

**Special Investigations and
Prosecutions Unit**

**Report on the Investigation into
The Death of Raynette Turner**



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EXECUTIVE SUMMARY

On July 8, 2015, Governor Andrew Cuomo signed Executive Order No. 147 (the “Executive Order”), appointing the Attorney General as a special prosecutor “to investigate, and if warranted, prosecute certain matters involving the death of an unarmed civilian . . . caused by a law enforcement officer.” On Saturday, July 25, 2015, Raynette Turner (“Ms. Turner”) was arrested for two counts of petit larceny and taken to the Mount Vernon Police Department (“MVPD”). Approximately 48 hours later, the MVPD found Ms. Turner deceased in a holding cell. On August 3, 2015, Governor Cuomo issued Executive Order No. 147.1, which expressly conferred jurisdiction upon the Attorney General to investigate any potential unlawful acts or omissions relating to Ms. Turner’s death.

Pursuant to Executive Orders No. 147 and 147.1, the Office of the Attorney General’s (“OAG”) investigation included, among other investigative steps:

- Review of the Westchester County Medical Examiner’s Office’s (“Medical Examiner”) autopsy, microscopy, and toxicology records;
- Review of video footage from several MVPD videos depicting virtually the entire duration of Ms. Turner’s confinement at the MVPD, including video footage from several different cameras monitoring the holding cells (“the Holding Cell Video”), the arrest processing area, the MVPD hallways, and the MVPD entrance or sally port (sometimes collectively referred to as “the Video”);
- Interviews of more than 40 witnesses including, among others, employees of the MVPD, court personnel, family and acquaintances of Ms. Turner, and arrestees who were in the custody of the MVPD at the same time as Ms. Turner; and
- Review of more than 1,700 pages of Ms. Turner’s medical records before and during her confinement at the MVPD.

The OAG finds that MVPD employees did not cause Ms. Turner’s death. The Medical Examiner’s records and the Video are the most salient evidence. The Medical Examiner found no physical trauma suggesting any form of physical abuse by the MVPD. There is no indication of any physical abuse on the Video, and none of the witnesses interviewed raised any suggestion of physical abuse. The Medical Examiner found that Ms. Turner’s death was caused by an enlarged heart, and that chronic cocaine and morphine use contributed to her death. Ms. Turner’s medical records prior to her arrest include records indicating drug use and chronic cardiac issues that corroborate the Medical Examiner’s findings.

Under these circumstances, the only conceivable theory for a homicide prosecution would be that MVPD employees failed to provide necessary medical care to Ms. Turner and that this failure resulted in her death. The only possible homicide charge would be criminally negligent homicide. For the reasons discussed below, no such charge is warranted in this case.

The Video shows that MVPD officers checked on Ms. Turner through periodic, in-person visits. Interviews of MVPD employees indicate that they also checked on her via a closed-circuit video monitor. While in custody, Ms. Turner made one request for medical attention – regarding her prescription medications – and MVPD employees promptly took her to a nearby hospital where she received medication. Ms. Turner was arrested on a Saturday. The hospital visit was Sunday evening. After the hospital visit, on late Sunday and Monday, the Video shows that Ms. Turner appeared to vomit or retch on many occasions. MVPD employees continued to check on her periodically. For example, from 11:45 am to 2:11 pm, MVPD employees were present at or near her cell approximately 10 times; during six of these visits the employees either interacted with Ms. Turner directly or looked into her cell. On Monday, MVPD employees also inquired about Ms. Turner’s medical condition twice, and, in response, Ms. Turner did not request additional medical attention. Finally, when an MVPD employee discovered that Ms. Turner was nonresponsive, emergency medical services (“EMS”) was contacted immediately.

The standard necessary to sustain a charge of criminally negligent homicide is that a defendant failed to perceive a substantial and unjustifiable risk that a death would occur and that the failure to perceive that risk constituted a gross deviation from reasonable care. The OAG finds no basis to conclude that any MVPD employee failed to perceive a substantial and unjustifiable risk that Ms. Turner’s death would occur or that any such failure to perceive that risk constituted a gross deviation from reasonable care.

As described in detail below, however, state regulations required in-person cell visits of Ms. Turner at least every thirty minutes. The general practice at the MVPD at the time of Ms. Turner’s incarceration was to conduct cell visits by closed-circuit television and not by in-person visits. MVPD employees readily acknowledged this practice during the OAG investigation. We raised this issue with the MVPD, and the MVPD has advised us that they are now ensuring that MVPD employees perform the required cell visits in person. While the failure to follow state minimum standards required remediation by the MVPD, we do not believe that the MVPD’s practice caused its employees to fail to perceive a substantial and unjustifiable risk that Ms. Turner’s death would occur. The Holding Cell Video provides a direct view of the cells that Ms. Turner was in, and the use of the Holding Cell Video was supplemented by periodic, in-person visits.

* * *

The following report details the OAG’s investigation and legal analysis. We also attach several exhibits to the report, including: (1) still photos from the Video (Exhibit A); (2) the Medical Examiner’s autopsy report (Exhibit B); and (3) copies of various MVPD policies and procedures (Exhibits C).

Executive Orders No. 147 and 147.1 also provide that the OAG may offer “any recommendations for systemic reform arising from the investigation.” The OAG’s recommendations cover two general issues. First, we recommend that policymakers address the need to more swiftly bring arrestees before arraignment judges for consideration of bail and possible release. Second, we recommend actions relating to detainee medical care, including that the New York State Commission of Correction (“COC”) review its minimum health care

standards and provide more precise guidance regarding the circumstances under which agencies should seek medical attention for inmates. Law enforcement personnel are not physicians and would benefit from clear standards regarding when to arrange for emergency medical care for arrestees.

STATEMENT OF FACTS¹

A. Ms. Turner's Arrest and Detention by the MVPD

1. Ms. Turner's Arrest

The MVPD arrested Ms. Turner on the afternoon of Saturday, July 25, 2015 for thefts at Restaurant Depot and Target. Both thefts are captured on store surveillance footage. The Restaurant Depot footage depicts a woman later identified to be Ms. Turner entering the store around 12:25 pm and leaving the store two minutes later, bypassing the cash registers, and entering the parking lot with a box of crab legs under her left arm. Restaurant Depot personnel did not apprehend Ms. Turner. Around 12:30 pm, a manager at Restaurant Depot called 911 to report the theft.

The Target surveillance footage shows that, at approximately 1:00 pm, Ms. Turner placed two boxes of headphones into her bag and walked toward the entrance/exit doors where she was stopped by security personnel. After being escorted to the Target Booking Room, Ms. Turner signed an Admission Statement acknowledging that she had stolen electronics and accessories worth more than \$600. One of the MVPD officers who responded recognized Ms. Turner from the prior Restaurant Depot surveillance video. The officer called the Restaurant Depot manager who had called 911. The Restaurant Depot manager identified Ms. Turner as the person who had stolen property from the Restaurant Depot approximately 90 minutes earlier.

The OAG neither received nor uncovered any allegation, indication, or evidence of wrongdoing by the MVPD officers in carrying out the arrest.

2. Arrival at the MVPD and the MVPD Intake Process

Ms. Turner arrived at the MVPD at approximately 2:40 pm on July 25, 2015. (Exhibit A at 1). MVPD employees placed her in the booking area and called her husband, Herman Turner, to notify him of the arrest.

MVPD Procedure No. 3.067 (Prisoner Suicide Prevention Screening) requires that a New York State-certified MVPD Desk Officer screen each arrestee to identify and reduce the risk of suicide. (Exhibit C at 8). After the arrestee is screened, he or she is placed into one of three levels of supervision: constant, active, or normal. Pursuant to Procedure No. 3.067, constant supervision requires "uninterrupted personal visual observation of prisoners" 24 hours per day. (Exhibit C at 8). An arrestee is placed on constant supervision when he or she is believed to be a suicide risk. Active supervision requires "immediate availability to prisoners" and that

¹ None of the information referenced in this report was obtained through the use of grand jury subpoenas. Any subpoenas issued were pursuant to New York State Executive Law Section 63(8).

“supervisory visits [are] conducted at a minimum of fifteen (15) minute intervals.” (Exhibit C at 8). The MVPD member must be able to “communicate orally with prisoner[s] and respond [to their inquiries].” (Exhibit C at 9). Normal supervision requires that the “condition” of a detainee be checked “by actual visits to cells at intervals not to exceed thirty (30) minutes.” (Exhibits C at 9).²

The on-duty Desk Officer, Sergeant Vincent Stufano, interviewed Ms. Turner and completed her “Suicide Prevention Screening Guidelines” form. During the screening process, an empty bottle of a benzodiazepine (which is used to treat panic disorders) was vouchered. Ms. Turner spoke about prior mental-health diagnoses and told Sgt. Stufano that she needed medications that she had been prescribed relating to these diagnoses. She made no complaints regarding her general health or physical condition. Ms. Turner also denied using or being under the influence of non-prescription drugs. Based upon Ms. Turner’s final score on the screening questions and Sgt. Stefano’s overall assessment of her, he placed her on “active supervision” requiring supervisory visits every 15 minutes.

