Commission of Correction

Final Report of the New York State Commission of Correction:

In the Matter of the Death of

Donny Ubiera, 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

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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 Donny Ubiera, who died on August 22, 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. Donny Ubiera was a 33-year-old male who died on 8/22/23 from Acute Methadone Intoxication while in the custody of the New York City Department of Corrections (NYC DOC) at the George R. Vierno Center (GRVC).

2. On 5/11/23, Ubiera was arraigned on charges of Assault 1st Degree, Attempted Murder, Robbery 1st Degree, Assault 2nd Degree, and CPW 3rd Degree. On 8/18/23, Ubiera pled guilty and was awaiting sentencing.

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5. On 3/29/23, Ubiera was received at Anna M. Kross Center (AMKC). There was no date or time documented on the Arraignment and Classification Risk Assessment Form. The receiving facility staff completed the form but did not sign it. The receiving facility supervisor completed the form, however, did not put the date or time on it. The securing order noted that medical and psychiatric attention was required.

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[redacted]

10. [redacted]

11. [redacted]

12. [redacted]

13. [redacted]

14. On 4/17/23, [redacted] Ubiera had a scheduled video conference with his attorney on that date to discuss his case.

15. [redacted]

16. [redacted] Ubiera had court on 4/14/23, at which time the case was adjourned until 4/28/23. Per Webcrimes, the court information system, the case was on the motions calendar, but the decision was reserved. Ubiera had not yet been arraigned on his charges.

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23. On 5/10/23, Ubiera transferred to GRVC.

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[redacted]

34. [redacted]

35. [redacted]

36. [redacted]

37. [redacted]

38. [redacted]

39. [redacted]

40. [redacted]

41. [redacted]

42. On 8/21/23 in the morning, Ubiera was not produced by DOC staff for his [redacted].

43. On 8/22/23 at approximately 5:10 a.m., Corrections Officer (CO) S.C. was working the housing area and noted that Ubiera did not get up for breakfast. CO S.C. went to Ubiera's cell to wake him but received no response. CO S.C. noted that Ubiera was unresponsive. CO S.C. called a medical emergency. CO S.C. initiated Cardiopulmonary Resuscitation (CPR) and CO P. responded and continued CPR while CO S.C. attempted to get Narcan. CO S.C. was unable to locate the Narcan. CO V. responded and administered Narcan. Captain L. responded and assisted with CPR. CO V. reported that he gave Narcan three times. Upon medical staff arrival to the housing area, [redacted]

44. [redacted]

45. [redacted]

46. Per the NYC DOC Closing report on 8/21/23 between 11:00 a.m. and 11:05 a.m., Ubiera was seen on camera drinking an unknow liquid from an unsealed milk carton given to him by another incarcerated individual. That individual and Ubiera then entered Ubiera's cell and removed commissary items from Ubiera's cell.

47. On 8/22/23, a review of the 13B post housing logbook revealed:
At 12:15 a.m., general supervision tour completed and nothing to report.
At 1:00 a.m., general supervision tour completed and nothing to report.
At 1:30 a.m., general supervision tour completed and nothing to report.
At 2:25 a.m., ADW was on post and general supervision tour completed and nothing to report.
At 3:00 a.m., general supervision tour completed and nothing to report. Food cart on unit. There were no logbook entries after 3:00 a.m.
At 5:28 a.m., the medical team arrived.

The lack of documentation in the housing logbook after 3:00 a.m. is a violation of 9 NYCRR § 7003.3(j) which states:
All written records pertaining to facility housing supervision required pursuant to this section shall be recorded in ink in a bound ledger of consecutively numbered pages which shall be maintained in each housing area. Such records shall include, but not be limited to, the following information:
(4) when general supervision is conducted, the date and time each supervisory visit is performed pursuant to the requirements of section 7003.2(b) of this Part and the signature of facility staff conducting the supervisory visit;

48. On 8/22/23, a review of Gentech video by Commission staff revealed:
At 12:09 a.m., CO S.C. completed a tour and looked into cell 38.
At 12:57 a.m., CO S.C. completed a tour and looked into cell 38.
At 1:28 a.m., CO S.C. completed a tour and looked into cell 38.
At 2:15 a.m., ADW C. and CO S.C. conducted a supervisory tour.
At 2:55 p.m., CO S.C. completed a tour and looked into cell 38.
At 3:08 a.m., CO S.C. conducted a tour with Captain L.
At 3:54 a.m., CO S.C. completed a tour and looked into cell 38.
At 4:30 a.m., CO S.C. completed a tour and looked into cell 38.

49. As a result of the NYC DOC investigation, per the NYC DOC closing report, Memorandums of Complaints were issued to CO S.C. for repeatedly leaving his post and entering the A Control post, to CO S.T. for failure to assure that Narcan was present at the start of the tour, and to CO E.R., who worked the 1:00 p.m. to 9:30 p.m. tour, for failure to conduct supervisory tours from 6:00 p.m. until 9:00 p.m. and for a failure to conduct the 8:00 p.m. count as documented in the logbooks.

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 sign and date the Arraignment and Classification forms.

2. The Commissioner shall conduct a review to assure that staff are complying with the requirements of 9 NYCRR §7003.3(j) and documenting the supervision of housing areas in logbooks.

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 the requested reviews were completed with corrective actions taken. The Commission will verify corrective actions taken at a later scheduled minimum standards evaluation.

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

Correctional Health Services shall conduct a quality assurance review to determine why the 730 Mobile Team notes entered after the terminal event were all dated for the same date which was after the terminal event.

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

In a response dated 11/7/25 to the Commission's preliminary report, Correctional Health Services indicated that no review was necessary as CHS has implemented methods to avoid charting where a patient is deceased. The Commission did not accept this response and will follow up 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-0087
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