



**Commission of
Correction**

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

In the Matter of the Death of

**William Johnstone,
an incarcerated individual of the
George R. Vierno Center**

December 17, 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

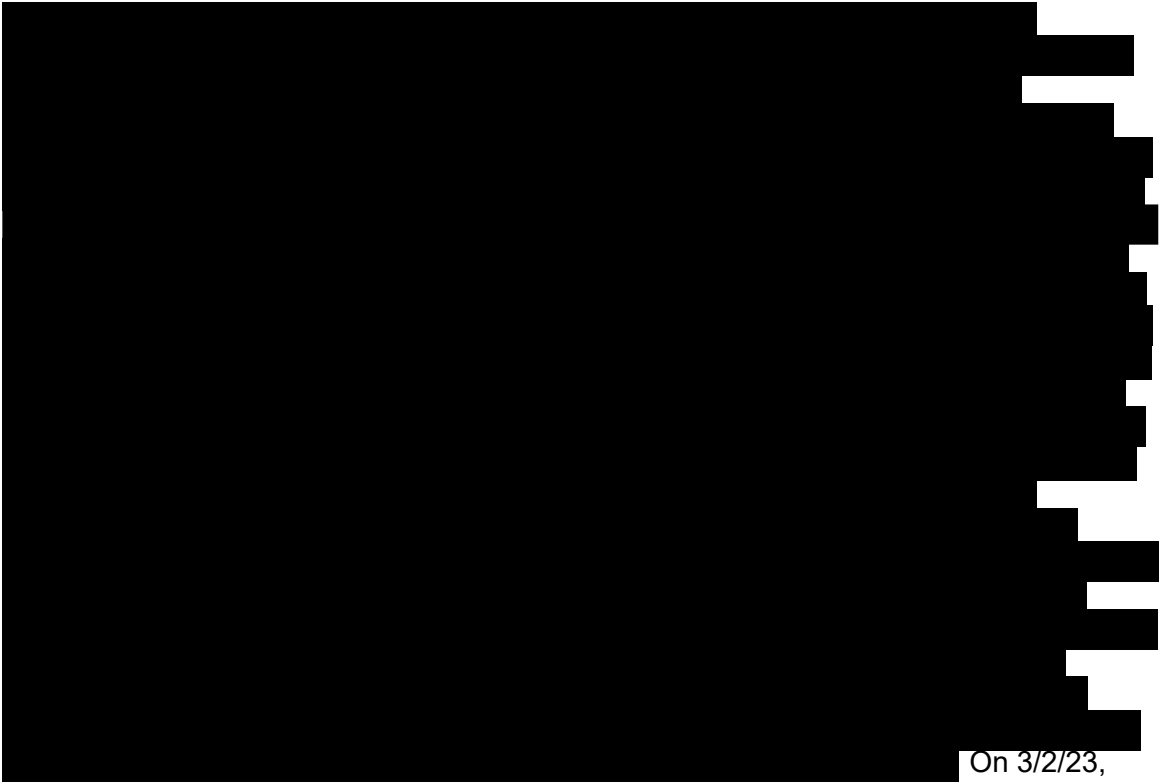
Elizabeth Gaynes
Commissioner

GREETINGS:

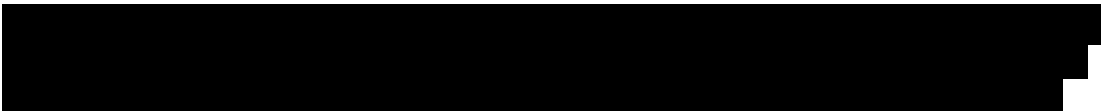
WHEREAS, the Medical Review Board has reported to the NYS Commission of Correction pursuant to Correction Law, section 47 (1)(d), regarding the death of William Johnstone, who died on July 15, 2023, as result of circumstances which occurred while an incarcerated individual in the custody of the New York City Department of Correction, the Commission has determined that the following final report be issued.

FINDINGS:

1. William Johnstone was a 47-year-old male who died on 7/15/23 from a myocardial infarction due to hypertensive cardiovascular disease while in the custody of the New York City Department of Correction (NYC DOC) at the George R Vierno Center (GRVC). Johnstone had an extensive cardiac history and was non-compliant with his medications. The Medical Review Board opines that NYC DOC and Correctional Health Services (CHS) failed to appropriately assess and monitor Johnstone during his incarceration. The Board opines that had Johnstone been provided an appropriate treatment plan with consistent follow up by medical and had been monitored for medication compliance, his death could have been prevented.