In addition to implementing the “Suicide Prevention Screening Guidelines,” the Desk Officer is responsible for supervising the detainee’s arrest processing. This includes determining whether the arrestee has any outstanding warrants and deciding whether “booking” or arrest is appropriate. Pursuant to MVPD procedure, when court is not in session, a Desk Officer also is authorized to set pre-arraignment bail and issue a Desk Appearance Ticket (“DAT”), which releases the arrestee from police custody and directs the arrestee to appear in court on a specific date and time. (Exhibit C at 4 - 5).³ MVPD officers told us that, pursuant to MVPD procedure, before they issue a DAT, an arrestee must be fingerprinted and his or her record must be checked for outstanding warrants.⁴ The Desk Officer may also consider the underlying facts of the case as well as the arrestee’s criminal and bench warrant history.

Based upon our interviews with the MVPD desk officers, Ms. Turner was not considered for the issuance of a DAT. In addition, Ms. Turner was not fingerprinted at the time of her arrest. Therefore, while some warrant information and criminal history were available to Sgt.

² MVPD Procedure No. 3.067 is consistent with the New York State Minimum Standards and Regulations for Management of City Jail – Town and Village Lockups (“State Minimum Standards”), which require that “the condition of prisoners shall be checked, by actual visits to cells and detention rooms, at intervals not to exceed 30 minutes.” 9 NYCRR § 7504.1(a) (emphasis added). Notwithstanding MVPD Procedure No. 3.067 and the State Minimum Standards, the MVPD procedure defining detention protocols (Mount Vernon Police Department Detention and Transportation Procedures – TC-1 2006 – 02/27/06) simply requires that employees “note prisoner activity” every 15 or 30 minutes, without specifying that observations of prisoner activity must be based upon actual visits. (Exhibit C at 2). As noted above, MVPD employees informed the OAG that they did their supervision visits by observing prisoners via closed-circuit television. While the use of closed-circuit television to monitor detainees is an appropriate adjunct to actual cell visits, it may not be used “as a substitute for such visits.” 9 NYCRR § 7504.1(g).

³ MVPD Procedure No. 3.050 provides that (a) the Desk Officer shall “promptly” have fingerprinted any person eligible for a DAT and (b) no DAT “shall be issued until the prisoner has been fingerprinted and a record check for outstanding warrants has been completed.” (Exhibit C at 5).

⁴At the MVPD, arrestees can only be fingerprinted by individuals assigned to the Detective Bureau. Monday through Friday, detectives assigned to the Criminal Investigations Unit (“CIU”) fingerprint all arrestees. On weekends, arrestees are fingerprinted if and when a detective is available.

Stufano, the complete, comprehensive, multi-state information supplied after fingerprint submission was not. MVPD officers indicated that, pursuant to MVPD practice, Ms. Turner would not have been actively considered for a DAT, because she had been arrested for two unrelated offenses in one day and the dollar value of the goods stolen exceeded \$600. When Ms. Turner was ultimately fingerprinted, it was determined that she had a bench warrant history, aliases, a probation revocation, and multiple convictions, which MVPD employees advised us would have caused them not to issue a DAT.

3. Relocation to the Cell Block

Pursuant to MVPD Policy Article XIX, prisoner attendants are generally responsible for the “care and safekeeping” of detainees, serving meals and, if necessary, rendering first aid. (Exhibit C at 3). There are three prisoner attendant posts at the MVPD; attendants may be assigned to the first floor holding cells (“cell block”), the second floor holding cells, or as the “runner” who escorts arrestees between the cell block and the second floor holding cells. Both law enforcement officers and civilian employees perform prisoner attendant functions.

At approximately 3:00 pm, Ms. Turner was escorted from the booking area to the cell block by Prisoner Attendant Carlo Jean-Baptiste and placed into cell number 31. (Exhibit A at 2).

Police Officer Bahiyah Morris was the attendant for the cell block from 4:00 pm to midnight. At approximately 5:15 pm, Officer Morris served Ms. Turner dinner. According to the Video, after eating dinner, Ms. Turner spent several hours lying down on a bench in her cell. During that period, she can also be seen intermittently standing, walking to the cell door, and sitting on the bench in the cell. Occasionally, while seated, Ms. Turner can be seen bending forward or doubling over. This was a somewhat infrequent occurrence on the first day that Ms. Turner was detained, but it happened with greater frequency on the second and third days that she was detained.

4. The Morning and Afternoon of Sunday, July 26, 2015

According to the Video, from approximately midnight until 5:00 am, Ms. Turner was asleep, lying on the cell bench and turning occasionally. At approximately 6:25 am, she sat up on the bench. She can also be seen rocking back and forth at that time. Prisoner Attendant Jean-Baptiste worked the 8:00 am to 4:00 pm shift and provided Ms. Turner a sandwich and a drink for breakfast shortly after 8:00 am. Until about 4:00 pm, Ms. Turner was primarily lying down, but occasionally can be seen standing, eating, and doubling over while seated on the cell bench.

Police Officer Ryan Hughes was assigned as an attendant from 4:00 pm to midnight. At approximately 4:05 pm, Ms. Turner asked him if she could call her husband. (Exhibit A at 3). Officer Hughes told her that she was not permitted to make a telephone call at that time, but as a courtesy, he offered to call her husband on her behalf. Ms. Turner provided Officer Hughes with the telephone number, and at approximately 4:15 pm Officer Hughes called her husband, Herman Turner, to let him know that Ms. Turner was scheduled to have a court appearance on Monday.

5. Montefiore Mount Vernon Hospital Visit on Sunday Evening

At approximately 4:40 pm, Ms. Turner told Officer Hughes that she had not had her hypertension medication in a few days, and she asked to go to the hospital to obtain that medication. Shortly thereafter, Officer Hughes called the front desk and reported that Ms. Turner needed her medication. At approximately 5:45 pm, Police Officer Michael Paulson and Probationary Police Officer (“PPO”) Nazeem Whipper escorted Ms. Turner from her cell to a police car for transport to Montefiore Mount Vernon Hospital (“MMVH”), which is approximately a tenth of a mile from the MVPD. (Exhibit A at 4). The Video shows that Ms. Turner walked without assistance to the transporting police car with Officer Paulson and PPO Whipper.

They arrived at MMVH shortly thereafter and remained at the hospital until approximately 10:00 pm. According to the medical records, upon arrival Ms. Turner’s chief complaint was “needs meds.” The medical records also state that Ms. Turner had “pain/discomfort” on the left side of her body, and the pain was rated a “7” on a scale of 0 to 10 (with 10 being the highest level of pain). During her triage interview, Ms. Turner reported that she was at the hospital “for medication that she ha[d] not had from yesterday.” Ms. Turner was subsequently taken to an examining room where, according to Officer Paulson and PPO Whipper, she indicated that she was hungry and was provided with food and a beverage.

At the hospital, Ms. Turner met with nurses, a general physician, and a psychiatrist. The triage notes indicate: “revisit/miscellaneous medication refill . . . patient is in police custody needs to be medicated.” The hospital records indicate that she was currently being prescribed drugs to treat hypertension, anxiety, and insomnia. She denied the use of alcohol or non-prescription drugs. Ms. Turner was designated as triage category “4” on a scale of 1-5 (1 is the highest urgency level).⁵ MMVH staff provided bridge medications⁶ to Ms. Turner consistent with those she had been receiving prior to her arrest, including blood pressure, anxiety, and insomnia medications. In short, the drugs Ms. Turner received at MMVH were the same as those that she was already being prescribed or generic preparations thereof. At approximately 10:00 pm, Ms. Turner was discharged from MMVH. The hospital records state that her condition was “stable.” Ms. Turner was provided with patient information on hypertension and instructions to follow up with her primary care physician and psychiatrist upon her release from custody. MMVH did not give any specific instructions or warnings to the MVPD concerning Ms. Turner’s continued care.

Officer Paulson, PPO Whipper, and Ms. Turner returned to the MVPD at approximately 10:00 pm. (Exhibit A at 5). Prisoner Attendant Brian Burrell was on duty at the time; he placed Ms. Turner in cell number 29, because her original cell (number 31) was being cleaned. Prisoner Attendant Burrell then gave Ms. Turner a sandwich and a drink. After eating, Ms. Turner lay

⁵ See generally <http://www.ahrq.gov/sites/default/files/wysiwyg/professionals/systems/hospital/esi/esihandbk.pdf>.

⁶ “Bridge medication” refers to a quantity of medication provided to an individual who would otherwise not have access to his or her prescription(s), in order to carry that person to a time when regular access can resume.

down on the bench in her cell. Between approximately 11:15 pm and midnight, Ms. Turner appears to vomit or retch five to six times.⁷

6. Fingerprinting Early Monday Morning

The Video shows that Police Officer Ian Yearwood and Detective Juliet Roach, members of the MVPD Detective Division, escorted Ms. Turner from cell number 29 to the MVPD fingerprinting machine at approximately 2:15 am. (Exhibit A at 6). Ms. Turner returned to her cell at approximately 2:30 am. (Exhibit A at 7). According to the Video, she appears generally to sleep during the rest of the night, but her sleep was interrupted at various times when she can be seen awakening, leaning over the toilet, and vomiting or retching.

