Commission of Correction

Final Report of the New York State Commission of Correction:

In the Matter of the Death of

Manuel Luna, 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 Manuel Luna, who died on January 19, 2024, 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. Manuel Luna was a 30-year-old male who died on 1/19/24 from Acute Intoxication due to the combined effects of Methadone, Diphenhydramine and Sertraline while in the custody of the New York City Department of Corrections (NYC DOC) at the George R. Vierno Center (GRVC).

2. [redacted]. In October 2023, Luna was arrested on a charge of Robbery 2nd Degree. Luna was arraigned on charges of Robbery 1st Degree, two counts of Robbery 2nd Degree, and Robbery 3rd Degree. These charges were abated by his death.

3. [redacted].

4. On 10/5/23, Luna was received in NYC DOC at the Eric M. Taylor Center (EMTC). [redacted] There was no indication of any action taken or any notifications made. The screening form was not signed by a supervisor. [redacted] The securing order noted that medical attention and protective custody were needed. A review of the documentation by Commission staff revealed that Correction Officer (CO) R.W. noted on the arraignment and classification form that there were no documents that indicated protective custody. The receiving facility staff filled out the Arraignment and Classification Form however, they did not sign or date the form. The receiving facility supervisor did not complete the Arraignment and Classification form. There was no documentation provided to indicate that Luna was placed on suicide watch or was classified for protective custody as per the securing order from the judge.

This was a violation of 9 NYCRR §7013.7(a) which states:
Each incarcerated individual 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 individual'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 incarcerated individual relating to the following: any other relevant information concerning the safety or welfare of the individual.

There was a medical flagging notice form that indicated immediate medical attention was required.

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6. The assessment was terminated by NYC DOC due to Luna being on "high time". A large amount of the assessment was based on chart review. "High time" refers to the time an individual has left to be housed to meet the housing requirement time frame. NYC DOC directive requires that an individual be appropriately housed within 24 hours of their admission. he

Medical Review Board finds the practice of terminating a clinical assessment of a patient by NYC DOC to be an unacceptable practice. Absent a facility emergency that requires the immediate secure confinement of individuals, the clinical assessments being completed are a necessary and required component of housing and classification per the requirements of 9 NYCRR §7013.8(a), (b), (c-3) which state:

(a) After initial screening and risk assessment is completed and prior to determining each inmate's primary housing assignment, the inmate shall be placed in a housing unit within a housing area(s) designated for classification purposes. Such housing area(s) may be utilized on a temporary or permanent basis, given the needs and physical plant limitations of each facility.

(b) *Placement in such housing areas shall be temporary pending completion of the classification process, including the determination of appropriate housing, which shall be completed within five business days of each inmate's admission to the facility. The chief administrative officer may extend the time to complete the classification process for a particular inmate up to an additional 10 business days if he concludes that additional time is necessary to make a determination of appropriate housing*

(c) *In arriving at a determination of each inmate's housing assignment, the chief administrative officer shall base his/her decision on the following information, if such information is available and accessible to the chief administrative officer: (3) history of medical/mental illness*;

Proper compliance with the standard requires that individuals to be placed in appropriate pre-classification areas and for the necessary assessments from security, medical and mental health to occur so that proper classification and placement can be made. The Board finds that interrupting a clinical assessment is an impediment to the classification process.

Commission staff reviewed NYC DOC's policy and procedure for new admission processing. A teletype order from NYC DOC HQ-01046 dated 4/23/18 indicated that Operations Order 22/07 "Processing and Monitoring New Admissions" was amended to read:

Whenever a new admission inmate must exit the new admission process for post arraignment hold procedures "bail expediting program (bex)", court appearance, hospital transfer, urgi-care, infirmary or mental health referral, the 24-hour new admission tracking clock "stops" until the inmate has completed any of the above processes or the medical/mental health evaluation is completed. This applies at any time during the new admission processing.

As Luna was referred to mental health for an assessment based off his initial risk assessment, it does not appear that NYC DOC staff complied with their policy requirements.

7. [redacted]

8. [redacted]

9. [redacted].

10. [redacted]

11. [redacted]

12. [redacted]

13. [redacted].

14. [redacted]

15. [redacted].

16. [redacted]

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20. On 10/11/23, . Luna was not delivered for court Luna was not produced by NYC DOC staff for a video teleconference with his attorney due to another individual being disruptive.

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28. On 10/24/23, Luna was not produced by NYC DOC staff . On 10/25/23, Luna was not produced by NYC DOC staff due to being at court.

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31. On 10/26/23, twice on 10/27/23 and on 10/28/23, Luna was not produced by NYC DOC staff .

32. On 10/28/23 and 10/29/23, Luna was involved in an altercation with a peer in the housing area.

33. On 10/30/23, Luna was not produced by NYC DOC staff . Luna was not produced by NYC DOC staff . On 10/31/23 at two different times, Luna was not produced by NYC DOC staff .

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36. On 11/1/23, Luna was not produced by NYC DOC staff . On 11/2/23, Luna was not produced by NYC DOC staff . Luna was not produced by NYC DOC staff . On 11/3/23, Luna was not produced by NYC DOC staff .