2. 

On 3/2/23, Johnstone was arrested for Robbery 1st Degree which was abated by his death. On 3/27/23, Johnstone was charged with Robbery 1st, 2nd, and 3rd Degrees. These charges were abated by his death.

3. 

[REDACTED]

4. On 3/10/23, Johnstone was admitted to NYC DOC at the Eric M Taylor Center (EMTC).

[REDACTED]

5. On 3/28/23, Johnstone was received at EMTC and per the securing order, Johnstone required medical attention and a psychiatric evaluation. The Arraignment and Classification Risk Screening Form completed by Correction Officer (CO) A. noted that the securing order did not indicate that medical or mental health was requested. The form was not completed by the receiving facility 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.

- 6.

[REDACTED]

[REDACTED] During an interview with Commission staff, Dr. [REDACTED] noted that the community fill database would verify all pharmacies for any recent filling of a prescription.

[REDACTED]

[REDACTED]

7.

[REDACTED]

During an interview with Commission staff, NP [REDACTED] reported that when individuals refuse step three, they are referred to mental health and that if they are cleared by mental health staff, they can be sent back to medical in order to complete the intake process. During an interview with Commission staff, Dr. [REDACTED] noted that step three was not necessary at the time of the admission and was required to be completed prior to an individual being sent to a program.

8.

[REDACTED]

The Medical Review Board opines that Johnstone had been discharged from Mt. Sinai hospital 3/10/23 with an optimal treatment regimen for the management of his cardiovascular disease which consisted of Coreg 6.25mg twice a day, Jardiance 10mg daily, Lasix 40mg daily, Entresto 24-26mg twice a day, and Aldactone 25mg daily. The Board opines that this medication regimen would have been optimum to prevent an acute myocardial infarction and failure to obtain records from Mt. Sinai hospital and continue the prescribed treatment program was a neglectful failure to maintain continuity of care.

9.

[REDACTED]

[REDACTED]

10.

[REDACTED]

11.

[REDACTED]

12.

[REDACTED]

13.

[REDACTED]

14.

[REDACTED]

15.

[REDACTED]

[REDACTED]

16. On April 2, 7, 18, 26, 29, and 30, 2023, Johnstone was not produced by DOC staff for his [REDACTED]. During an interview with Commission staff, Dr. [REDACTED] stated that there was no process in place at that time for the recurrent no show of chronic appointments. The incarcerated individual would continue to be rescheduled.

17. [REDACTED]

18. [REDACTED]

19. [REDACTED]

20. [REDACTED]

21. [REDACTED]

22. [REDACTED]

23. From May 1 to 4, 2023 and on May 6, 8, 10, 11, 15, 16, 18, 19, 2023, from May 22 to 26, 2023 and from May 28 to 31, 2023, Johnstone was not produced by DOC staff for his

[REDACTED]

24.

[REDACTED]

25. On June 1, 2, 4, 5, 6, 2023, from June 13 to 17, 2023, from June 19 to 22, 2023 and from June 25 to 29, 2023, Johnstone was not produced by DOC staff for his [REDACTED]. The Medical Review Board opines that the over 19 missed medical appointments and no EKG completed on a patient with known cardiac history, and a failure to obtain and review recent hospital records was a collective gross failure by CHS to assure continuity of cardiac care for Johnstone.

26.

[REDACTED]

27.

[REDACTED]
On 6/13/23, 6/14/23, and 6/15/23, Johnstone was not produced by DOC staff for [REDACTED]

[REDACTED]

A copy of this policy was requested by the Commission from CHS for the review of this case. In a communication from CHS administration dated 8/11/25, CHS responded that there was no policy for sick call. The Medical Review Board finds that CHS is utilizing an unestablished or formalized policy to close out individual sick call requests if they have not been produced by DOC staff in three days. The Board finds that this policy lacks verification of the requesting individual's status which lead to the medical necessities of that individual going unaddressed.

28.

[REDACTED]

29.

[REDACTED]

30. On 7/1/23, Johnstone was not produced by DOC staff for his [REDACTED]. On July 3, 4, 6, and 7, 2023, Johnstone was not produced by DOC staff for his [REDACTED].