7. Monday Morning

Prisoner Attendant Burrell was assigned to the cell block during the 8:00 am to 4:00 pm shift. The Video indicates that between approximately 8:00 am and 8:20 am, Ms. Turner leaned over the toilet and vomited or retched several times. During that time period, Ms. Turner is handed toilet paper, and a cup is left in the opening of her cell. (Exhibit A at 8).

At 9:00 am, Prisoner Attendant Burrell began his assignment as a “runner,” taking arrestees back and forth between the first floor cell block (where Ms. Turner was) and the holding cells located on the second floor. At approximately the same time, Prisoner Attendant Ricardo Atkinson began his 9:00 am to 5:00 pm shift and was assigned to the first floor cell block. Prisoner Attendant Atkinson is a civilian MVPD employee and not a police officer.

According to the Video, at approximately 9:35 am, Prisoner Attendant Michael Barnes escorted Ms. Turner from cell number 29 to an interview room where she was interviewed by Ms. Lillian Mizell Harris, Program Assistant for Pre-Trial Services Institute of Westchester County (“PTSI”). (Exhibit A at 9). PTSI is responsible for making recommendations to the court about whether arrestees should be released at arraignment. According to Harris, during the PTSI interview, Ms. Turner rubbed her stomach and said that she did not feel well. Ms. Turner did not request medical assistance, and Harris did not feel that Ms. Turner’s words or actions were cause for concern.⁸ Upon completion of the interview, Ms. Turner stood and walked unassisted out of the interview room. After the PTSI interview, the Video shows that Prisoner Attendant Atkinson escorted Ms. Turner back to cell number 29. (Exhibit A at 10).

⁷ The Video does not clearly show whether Ms. Turner vomited at any particular point. This report refers to vomiting or retching in instances where it appears that she vomited or retched based upon her posture while leaning over the toilet.

⁸ Prior to the OAG’s interview of Ms. Harris on August 13, 2015, Ms. Harris told the press that Ms. Turner did not seem to Ms. Harris to have been seriously ill. See <http://www.lohud.com/story/news/local/westchester/mount-vernon/2015/07/30/raynette-turner-screener-speaks/30903989/>.

8. Ms. Turner's Return from a Court Holding Cell Due to Illness

According to the Video, at approximately 9:49 am, Prisoner Attendant Atkinson led Ms. Turner and three other female arrestees from the first floor cell block to the elevator. (Exhibit A at 11). Prisoner Attendant Burrell escorted them onto the elevator and up to the court holding cells on the second floor.

According to the court holding cell Video,⁹ the female detainees, including Ms. Turner, were escorted into the female court holding cell. Ms. Turner entered the cell, stood near the wall, and appeared to speak with Prisoner Attendant Burrell. According to him, Ms. Turner asked if she could go back downstairs to her cell, because she did not feel well and wanted to lie down. This conversation was substantiated by one of the female arrestees in the court holding cell. The Video shows that Prisoner Attendant Burrell escorted Ms. Turner out of the court holding cell approximately one minute after she entered.

Prisoner Attendant Burrell then walked Ms. Turner to the first floor, where they met Prisoner Attendant Atkinson. According to Prisoner Attendant Burrell, during this time he asked Ms. Turner how she was feeling and she replied "a little better." According to the Video, at approximately 9:52 am (three minutes after she had been escorted out of cell number 29). Prisoner Attendant Atkinson escorted Ms. Turner to cell number 23. (Exhibit A at 12). Ms. Turner walked unassisted to and from the court holding cell. According to Prisoner Attendant Atkinson, he asked Ms. Turner if she was okay and she replied, "Yes, I just want to lie down."¹⁰

The Video next shows that, between approximately 9:52 am and 10:37 am, Ms. Turner leaned over the toilet six times. At least twice during that time she appeared to place her fingers in her mouth and vomit or retch. At approximately 10:55 am, Prisoner Attendant Atkinson left food and a drink for Ms. Turner in the opening of the door of cell number 23 (Exhibit A at 13).

⁹ There is a time difference of approximately ten minutes between the video recordings from the jail cells on the first floor and the video recordings from the court holding cells on the second floor. According to Strategem Security (the company that installed the video surveillance cameras at the MVPD), various cameras throughout the MVPD are connected to one of several servers, and all cameras on a given server are time-stamped to that server's internal clock. Each server is reliant on its own internal clock due to the unavailability of a Network Time Protocol ("NTP") server on the MVPD network to sync all of the servers' internal clocks. Accordingly, while every MVPD camera server clock is internally consistent (*i.e.*, there is a sequential passage of time), the camera server clocks may differ from one another by several minutes where the cameras are not connected to the same server. Further, Strategem indicated that the camera servers utilize a video cache when there is no motion detected, holding the video until the camera detects motion again.

¹⁰ Even if Ms. Turner had remained upstairs and eventually appeared in the courtroom for arraignment, there was no accusatory instrument upon which to arraign her. The practice at the MVPD is that if an arrest is made between 8:30 am Saturday and the end of the weekend, the arresting officer needs to appear at the Westchester County District Attorney's office on the following Monday morning so that an Assistant District Attorney can draft the accusatory instrument. The arresting officer, PPO Elias Reyes, was due to appear at the District Attorney's office at 9:00 am that morning so that accusatory instruments could be prepared and filed. However, at approximately 8:05 am, shortly after beginning his shift, PPO Reyes was dispatched to another matter and therefore did not appear at the District Attorney's office.

At approximately 11:01 am, Prisoner Attendant Atkinson and a maintenance worker walked through the cell hallway and passed by cell number 23. At that time, Ms. Turner was lying down. From approximately 11:01 am to approximately 11:44 am, Ms. Turner continued to lie down. At approximately 11:44 am, Police Officer Tiffany Sexton walked down the cell hallway; Ms. Turner lifted her head from the bench as she passed and then sat up and got toilet paper (11:44 am), leaned over while sitting on the bench (11:44 am), leaned over the toilet (11:45 am), and used toilet paper to wipe her mouth (11:47 am). (Exhibit A at 14). Between approximately 11:50 am and 12:15 pm, Ms. Turner sat on the bench with little movement. From approximately 12:15 pm to 12:26 pm, Ms. Turner again lay down on the bench.

9. The Two and a Half Hours Prior to Ms. Turner's Death

At approximately 12:26 pm, Prisoner Attendant Atkinson escorted Ms. Turner back to cell number 29. (Exhibit A at 15). Ms. Turner walked unaided to the cell. Shortly after entering cell 29, Ms. Turner appeared to double over while sitting on the cell bench. Between approximately 12:28 pm and 1:21 pm, the Video shows Ms. Turner leaning over the toilet and, at times, placing her fingers in her mouth. She appears to retch or vomit several times.¹¹ In between, she lay on the cell bench. She did not, according to every MVPD employee on duty at the time, request medical assistance.¹² Similarly, no inmate interviewed by the OAG said that Ms. Turner requested medical attention on Monday or that MVPD employees ignored any request.

At approximately 12:58 pm, Officer Sexton pointed out to Ms. Turner that there was food and drink in the opening of the door to cell number 29. (Exhibit A at 16). At approximately 12:59 pm, Prisoner Attendant Atkinson escorted a female prisoner through the cell hallway and looked briefly into Ms. Turner's cell. At approximately 1:10 pm, Prisoner Attendant Barnes handed Ms. Turner toilet paper. (Exhibit A at 17). At approximately 1:11 pm, Ms. Turner leaned over the toilet and appeared to vomit or retch. Around that time, Prisoner Attendant Atkinson escorted a female prisoner through the cell hallway and walked by cell number 29. (Exhibit A at 18). At approximately 1:21 pm, Ms. Turner took a cup from the opening of the door to cell number 29, took a sip, and put the cup back. (Exhibit A at 19).

At 1:25 pm, Ms. Turner lay down on the cell bench for the last time and did not get up again. At approximately 1:41 pm, Prisoner Attendant Barnes walked into the room next door to cell number 29 and walked out. At approximately 1:51 pm, Prisoner Attendant Burrell walked

¹¹ Repeated vomiting is symptomatic of many non-fatal conditions, but it can also be evidence of a serious medical problem. As discussed below, the OAG recommends that the N.Y.S. Commission of Correction, in conjunction with the Medical Review Board ("MRB"), determine if more specific guidance should be provided to law enforcement officers to better address when emergency medical care should be provided to arrestees.

¹² Arrestees need not affirmatively request medical care in order to receive it. For example, there are instances in which mental illness or physical incapacitation would prevent an individual from requesting care or recognizing that it is needed. As discussed below in the Legal Analysis section, however, the MVPD's prompt response to Ms. Turner's prior request to be taken to the hospital and Ms. Turner's responses to the MVPD's inquiries about her health during the hours prior to her death are relevant to the key legal issue: whether any MVPD employee's failure to perceive a substantial and unjustifiable risk of Ms. Turner's death was a gross deviation from reasonable care, as required for a charge of criminally negligent homicide.

into the room next to cell number 29 and then walked out. At approximately 2:10 pm, Prisoner Attendant Burrell walked by cell number 29, looked briefly into the cell, walked by the cell again while escorting a female prisoner through the cell hallway, and again looked briefly into the cell. (Exhibit A at 20). At approximately 2:13 pm, Ms. Turner moved slightly while lying on the cell bench, partially on her right side and partially on her stomach. According to the Video, Ms. Turner did not move again after 2:13 pm.