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40. [redacted]

41. [redacted].

42. [redacted].

43. [redacted]

44. [redacted].

45. [redacted]

46. [redacted].

47. [redacted]

48. [redacted]

49. [redacted]

50. [redacted]

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56. On 12/11/23, Luna was not produced by NYC DOC staff .

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63. On 12/28/23, Luna was not produced by NYC DOC staff .

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68. On 1/11/24, per LMHC K.R. Luna was not produced by NYC DOC staff due to administrative reasons.

69. On 1/11/24, Luna was involved in an altercation with a peer. .

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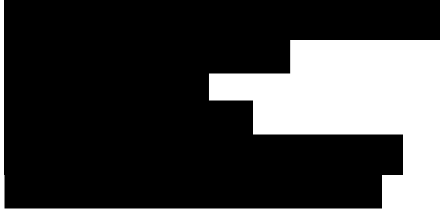
74. On 1/19/24 at 12:22 a.m., per the movement record, Luna was transferred to GRVC 5a. Per the NYC DOC Closing report,
at 2:22 a.m., Luna entered the housing area with his property and was secured in cell 14. There was no further documentation in the logbook regarding Luna. In the Gentech video received by Commission staff at 5:03 p.m., Luna was seen by Commission staff sitting in the dayroom playing cards.

75. On 1/19/24 at 8:46 p.m., Captain C. came into the GRVC 5A housing unit with a mattress for Luna in cell 4. Captain C. and CO M. went to Luna's cell and noted that Luna was on his bunk on his back and was unresponsive. Captain C. noted that Luna was pulseless and pale, with foam coming from his mouth. A medical response was called. Captain C. initiated Cardiopulmonary Resuscitation (CPR) and CO M. retrieved the Narcan from the control desk. Captain C. administered one dose of Narcan without the desired effect.

76. Review of the 1/19/24 Gentech video by Commission staff revealed:
At 5:03 p.m., Luna was seen sitting in the dayroom playing chess.
At 5:05 p.m., Luna walked to his cell with his dinner tray
At 5:36 p.m., Luna returned to the dayroom to play chess.
At 5:46 p.m., Luna returned to his cell. Luna remained in his cell until the terminal event.
At 8:46 p.m., Captain C. came in to the housing unit with a mattress for Luna and he was found unresponsive.

Another individual made a statement that Luna arrived without a mattress. This was a violation of 9 NYCRR §7005.9(a) Bedding which states:
Upon admission to a facility all prisoners shall be provided at facility expense with an issue of clean bedding in good condition

77. The Commission staff's review of the GRVC 5A logbook for 1/19/24 revealed:
At 1:30 p.m., CO M. assumed the post.
At 2:00 p.m., active supervision tour complete and nothing unusual to report
At 2:11 p.m., sanitation was in progress and the janitor's closet open.
At 2:20p.m., CO M. advised that all metal pans and tops from the dayroom are to be returned to the mess hall per the captain.
At 2:30 p.m., active supervision tour complete and nothing unusual to report
At 3:00 p.m., institutional lock in in progress. General supervision tour of area completed and nothing unusual to report.
At 3:35 p.m., general supervision tour of area completed and nothing unusual to report.
At 3:40 p.m., CO M. off unit for personal, control room notified, area supervisor to be notified.
At 4:00 p.m., institutional lock out in progress. Active supervision tour of area completed and nothing unusual to report.
At 4:30 p.m., active supervision tour of area completed and nothing unusual to report. Food wagon on post.
At 5:00 p.m., active supervision tour of area completed and nothing unusual to report. Tour with Captain C.
At 5:30 p.m., active supervision tour of area completed and nothing unusual to report.
At 5:55 p.m., Iman ███. in for religious counselling.
At 6:00 p.m., CO M. noted that active supervision tour of area completed and nothing unusual to report. Cell doors were obstructed and easily manipulated. "This officer does consistent tours attempting to secure cell doors and remove obstructions from locking mechanisms".
At 6:30 p.m., 7:00 p.m., 7:30 p.m., and 8:00 p.m., active supervision tour of area completed and nothing unusual to report.
At 8:30 p.m., active supervision tour of area completed and nothing unusual to report. All individuals have been notified to prepare for institutional lock in.
At 8:45 p.m., a medical response was called for Luna.

78. 

79. Per the NYC DOC Special Investigations Unit Closing Report, this incident was closed without any charges or any administrative actions brought against staff.

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 Luna 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 supply a mattress to Luna in comportment with 9 NYCRR §7005.9(a).

3. The Commissioner shall conduct a review of the “high time policy” with compliance with 9 NYCRR §7013.8 (a),(b), and (c)(-3) to assure that clinical assessments are not terminated for individuals as they are part of the classification process.

A report of the findings and any corrective actions shall be forwarded to the Medical Review Board upon completion.

In a response dated 11/18/25 to the Commission’s preliminary report, NYC DOC indicated that the requested reviews and investigations were completed with corrective actions taken. The Commission will verify corrective actions taken at a later scheduled minimum standards 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
2024-M-0014
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