31. [REDACTED]

32. [REDACTED]

33. [REDACTED]

34. [REDACTED]

35. On 7/15/23 at 1:50 p.m., a medical response was called on unit 4A 15 cell for an individual, Johnstone, with a seizure. DOC staff then notified medical that the individual was not breathing. Medical staff arrived. [REDACTED]

[REDACTED]

At 2:28 p.m., Urgi care Dr. [REDACTED] arrived. EMS arrived [REDACTED]

[REDACTED]



36. A review of the recorded Gentech video of unit 4A by Commission staff revealed:

On 7/14/23 at 8:48 p.m., CO S.A. completed a security round with the Captain but did not look in the cells.

At 8:53 p.m., an incarcerated individual walked behind CO S.A. smoking. There was no indication that this was addressed by CO S.A.

At 9:45 p.m., CO S.A. completed a supervisory tour.

At 9:50 p.m. a captain was on the unit but did not make any supervisory tour. The captain emptied a cell with multiple incarcerated individuals in it and there were multiple incarcerated individuals walking around smoking.

At 11:35 p.m., CO S.A. completed a supervisory tour, and CO S.A. spoke to Johnstone.

At 11:58 p.m., CO S.A. completed a supervisory tour.

On 7/15/23 at 12:22 a.m., CO S.A. completed a supervisory tour, and the captain walked the housing area without looking in the cells.

From 1:28 a.m. until 3:58 a.m., CO S.A. was in the control post.

At 3:58 a.m., CO S.A. completed a supervisory tour without looking in cells.

At 4:13 a.m., an incarcerated individual is seen setting up breakfast trays.

At 4:32 a.m., a captain made a supervisory tour without looking in the cells.

At 4:59 a.m., an incarcerated individual looked in Johnstone's cell.

At 6:10 a.m., CO M.R. completed a supervisory tour.

From 6:26 to 7:20 a.m., there was no movement on the camera.

At 8:10 a.m., CO M.R. completed a supervisory tour. CO M.R. then entered the control station.

At 9:10 a.m., another incarcerated individual spoke to Johnstone.

At 9:47 a.m., CO M.R. completed a supervisory tour on one side of the housing area but did not look in the cells.

From 10:38 a.m. until 10:48 a.m., CO M.R. was watching television.

At 11:00 a.m., CO M.R. did not perform the count, and no supervisory tour was conducted.

At 11:30 a.m., CO M.R. and Captain T.B. conducted a supervisory tour and did not look in Johnstone's cell.

From 12:05 p.m. until 1:46 p.m., CO M.R. remained in the control post and no supervisory tours were conducted.

At 1:46 p.m., CO M.R. completed a supervisory tour and stopped at Johnstone's cell and immediately went to the A station to retrieve Narcan.

A review of the 4A Housing logbook by Commission staff revealed:

On 7/14/23:

At 8:30 p.m., active supervision tour, nothing to report.

At 9:00 p.m., institutional lock in in progress. CO A. assumed post. Count taken and verified 43 live bodies.

At 9:30 p.m. and 10:00 p.m., active supervision tour completed and nothing to report.
At 10:30 p.m., 11:00 p.m., and 11:30 p.m., general supervision tour completed and nothing to report.

On 7/15/23:

At 12:00 a.m., 12:30 a.m., 1:00 a.m., 1:30 a.m., 2:00 a.m., 2:30 a.m., general supervision tour completed and nothing to report.

At 2:07 a.m., Captain P. on post and tour of area completed. Nothing to report.

At 3:00 a.m., 3:30 a.m., and 4:00 a.m., general supervision tour of area, nothing to report.

At 4:00 a.m., food cart on post.

At 4:30 a.m., general supervision tour, nothing to report.

At 5:00 a.m., institutional lock out afforded and feeding in progress.

At 5:30 a.m., CO A. remained on post and count taken.

At 5:30 a.m., CO M.R. assumed post.

At 6:00 a.m., 6:30 a.m., 7:00 a.m., 7:30 a.m., 8:00 a.m., 8:30 a.m., 9:00 a.m., 9:30 a.m., and 10:00 a.m., active supervision tour of area with nothing to report.

At 9:45 a.m., DOT medications.

At 10:15 a.m., food wagon on post.

At 10:30 a.m. and 11:00 a.m., active supervision tour completed with nothing to report.

At 11:05 a.m., institutional feeding in progress.

At 11:25 a.m., institutional feeding completed.