At approximately 2:50 pm, the Video shows that Prisoner Attendant Atkinson approached Ms. Turner's cell. (Exhibit A at 21). Atkinson told us that he was attempting to inform Ms. Turner that she was going to be taken up to the court holding cell for arraignment. When Ms. Turner did not respond, Prisoner Attendant Atkinson reached through the cell bars and shook Ms. Turner, but she remained motionless. At that point, he opened the cell door and attempted to awaken her.

At approximately 2:51 pm, Officer Sexton went to cell number 29 and performed a sternum rub (a technique used to awaken an unconscious individual) on Ms. Turner; it failed to rouse her. (Exhibit A at 22). At approximately 2:51 pm, Prisoner Attendant Atkinson notified the front desk and requested an ambulance, which was summoned. At approximately 2:54 pm, Sergeant Gregory Addison responded to Ms. Turner's cell with a defibrillator, which was not ultimately used, since Sgt. Addison noted lividity (a pooling of blood that can be a visible sign of death). (Exhibit A at 23). At approximately 3:04 pm, a TransCare Emergency Medical Technician arrived at cell number 29. (Exhibit A at 24). At 3:08 pm, the technician pronounced Ms. Turner deceased.

B. Jail Forms

An MVPD "Jail Form" is maintained for each detainee, upon which prisoner attendants must make a record of each supervisory visit they performed including the date, the time, and their observations of the arrestee during the visit, such as whether he or she was awake, sleeping, or eating. The Jail Forms memorialize the official supervisory visits. As discussed above, MVPD employees primarily performed supervisory visits by closed-circuit television rather than actual visits to jail cells. While we primarily relied on the Video for our assessment of Ms. Turner's conduct and condition, we also compared the descriptions contained on the Jail Form to what we observed on the Video. For several entries, there are inconsistencies between the Video and the descriptions of Ms. Turner's conduct on the log (e.g., the log states "laying down" when the Video shows that she was sitting). (Some of these inconsistencies may be due to individual employees using different watches or clocks to note the times). The Video also shows that MVPD employees performed periodic, in-person visits that were not necessarily reflected on the Jail Form.

Prisoner Attendant Atkinson was responsible for maintaining and updating Ms. Turner's Jail Form (as well as those of 28 other inmates in the cell block) in the hours immediately preceding her death. As noted previously, Prisoner Attendant Atkinson is a civilian employee of the MVPD. Several entries by Prisoner Attendant Atkinson on Monday morning/afternoon did not correspond to the Video. For example, the Jail Form notes that Ms. Turner's lunch was served at 11:30 am, but according to the Video, lunch or another meal was actually served at

10:55 am. Similarly, the Jail Form indicates that Ms. Turner was moved to cell number 29 at 11:45 am; according to the Video, she was actually moved at 12:26 pm. In addition to these inaccuracies, Prisoner Attendant Atkinson subsequently changed the times of several entries on Monday, July 27, 2015. From 10:00 am to 12:00 pm and from 2:00 pm to 3:00 pm, the Jail Form indicates that Prisoner Attendant Atkinson made entries on Ms. Turner's Jail Form every fifteen minutes, as he was required to do, since she was on active supervision. But, from 12:00 pm to 2:00 pm, he originally made entries every 30 minutes.

According to Prisoner Attendant Atkinson, after he discovered that Ms. Turner was unresponsive and called EMS, he changed the time entries (between 12:00 pm and 2:00 pm) to reflect that he had in fact been checking on Ms. Turner by video and in person every fifteen minutes. Prisoner Attendant Atkinson made the time changes in a readily visible and apparent manner: by writing on top of the prior entries (and thereby creating somewhat illegible, visibly altered time entries). He did not make any changes to the fields describing his observations about Ms. Turner; as a result, several of the description fields are at odds with the Video.

We were not able to verify whether Atkinson conducted visits every fifteen minutes between noon and 2:00 pm as he maintained. As discussed above, the practice at the MVPD is to conduct many of these visits by video and not in person, and there is no camera recording the room in which the attendants monitor the video screens of the cells. The Video reflects that Prisoner Attendant Atkinson himself walked by, checked, or interacted with Ms. Turner approximately six times between 11:00 am and 3:00 pm. But, even if Prisoner Attendant Atkinson did perform fifteen-minute check-ins by video, by his own account, he failed to record accurately what he observed during those check-ins. In addition, he failed to record accurately when Ms. Turner was provided with lunch and when she moved cells. Accuracy of the Jail Forms is important for the effective functioning of the MVPD. The OAG recommended to the MVPD that it take administrative action relating to Prisoner Attendant Atkinson and the OAG has been advised that the MVPD intends to do so. The MVPD's administrative action can range from a reprimand to termination.

C. Summary of Medical Examiner and Prior Medical Treatment Records

1. Westchester County Medical Examiner

At approximately 3:11 pm on Monday, July 27, Officer Allen notified the Medical Examiner of Ms. Turner's death and at approximately 4:30 pm, representatives of the Medical Examiner responded to the MVPD. At approximately 5:00 pm, they removed Ms. Turner's body to the Medical Examiner's facilities.

On July 28, 2015, the Medical Examiner performed a comprehensive autopsy of Ms. Turner's body. (Exhibit B). During the autopsy, the Medical Examiner physically examined the body, analyzed the bodily fluids, and performed a histologic examination of bodily tissues. The Medical Examiner also reviewed some of Ms. Turner's physical and mental health history, which included some general health issues as well as chronic drug use (both prescription and non-prescription).

Ms. Turner's heart was found to be enlarged; microscopic analysis of Ms. Turner's cardiac muscle fibers disclosed that she suffered from "hypertrophic myofibers and foci of fibrosis" (an unusual thickening of her cardiac tissue). The Medical Examiner determined that Ms. Turner's manner of death was "natural" and her cause of death was "[c]ardiomegaly with myocardial fibrosis" (i.e., an enlarged heart with thickened, less compliant cardiac tissue) (Exhibit B at 9, 32).

The Medical Examiner's toxicology report revealed the presence of numerous prescription drugs as well as cocaine and morphine or their metabolites in Ms. Turner's system. Specifically, toxicological analysis revealed that Ms. Turner had consumed cocaine as well as morphine, but not in the hours immediately preceding her death. Her overall toxicological profile indicated chronic cocaine and morphine use. (Exhibit B at 13 - 14). This finding was corroborated by statements of two of Ms. Turner's acquaintances.¹³ Accordingly, the Medical Examiner's conclusion that "chronic cocaine and morphine use" contributed to Ms. Turner's death was independently corroborated by evidence of actual use.

As discussed below, Ms. Turner's blood and urine also contained substances (or their metabolites) that, through various medical records, the OAG was able to link to prescription drugs that Ms. Turner received prior to her arrest or at MMVH the night before her death.

2. Prior Medical Treatment Records

During the course of the investigation, we obtained and reviewed multiple sets of medical records from various health care providers (in addition to the MMVH records) consisting of more than 1,700 pages. The relevant material is discussed below.

The Medical Examiner's toxicology report was corroborated by the medical records we obtained from a mental-health services provider where Ms. Turner was seen as a regular patient until two days prior to her arrest. Many of the substances identified in the Medical Examiner's toxicology screen had been prescribed to Ms. Turner at that facility, a fact disclosed in the provider's medical records. Further, approximately three months prior to her death, Ms. Turner was asked by the provider about a urine screen that tested positive for cocaine use; Ms. Turner claimed that the results were invalid.

Finally, from 2000 to 2013, Ms. Turner was screened for cardiac abnormalities; the medical records from several entities foreshadow the cardiac issues to which, according to the Medical Examiner's report, she ultimately succumbed. Various hospital records reveal that as early as 2000, Ms. Turner showed evidence of "borderline cardiomegaly"; in 2012 and 2013, she displayed evidence of an enlarged heart; and in July 2013, Ms. Turner reported experiencing "chest pain." Over the years, Ms. Turner was also treated for hypertension, back and leg pain, swollen legs, shortness of breath, and abdominal pain.

At the time of her incarceration, the MVPD did not possess the medical records the OAG obtained after Ms. Turner's death. Additionally, during her screening process, Ms. Turner

¹³ The MVPD informed the OAG that Herman Turner provided the names of these two individuals. The OAG subsequently interviewed these two individuals.

specifically denied the drug use that, according to the Medical Examiner, contributed to her death.

LEGAL ANALYSIS

The autopsy report found, in sum, that Ms. Turner's manner of death was "natural" due to an enlarged heart resulting partially from drug use. Based upon the Video, the autopsy report, and interviews of MVPD officers and other arrestees, there is no evidence of any use of force by MVPD officers against Ms. Turner. Under these circumstances, the only possible theory of homicide prosecution is that an MVPD employee was criminally negligent in failing to provide Ms. Turner with necessary medical care and that such criminal negligence resulted in her death. For the reasons discussed below, such a prosecution could not properly be sustained under the facts presented here.

