the disciplinary proceedings against CO S.S. are still pending.

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 Mejia 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 staff that failed to maintain active supervision in compliance with 9 NYCRR §7003.3(a). Administrative action should be taken if staff are found to be in violation of department directives.

In a response dated 8/13/25 to the Commission's preliminary report, NYC DOC indicated that the requested investigations were completed. NYC DOC indicated that administrative action was taken against staff who were found to be in violation of department directives. Each facility issued a memorandum entitled, "Arrestment and Classification Risk Screening Form-ARC 239" dated between July 12, 2024, and October 15, 2024, regarding completion of the form. Each facility issued memorandums entitled "Types of Supervision" between February 22, 2024, and February 27, 2024, regarding active supervision and general supervision. These memorandums were read at 21 consecutive roll calls and facility commanders were directed to assure strict compliance with the memorandums. The Commission will verify compliance with the minimum standard issues 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 24th day of September 2025.



Yolanda Canty
Commissioner
Commission of Correction

YC:DC:vc
2021-M-0078
September 24, 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