At 11:30 a.m., active supervision tour completed with nothing to report.

At 11:40 a.m., PREA unannounced round walk through tour of area. Watch tour pipe utilized.

At 12:00 p.m., 12:30 p.m., and 1:00 p.m., active supervision tour completed nothing to report.

At 1:15 p.m., CO M.R. off post for a personal reason.

At 1:45 p.m., CO M.R. assumed post and while this writer was making tour of area and noted that Johnstone was not responding in my checking that time, this writer notified the control officer and request medical emergency for said inmate and utilized Narcan at this time inner left nasal and administered CPR. Said inmate not responding and utilized 2nd dose of Narcan in said inmate's right nostril and keep continuing CPR until medical team arrived in area.

37. A search of Johnstone's cell after the terminal event revealed that there were multiple bags of medications to include Lisinopril, Lipitor, and Metformin.
38. CO M.R. was the subject of a Memorandum of Complaints (MOC) for 3.05.130 Post Abandonment and 3.05.120 Efficient Performance of Duty. CO M.R. did not perform his counts at 7:00 a.m. and 12:00 p.m. and did not observe for signs of life as per Directive 4517R Inmate Count Procedures and from 12:04 p.m. until 1:46 p.m., CO M.R. was off post and in the control room.
39. CO K.C. assigned to the 4A control allowed CO M.R. to remain in that post for extended periods of time and was subject to a MOC for violating Rules and Regulations 2.30.030 and 3.05.120.
40. CO (former Captain) T.B. failed to conduct adequate tours when touring at 11:28 a.m. and was subject to a MOC for 3.20.030 Conduct Unbecoming an Officer or Employee, 3.20.300 Conduct of a nature to bring discredit, and 3.05.120 Members of the

department are responsible for the efficient performance of the duties and for the proper supervision of any inmates under their direction. CO T.B. was suspended, modified, transferred and demoted regarding this incident.

41. CO S.A. failed to conduct proper tours in that he did not look inside the cells to observe signs of life. At 1:30 a.m., CO S.A. was off post when an incarcerated individual was witnessed generating sparks from an electrical outlet on the floor. At 3:59 a.m., CO S.A. watched the incarcerated individual in cell 3 manipulate the cell door to open it and jammed the locking mechanism on the door. A MOC was issued for CO S.A. for violations of the following:
- 1.30.10 CO shall be held responsible for the safety, sanitation and security of their post for the proper care, custody, control and treatment of inmates
 - 3.05.120 Efficient performance of duties,
 - 3.20.030 Conduct unbecoming an officer or employee
 - 3.20.300 Conduct of nature to bring discredit
 - 7.05.060 The officer taking counts must observe signs of life in each inmate on post
 - 7.05.090 A CO shall be constantly alert while on duty, observing everything that takes place on the post within sight or hearing and shall constantly patrol the post during the tour of duty

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 Johnstone 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.

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

In a response dated 11/18/25 to the Commission's preliminary report, NYC DOC indicated that the requested investigations were completed with corrective actions taken. The Commission will verify the corrective actions taken at a later scheduled minimum standards 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 if DOC staff was notified of the concerns of substance use on 4/27/23.
2. Correctional Health Services shall conduct a review of the failure of staff to address Johnstone's elevated blood pressure upon his admission and the care provided to Johnstone regarding his known heart disease.

3. Correctional Health Services shall conduct a review of the process when Step 3 of intake is reviewed with attention to whether Johnstone was returned to medical after the mental health evaluation.
4. Correctional Health Services shall conduct a review to determine why laboratory testing was not ordered for Johnstone until 5/3/23.
5. Correctional Health Services shall conduct a review to determine if the records of Johnstone's admission to Mt. Sinai Hospital were requested and reviewed, and why his discharge medications were not continued upon his admission.
6. Correctional Health Services shall determine why sick calls are closed out when an individual was not produced for three days despite indicating that there is no policy directing this.
7. Correctional Health Services shall conduct a review as to why Johnstone's EKG, ordered on 3/28/23 was not attempted until 7/8/23.

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

In a response dated 11/7/25 to the Commission's preliminary report, Correctional Health Services indicated that the requested reviews were completed with corrective actions taken. The Commission will verify 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, 12th Floor, in the City of Albany, New York 12210 on this 17th day of December 2025.



Yolanda Canty
Commissioner
Commission of Correction

YC:DC:vc
2023-M-0074
December 17, 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