A person is guilty of criminally negligent homicide under Penal Law Section 125.10 "when, with criminal negligence, he causes the death of another person." There are two theories of criminally negligent homicide: (1) a person engages in conduct that creates a risk; and (2) a person who owes a legally imposed duty to someone else fails to perform an act that he/she is legally required to perform. People v. Munck, 92 A.D.3d 63 (3d Dep't 2011) (for a person to be guilty of criminally negligent homicide by omitting to perform an act, there must be a legally imposed duty to act, such as a parent's duty to act for his or her child). In either case, criminally negligent homicide occurs when a person "fails to perceive a substantial and unjustifiable risk" that death will occur. New York Penal Law § 15.05 (defining criminal negligence).

The substantial and unjustifiable risk "must be of such nature and degree that the failure to perceive it constitutes a gross deviation from the standard of care that a reasonable person would observe in the situation." New York Penal Law § 15.05; People v. Boutin, 75 N.Y.2d 692, 696 (1990) ("The risk involved must have been 'substantial and unjustifiable,' and the failure to perceive that risk must have been a 'gross deviation' from reasonable care."). The Court of Appeals has made clear that careless, or even ordinary negligent behavior, is insufficient in and of itself to constitute criminal negligence. See People v. Ricardo B., 73 N.Y.2d 228, 235 (1989) ("[C]riminal liability cannot be predicated upon every careless act merely because its carelessness results in another's death.>").

The degree of carelessness required for criminal negligence "is appreciably more serious than that for ordinary civil negligence and the carelessness must be such that its seriousness would be apparent to anyone who shares the community's general sense of right and wrong." People v. Haney, 30 N.Y.2d 328, 334 (1972) ("Criminally negligent homicide, in essence, involves the failure to perceive the risk in a situation where the offender has a legal duty of awareness. It, thus, serves to provide an offense applicable to conduct which is obviously socially undesirable. '[It proscribes] conduct which is inadvertent as to risk only because the actor is insensitive to the interests and claims of other persons in society.'" (quoting Model Penal Code, Tent. Draft No. 9).

The MVPD's failure to perceive a substantial risk of Ms. Turner's death based on observations of restlessness and vomiting or retching (symptomatic of many non-fatal

conditions) is far afield from the particularly egregious factual circumstances under which New York courts have affirmed convictions for criminally negligent homicide. Cases finding criminally negligent homicide involve instances where affirmative harm was inflicted on the deceased or the medical condition and imminent death of the deceased were readily apparent, unlike here. The following cases are illustrative.

- People v. Flayhart, 72 N.Y.2d 737 (1988): Husband and wife defendants were properly convicted of criminally negligent homicide in the death of the husband's brother where: (a) the brother lived with them and was totally dependent upon their care; (b) the brother was mentally disabled and had cerebral palsy and epilepsy; (c) the brother weighed 75 pounds just before death and died of malnutrition and inflammation of the lungs; and (d) the brother had not seen his regular doctor during the last two years of his life. The court held that the jury properly found that defendants failed to perceive a substantial risk of death and failed to provide food and medical care, which ultimately brought about the brother's death.
- People v. Henson, 33 N.Y.2d 63 (1973): Defendants, parents of a four-year-old child who died of pneumonia, were properly convicted of criminally negligent homicide where: (a) they knew that the boy had been sick some days before his death; (b) the boy's body was covered with many black and blue marks; (c) the defendants went to a bar the night of the child's death; and (d) before doing so, they tied the boy up and told the babysitter to ignore any calls for help.
- People v. Rose, 41 A.D.3d 1033 (3d Dep't), app. denied, 9 N.Y.3d 926 (2007): The defendant mother was properly convicted after a guilty plea to criminally negligent homicide in the death of her three-year-old daughter where: (a) the defendant's boyfriend inflicted the fatal injuries on the child while the defendant was at work; and (b) the defendant clearly did not act as a reasonable parent in failing to seek medical assistance for her unresponsive child for approximately ten hours.
- People v. Baker, 4 A.D.3d 606 (3d Dep't), lv denied, 2 N.Y.3d 795 (2004): The court reduced the defendant babysitter's conviction of murder in the second degree to criminally negligent homicide in the death of a three-year-old child under her care where: (a) the child died of hyperthermia as a result of her prolonged exposure to excessive heat caused by a short circuit in furnace wiring; and (b) the child was unable to leave her bedroom, where the temperature reached 110 degrees and vent air reached 130 degrees. The court held that the defendant should have perceived a substantial and unjustifiable risk that the excessive heat, in combination with her inaction, would likely lead to the child's death.
- People v. Manon, 226 A.D.2d 774 (3d Dep't), app. denied, 88 N.Y.2d 1022 (1996): The defendant mother was properly convicted of criminally negligent homicide for the death of her newborn where: (a) the newborn died as a result of under-nutrition and dehydration; (b) the newborn's deterioration would have been

readily apparent a day or two prior to his death; (c) the defendant missed a scheduled medical appointment for the newborn two days prior to his death; (d) the newborn had lost 27% of his body weight since his last medical appointment 15 days prior to his death; (e) the defendant left the newborn propped up on the couch to feed himself despite medical advice not to do so; (f) the defendant refused assistance from a nurse; (g) there was trauma to the newborn's arms and ribs; and (h) the newborn died in a "filthy bassinet" in a home with an "intense odor."

- People v. Neer, 129 A.D.2d 829 (3d Dep't), app. denied, 70 N.Y.2d 802 (1987): The defendant father was properly convicted of criminally negligent homicide for the death of his four-year-old daughter where: (a) the girl's body was covered with contusions, lacerations and scars from injuries occurring over time, most recently between 24 to 48 hours before her death; (b) the girl suffered internal injuries including contusions of the superficial portions of the brain; (c) an autopsy revealed injuries to the girl's vaginal and anal areas; (d) many of the girl's injuries were readily visible; and (e) the girl died as a result of multiple internal and external injuries and excessive loss of blood. The court found sufficient evidence to uphold the jury's decision that the defendant could have realized the seriousness of the girl's condition.
- People v. Northrup, 83 A.D.2d 737 (3d Dep't 1981): The court reduced a conviction of murder in the second degree to a conviction of criminally negligent homicide of a defendant mother who demonstrated a gross deviation from the standard of care a reasonable parent would have exercised where: (a) the defendant had seen her boyfriend severely beat the boy about the head and limbs with a stick, force him to eat his own excrement and punch and slap the boy in the chest and face with sufficient force to cause the boy's head to strike a medicine cabinet, breaking the glass; (b) the defendant later undressed the boy and noticed redness and bruises about his head and body where he had been struck; (c) the defendant saw blood in the boy's urine and observed him frequently retching; (d) the defendant failed to obtain or provide medical care or assistance for her son; and (e) the autopsy determined that a jabbing blow to the child's abdomen had ruptured his small bowel, resulting in toxemia and death.

These cases make clear that the MVPD employees' conduct in this case was not the type of conduct that courts have found to be within the scope of criminally negligent homicide. In contrast to the cases cited above, MVPD employees were generally responsive to Ms. Turner. Ms. Turner made one request for medical attention, and MVPD officers promptly took her to the MMVH. After the hospital visit, Ms. Turner vomited or retched several times.¹⁴ When MVPD employees inquired about Ms. Turner's condition, Ms. Turner – who had asked for and received

¹⁴ The discussion of the number of instances of vomiting or retching in this report is based upon a review of the Video in its entirety. Constant supervision is only required for arrestees who are at risk for suicide. Checking in every 15 minutes – whether in person or by video – would not have alerted MVPD employees of each time Ms. Turner vomited or retched.

medical treatment less than 18 hours prior to her death – did not request additional medical treatment.

On Monday, July 27, from 11:45 am to 2:11 pm, MVPD employees were present at or near Ms. Turner’s cell approximately 10 times; during six of these visits the employees either interacted with Ms. Turner directly or looked into her cell. They also brought her toilet paper and food. Ms. Turner was able to walk unassisted: (a) to and from her PTSI interview and the court holding cell; (b) from the court holding cell to cell number 23; and (c) from cell number 23 to cell number 29. Ms. Turner also interacted with the PTSI employee, who is independent of the MVPD, and the PTSI employee did not observe any serious medical issues. Finally, when an MVPD employee discovered that Ms. Turner was non-responsive, EMS was immediately contacted. Under these circumstances, the OAG does not find a basis to conclude that any MVPD employee failed to perceive a substantial and unjustifiable risk that Ms. Turner’s death would occur or that any such failure to perceive that risk constituted a gross deviation from reasonable care.

For the foregoing reasons, a prosecution for criminally negligent homicide would be unsustainable under the facts presented here. And in light of the determination that no criminal negligence took place, manslaughter or more serious charges, which require culpable mental states such as “reckless” or “intentional,” are clearly inapplicable.

POLICY RECOMMENDATIONS

The OAG’s policy recommendations cover two general areas. First, we recommend that policymakers consider means of more swiftly bringing arrestees before arraignment judges for consideration of bail and potential release. Second, we address issues relating to arrestee medical care.

A. Arraignment Considerations

Ms. Turner was not arraigned and therefore remained in custody where she ultimately died approximately 48 hours after her arrest. Ms. Turner was not arraigned because she was arrested mid-afternoon on Saturday (July 25, 2015) and the next opportunity for arraignments in the City of Mount Vernon was Monday morning (July 27, 2015). On Monday morning, however, Ms. Turner still was not arraigned, because after being brought from her jail cell to the court holding cell adjacent to the arraignment court, she indicated that she was not feeling well and wished to return to her cell.

Recommendation: Expand the Availability of the Arraignment Court by Electronic or Other Means

New York Criminal Procedure Law requires that when a police officer makes a warrantless arrest, the arrestee, “without unnecessary delay,” must be brought before a judge and charged with an offense in an accusatory instrument, such as a criminal complaint. Criminal Procedure Law § 140.20(1). The Criminal Procedure Law is silent as to what time period constitutes an unnecessary delay, but the Court of Appeals has ruled that pre-arraignment delays

in excess of 24 hours are presumptively unreasonable and must be explained. People ex rel. Maxian ex rel. Roundtree v. Brown, 77 N.Y.2d 422, 427 (1991) (citing People ex rel. Maxian v. Brown, 164 A.D.2d 56 (1st Dep't 1990) (“[There is] no reason why the pre-arraignment process cannot be completed within 24 hours.”)).

In Ms. Turner’s case, pre-arraignment processing was not completed within 24 hours, as she was not fingerprinted until approximately 36 hours after her arrest. But even if she had been fingerprinted in a timely manner, the very earliest she could have been arraigned was Monday morning (July 27, 2015); Mount Vernon City Court does not convene on Sundays (which is not uncommon in courts outside of New York City). The most obvious means of avoiding prolonged pre-arraignment weekend incarceration would be to hold court on Sundays. To the extent that budgetary constraints make that goal impracticable in the short term, we recommend that policymakers explore expanding the use of video-facilitated arraignments as an alternative.

Many states, including Florida, New Jersey, and Pennsylvania, have embraced videoconferencing/closed circuit capabilities for court proceedings, including arraignments.¹⁵ In other states, court proceedings other than arraignments occur without the requirement that the judge, prosecutor, and defendant (with his or her defense attorney) all gather together in a courtroom. According to a 2010 survey by the National Center for State Courts, 80% of respondents using videoconferencing capabilities reported that the technology “helps to administer justice.”¹⁶ In Virginia, for instance, the use of videoconferencing has resulted in around-the-clock access to a magistrate.¹⁷ The states that use videoconferencing for court appearances also report large monetary savings. For example, in the survey referenced above, Pennsylvania officials estimated that its taxpayers saved approximately \$31 million using video technology.

In contrast, in New York, videoconferencing for court appearances is hardly ever used. Less than one half of the 62 counties in the State are legislatively permitted to employ videoconferencing.¹⁸ Westchester County is one of the 27 counties in New York where, subject to certain clearly defined exceptions, a defendant need not appear in person before a judge and

¹⁵ Courts have found that court appearances via video comport with due process requirements. See, e.g., In re Rule 3.160(a), 528 So.2d 1179,1180 (Fla. 1988) (“[D]ue process does not require the personal presence of a defendant in a courtroom before a judge when, through mechanical means, he can see the judge and the judge can see him”); State v. Phillips, 74 Ohio St. 3d 72, 95 (Ohio 1995) (“Arraignment of an accused via closed-circuit television is constitutionally adequate when the procedure is functionally equivalent to live, in-person arraignment”); Commonwealth v. Terebieniec, 408 A. 2d 1120, 1124 (Pa. Super. Ct. 1979) (finding “no unconstitutional prejudice inherent in [closed-circuit] arraignments”).

¹⁶ See <http://www.ncsc.org/Services-and-Experts/Areas-of-expertise/Technology/NCSC-Video-Conferencing-Survey.aspx>.

¹⁷ Id.

¹⁸ Where the practice is permitted, the arrestee must first consult with his or her attorney and agree to appear via video. See Criminal Procedure Law § 182.20.

electronic technology may be used in lieu of in-person appearances.¹⁹ The OAG recommends that video-facilitated arraignments be considered in Mount Vernon (and in every other jurisdiction with legislative authority to proceed in this manner). In addition, the OAG recommends that the Legislature explore expanding this method of court appearance for potential implementation statewide.

In making these recommendations, we are conscious of, and draw policymakers' attention to, critiques of arraignments performed via video-conferencing. *See, e.g.,* Shari Seidman Diamond, Locke E. Bowman, Manyee Wong, & Matthew M. Patton, *Efficiency and Cost: The Impact of Videoconferenced Hearings on Bail Decisions*, 100 J. Crim. L. & Criminology 3 (2010). Any prospective policies or legislation should be drafted with focused attention toward making the entire process fair and equitable. For instance, a videotaped arraignment policy could include the requirement that if an arraignment occurs by video and the defendant remains incarcerated, on the next date that court is in session the defendant may appear in person before a judge for a *de novo* bail review. The overarching goal must be to expedite arraignments without diminishing the rights of arrestees.²⁰

In Ms. Turner's situation, where she was ill and said that she wished to remain in or near her cell, arraignment could have been accomplished via videoconferencing had that technology been in use in Mount Vernon.

Recommendation: Increase the Personnel Authorized to Fingerprint Arrestees Subsequent to Arrest

The New York State Division of Criminal Justice Services ("DCJS") receives electronically transmitted arrestee fingerprints from law enforcement agencies 24 hours a day, seven days a week, 365 days a year.²¹ DCJS subsequently transmits information back to the law enforcement agency confirming arrestee identification, certifying past criminal history, and providing warrant information.²²

¹⁹ *See* Criminal Procedure Law §182.20 and §182.30. Pursuant to §182.30, the following limitations apply to electronic appearances:

- (1) The defendant may not enter a plea of guilty to, or be sentenced upon a conviction of, a felony;
- (2) The defendant may not enter a plea of not responsible by reason of mental disease or defect;
- (3) The defendant may not be committed to the state department of mental hygiene;
- (4) The defendant may not enter a plea of guilty to a misdemeanor conditioned upon a promise of incarceration unless such incarceration will be imposed only in the event that the defendant fails to comply with a term or condition imposed under the original sentence;
- (5) A defendant who has been convicted of a misdemeanor may not be sentenced to a period of incarceration which exceeds the time the defendant has already served when sentence is imposed.

²⁰ The District Attorney's Association of the State of New York ("DAASNY") is in the process of exploring ways that district attorneys can appear remotely at court appearances.

²¹ http://www.criminaljustice.ny.gov/pio/fp_services.htm.

²² *See* Criminal Procedure Law § 160.30.

Due to training-related issues, at the time of Ms. Turner’s incarceration, the MVPD authorized a limited number of officers to fingerprint arrestees. Because of the shortage of designated staff, Ms. Turner was not fingerprinted until approximately 36 hours after her arrival at the MVPD.²³ Accordingly, even if arraignments had occurred on Sunday, July 26, 2015, Ms. Turner would not have been arraigned, because in addition to the undrafted accusatory instruments, the court would not have had her full criminal and warrant history. Training more officers to take and transmit fingerprints to DCJS would allow more arrestees to be arraignment-ready sooner. We addressed this issue with the MVPD, and the agency is in the process of expanding its fingerprinting capabilities.

Further, allowing more officers to expeditiously confirm an arrestee’s criminal and warrant history could have the effect of allowing more low-level or misdemeanor-level offenders to be released on DATs, *i.e.*, desk appearance tickets – either alone or in conjunction with pre-arraignment bail.²⁴ See generally Criminal Procedure Law §§ 140.20(5), 160.10 (requiring fingerprinting prior to the issuance of an appearance ticket where the offense is a felony, a misdemeanor set forth in the Penal Law, or a misdemeanor not set forth in the Penal Law if the arrestee has a prior judgment of conviction for a crime). Significantly, the law regarding DATs generally is permissive; an officer may, but is not required to, issue the appearance ticket for any misdemeanor offense.²⁵

For many officers, the single most significant factor in the decision whether to issue a DAT for a misdemeanor is whether the individual has a bench warrant history and is therefore likely (or unlikely) to return to court. Although general criminal history and warrant information is available absent a comprehensive DCJS report, the information received from DCJS provides the most complete picture of an arrestee’s history. Further, the DCJS report proves the best means of corroborating an arrestee’s identity.

In Ms. Turner’s case, issuance of a DAT by the MVPD was highly unlikely; not only did she have a warrant history, but she was arrested for two separate crimes in one day (petit larcenies allegedly committed at two separate locations). However, fingerprinting earlier in the process could very well make a difference for other individuals. For instance, if an arrestee charged with low-level misdemeanor offenses was printed earlier in the process and found not to have an extensive criminal or warrant history, an officer might choose to issue a DAT and release the person from custody in lieu of holding him or her pending arraignment.

²³ This 36 hour time frame is in excess of the 24 hour period suggested by the Court of Appeals in Maxian. However, the MVPD may have prioritized fingerprinting Ms. Turner had a court been available before which to arraign her.

²⁴ See Criminal Procedure Law §§140.20(2)(b), 150.30.

²⁵ See Criminal Procedure Law § 150.20(1). Pursuant to Criminal Procedure Law § 140.20(3), in misdemeanor arrests such as Ms. Turner’s (and most Class E felony arrests), if the police officer is unable to bring the arrested person before a court with “reasonable promptness” “owing to unavailability” of the court,” the police officer must issue an appearance ticket, either with or without pre-arraignment bail. “Reasonable promptness” is not defined in the statute. Unlike the phrase “without unnecessary delay” in Criminal Procedure Law § 140.20(1), the Court of Appeals has not addressed the meaning of “reasonable promptness” in Section 140.20(3).

B. Medical Considerations

Recommendation: Update Policies to Require In-Person Arrestee Checks

Pursuant to the New York State Minimum Standards, “the condition of prisoners shall be checked, by actual visits to cells and detention rooms, at intervals not to exceed 30 minutes.”²⁶ MVPD officers informed the OAG that they performed many, if not most, of their monitoring visits by looking at the cells via closed-circuit television. While the use of closed-circuit television to monitor arrestees is an appropriate adjunct to actual cell visits, it may not be used “as a substitute for such visits.”²⁷

The MVPD policies are imprecise as to whether employees are required to perform in-person cell checks. MVPD Procedure No. 3.067 (Prisoner Suicide Prevention Screening) requires a New York State-certified MVPD Desk Officer to screen each arrestee to identify and reduce the risk of suicide. After the arrestee is screened, he or she is placed into one of three levels of supervision: constant, active, or normal. Pursuant to Procedure No. 3.067, constant supervision requires “uninterrupted personal visual observation of prisoners” 24 hours per day. (Exhibit C at 8). An arrestee is placed on constant supervision when he or she is believed to be a suicide risk. Active supervision requires “immediate availability to prisoners” and “supervisory visits to be conducted at a minimum of fifteen (15) minute intervals.” (Exhibit C at 8). The MVPD member must be able to “communicate orally with prisoner[s] and respond [to their inquiries].” (Exhibit C at 9). Normal supervision requires that the “condition” of a detainee be checked “by actual visits to cells at intervals not to exceed thirty (30) minutes.” (emphasis added). (Exhibit C at 9). However, MVPD Procedure No. 3.067 addresses the screening process, not the detention process.

The MVPD procedure outlining detention protocols (Mount Vernon Police Department Detention and Transportation Procedures – TC-1 2006 – 02/27/06) simply requires that employees “note prisoner activity” every 15 or 30 minutes, without specifying that observations of prisoner activity must be based upon actual visits. (Exhibit C at 2). Other than requiring a “[p]hysical check of cell block” at the start of a member’s tour, the MVPD detention policy does not mandate that cell checks entail actual cell visits. (Exhibit C at 1). Further, even in Procedure No. 3.067, the phrase “actual visits” is only used to describe normal supervision every 30 minutes (Exhibit C at 8 - 10).

We have addressed this issue with the MVPD and the agency is updating its written policies to reflect the state minimum standards. The MVPD now requires prisoner attendants to perform cell checks in-person, within the appropriate periods of time.²⁸

²⁶ 9 NYCRR § 7504.1(a) (emphasis added).

²⁷ 9 NYCRR § 7504.1(g).

²⁸ The N.Y.S. Commission of Correction is the state agency that oversees local prisons. We reviewed the COC’s on-site visit summaries for the MVPD for the past ten years. While the NYS COC noted issues concerning the accuracy of MVPD Jail Forms, it never cited the MVPD for failure to perform actual cell checks.

We note that compliance with the state minimum standards may require funding for additional personnel. On the date of Ms. Turner’s death, one individual (Jail Attendant Atkinson) was responsible for the care and well-being of 28 arrestees at the same time. State and local policy makers should consider the need to provide additional funding to assure compliance with all applicable state standards.

Recommendation: Re-evaluate New York State Minimum Standards Concerning Detainees Who May Need Medical Attention

The New York State Minimum Standards and Regulations for Management of City Jails – Town and Village Lockups provide that, “for situations of an emergency nature, the facilities of a conveniently located hospital, particularly emergency ward services, shall be utilized.”²⁹ Further, the National Commission on Correctional Health Care states: “Inmates [shall] have access to care to meet their serious medical, dental, and mental health needs.”³⁰ The MVPD policy governing Medical Attention to Prisoners is consistent with this standard. The MVPD policy requires that: “Prisoners who are apparently in need of medical . . . care shall promptly receive first aid if necessary, and then be transported to the proper treatment facility.”³¹ (Exhibit C at 6).

There is inherent ambiguity in what constitutes a matter “of an emergency nature,” what “serious medical . . . needs” are, and how a person “apparently in need of medical . . . care” presents himself or herself.

The OAG recommends that the New York State Commission of Correction, in conjunction with the Medical Review Board (“MRB”), re-evaluate the minimum standards to determine if more specific language would better address when emergency medical care should be provided to inmates. It would be helpful if the phrase “emergency nature” could be elucidated so that police departments and law enforcement officers have better guidance as to when detainees should be transported to a hospital. Inasmuch as part of the MRB’s duties is “to recommend such changes as it shall deem necessary and proper to improve the quality and availability of medical care,”³² this recommendation seems well suited to the Board’s mission.

²⁹ 9 NYCRR § 7503.1(a) (emphasis added).

³⁰ National Commission on Correctional Health Care, *Standards for Health Services in Jails* § J-A-01 (2014) (emphasis added).

³¹ Mount Vernon Police Department Operational Procedures – PRISONERS – MEDICAL ATTENTION, Procedure No. 3.064 Revised 1/4/93, (Exhibit C).

³² Correction Law §47(1)(e).

CONCLUSION

For the reasons stated above, we find that a homicide prosecution could not properly be sustained under the facts of this case. There is no basis to conclude that any MVPD employee failed to perceive a substantial and unjustifiable risk that Ms. Turner's death would occur or that any such failure to perceive that risk constituted a gross deviation from reasonable care. The OAG has recommended, and the MVPD has taken steps or has agreed to: (1) ensure that MVPD employees perform required cell visits in person and update MVPD's policies to reflect that in-person visits are required; (2) take administrative action relating to Prisoner Attendant Atkinson; and (3) expand the MVPD's fingerprinting capabilities. Finally, the OAG calls upon:

- (a) policymakers to address means of more swiftly bringing arrestees before arraignment judges for consideration of bail and possible release;
- (b) the COC, in conjunction with the Medical Review Board, to reevaluate the minimum standards and determine if more specific language would better address when emergency medical care should be provided to arrestees; and
- (c) policymakers to address the need to provide funding for the staffing required to ensure compliance with state regulations concerning the care of arrestees.

MOTION : POST-ALARM



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MOTION : POST-ALARM



C02[Cell 31230]7/25/2015 2:51:48 PM

MOTION : POST-ALARM



012[Cell 31230]7/26/2015 4:06:18 PM

MOTION : POST-ALARM



MOTION : POST-ALARM



MOTION : POST-ALARM



C01[Cell 29]7/27/2015 2:13:45 AM

MOTION : POST-ALARM



C01[Cell 29]7/27/2016 2:28:33 AM

MOTION : POST-ALARM



C01[Cell 29]7/27/2015 8:18:00 AM

MOTION



C01[Cell 29]7/27/2015 9:35:10 AM

MOTION : POST-ALARM



C01[Cell 29]7/27/2016 9:39:40 AM

MOTION : POST-ALARM



C01[Cell 29]7/27/2015 9:49:35 AM

MOTION : POST-ALARM



C06[Cell 23&24]7/27/2015 9:52:37 AM

MOTION : POST-ALARM



C06[Cell 23&24]7/27/2015 10:55:30 AM

MOTION : PRE-ALARM



MOTION : POST-ALARM



MOTION



MOTION : POST-ALARM



C01[Cell 29]7/27/2016 1:10:39 PM

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Department of
Laboratories and Research
93 State Road Valhalla, NY 10988

AUTOPSY REPORT

M2015-1581

Report of death by Dr. Benjamin Bristol M.D., Medical Examiner

Name: Raynette Turner

Residence: 409 South 2nd Avenue Mount Vernon, NY

Place of death: Mount Vernon Police Department

Age: 42

Sex: F

Race/Ethnicity: Black

Date & Time

Of Death: 7/27/2015 15:08

Examiner Notified: 7/27/2015 15:11

Of arrival at scene: 7/27/2015 16:28

Reported By: PO Allen

Primary police agency: Mount Vernon, NY Police Department

I hereby certify that I, Dr. Benjamin Bristol, MD have performed an autopsy (in the presence of Dr. Richards) on the above named person at the Medical Examiner's Facility, Valhalla, NY., on 7/28/2015 10:30 a.m.

Signed: Dr Ben Bristol
Dr. Benjamin Bristol
Pathologist/Medical Examiner

A certified true and correct copy

Ben Bristol, MD
Office of the Medical Examiner



Department of
Laboratory and Research
10 Davis Road Valhalla, NY 10595

AUTOPSY REPORT

NAME: Raynette Turner

CASE NUMBER: M2015-1581

- 1 -

EXTERNAL DESCRIPTION:

The deceased is a 42 year old black female who measures 5 feet 5 inches and weighs 192 pounds. The deceased is in a full state of rigidity. The body has posterior fixed lividity which is purplish red in color. The head is normocephalic, atraumatic. The face is congested. The scalp hair is long and black in a bun in the back. The irides are brown with white sclerae. The conjunctivae are congested without petechiae. The mouth is partially edentulous. Dentures are received in the bra of the deceased. The nose has a small amount of dried yellow phlegm coming from it. The neck has the trachea in the midline. The chest is well expanded and symmetrical. The breasts are soft on palpation. The abdomen is slightly protuberant with what appears to be several old laparoscopic scars and a suprapubic Pfannenstiel type scar. The genitalia are normal external female genitalia. The extremities are symmetric. There is toenail polish. The left forearm has three old fine scars measuring $\frac{1}{2}$ inch each. The fingernails are trimmed. The back is free of trauma or deformity.



Department of
Laboratory and Forensic
© Donat P. V. V. NY 10588

AUTOPSY REPORT

NAME: Raynette Turner

CASE NUMBER: M2015-1581

- 2 -

PRIMARY INCISION:

The body is opened by the usual Y-shaped thoracoabdominal incision. The abdominal pannus measures 1 ½ inches in thickness. The pericardial sac, pleural cavities and peritoneal cavity are free of excess fluid or adhesions.

CENTRAL NERVOUS SYSTEM:

The scalp is reflected by the usual intermastoid coronal incision. The soft tissues of the scalp are unremarkable. The underlying skull bones and dura are intact. The brain weighs 1500 grams. The leptomeninges are thin and transparent. There is no evidence of epidural, subdural or subarachnoid hemorrhage. The sulci and gyri are unremarkable. The gray and white matter is well delineated. No lesions are seen within the brain parenchyma. The cerebellum, midbrain, pons and medulla are unremarkable. The blood vessels at the base of the brain are thin walled and widely patent. The soft tissues and muscles of the back of the neck in the upper cervical region are reflected through the same incision and they fail to reveal hemorrhage. The tectorial membrane is incised and no hemorrhage is seen in the ligaments. There is no hemorrhage in



Department of
Laboratory and Research
10 Dana Road Valhalla, NY 10988

AUTOPSY REPORT

NAME: Raynette Turner

CASE NUMBER: M2015-1581

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the anterior paraspinal muscles. The cervical spine is intact on inspection and palpation.

CARDIOVASCULAR SYSTEM:

The weight of the heart is 370 grams. The epicardial surface is normal. The coronary arteries are large vessels with no atherosclerosis. The endocardium is smooth and glistening. The myocardium is brown and meaty. The valves are thin and pliable. The valves measure as follows: aortic 6 cm, pulmonic 6 cm, mitral 8 cm and tricuspid 12 cm. The left ventricle wall thickness is 1.4 cm while the right ventricle measures 0.3 cm in thickness. The aorta and major branches are thin and pliable.

NECK:

The soft tissues and strap muscles are dissected in a layer-wise fashion. There is no hemorrhage into any of the structures of the neck. The hyoid bone is intact. The larynx is a pliable cartilaginous structure without obstruction. The thyroid is of usual sized brown colloidal gland. The trachea is without obstruction. The laryngeal and tracheal mucosa is unremarkable.



Department of
Laboratories and Research
19 Dana Road, Yonkers, NY 10595

AUTOPSY REPORT

NAME: Raynette Turner

CASE NUMBER: M2015-1581

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RESPIRATORY SYSTEM:

The weight of the right lung is 650 grams and the left lung 570 grams. The lungs are voluminous, touching in the midline with abundant edema fluid on cut section and in the bronchi. The pleural surfaces are gray. The parenchyma is a soft gray-red in color. The pulmonary arteries are patent.

GASTROINTESTINAL SYSTEM:

The esophagus is lined by intact mucosa. The stomach has usual rugal folds. The stomach contains 12 cc of yellow fluid. The stomach has a small volume and has had a gastric operation (gastric sleeve). A metallic patch covers the fundus of the stomach. The small and large bowels are unremarkable. The appendix is present.

LIVER:

The weight of the liver is 2300 grams. There is no gallbladder. There are staples in the gallbladder fossa. The capsule of the liver is intact. The liver is a dark brown, soft organ.



Department of
Laboratories and Research
90 Town Street Yonkers, NY 10590

AUTOPSY REPORT

NAME: Raynette Turner

CASE NUMBER: M2015-1581

- 5 -

SPLEEN:

The weight of the spleen is 200 grams. The capsule is intact. The parenchyma is dark red with a myriad of enlarged white follicles.

PANCREAS:

The pancreas is of usual adult size and has soft, tan lobular parenchyma.

ADRENALS:

The adrenals are normally situated, have yellow cortices and brown medullae.

GENITOURINARY SYSTEM:

The weight of each kidney is 225 grams. The capsules are intact with a smooth cortical surface. The collecting system is normal. The bladder has focal erythematous mucosa. The internal genitalia, including the uterus, tubes, ovaries, cervix and vagina are unremarkable except for the presence of several staples in the broad ligament. There is 5 ml of urine.



Department of
Laboratory and Research
90 Demarest Village, NY 10522

AUTOPSY REPORT

NAME: Raynette Turner

CASE NUMBER: M2015-1581

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MUSCULOSKELETAL SYSTEM:

The muscles are well developed. The skeletal system is intact on inspection and palpation. The back is dissected in a layered fashion. There is no trauma to the back.

LYMPHATIC SYSTEM:

There is no lymphadenopathy.



Department of
Laboratories and Research
19 Chen Road Valhalla, NY 10595

AUTOPSY REPORT

NAME: Raynette Turner

CASE NUMBER: M2015-1581

- 7 -

PERTINENT ANATOMICAL FINDINGS:

- 1. CONGESTION AND EDEMA OF LUNGS**
- 2. STATUS POST CHOLECYSTECTOMY**
- 3. GASTRIC PATCH WITH REDUCTION IN GASTRIC VOLUME
(GASTRIC SLEEVE)**
- 4. FACIAL CONGESTION**



Department of
Laboratories and Research
29 Dana Road, Yonkers, NY 10596

AUTOPSY REPORT

NAME: Raynette Turner

CASE NUMBER: M2015-1581

- 8 -

CAUSE OF DEATH:

~~PENDING FURTHER STUDY AND INVESTIGATION~~

*Cardiomegaly with Myocardial Fibrosis; Chronic
Use of Cocaine and Morphine*

Manner: Natural

Ben Bristol MD 10/5/15
Benjamin Bristol, M.D.

Pathologist/Associate Medical Examiner

BB:dmr

August 3, 2015



Department of
Laboratory and Research
10 Zion Road, Yonkers, NY 10596

AUTOPSY REPORT

NAME: Raynette Turner

CASE NUMBER: M2015-1581

- 9 -

TOXICOLOGY:

CARDIAC AND FEMORAL BLOOD, GASTRIC, URINE, LIVER, BRAIN
AND OCULAR FLUID ARE SUBMITTED FOR DRUG AND ALCOHOL
ANALYSIS.

HISTOLOGY:

SECTIONS ARE SUBMITTED AS WELL AS RETAINED.
VIRAL CULTURES ARE TAKEN. VITREOUS CHEMISTRY IS PERFORMED.

Ben Bristol, M.D.
Benjamin Bristol, M.D.

Pathologist/Associate Medical Examiner

BB:dmr

August 3, 2015



Department of
Laboratory and Research
10 Green Road, Yonkers, NY 10595

MICROSCOPIC EXAMINATION

NAME: Raynette Turner

JOB NUMBER: M2015-1581

Heart (9): The endocardium and epicardium are unremarkable. The myocardium shows hypertrophic myofibers and foci of fibrosis.

Lungs (8): Congestion, edema and emphysema are noted. Sparse scattered lymphocytes are present in submucosa of bronchus.

Spleen (1): The follicles are unremarkable. The sinusoids are congested.

Pancreas (2): Partly autolyzed.

Liver (1): Acute congestion is noted. The hepatocytes reveal microvesicular cytoplasm.

Kidneys (1): There are normal tubules, spiral arterioles and glomeruli. No Kimmelstiel-Wilson lesions are noted. Histology is well preserved.

Adrenals (1): There is a congested layer of glomeruli, fasciculi and reticularis. The medulla of the adrenal is unremarkable.

Thyroid (1): Unremarkable

Brain (1): There are normal amphophilic neurons and no ischemia is present.

Appendix (3): The appendix shows obliteration of the lumen.

Esophagus (1): Unremarkable

Large and small intestines (2): These are well preserved tissues without inflammation and without neoplasia.

Uterus (1): Endometrial glands and myometrium are unremarkable.



Department of
Laboratory and Research
20 Dana Road, Yonkers, NY 10596

MICROSCOPIC EXAMINATION

NAME: Raynette Turner

JOB NUMBER: M2015-1581

Bone marrow (1): Normal adipose cells are present along with normal bony spicules.

Myeloid cells and erythrocytes are in normal numbers.

Pituitary (1): Unremarkable

Ben Bristol, MD

Benjamin Bristol, M.D.

Pathologist/Associate Medical Examiner

BB:dmr

September 23, 2015



WESTCHESTER COUNTY
DEPARTMENT OF
LABS AND RESEARCH
Division of Forensic Toxicology
10 Dana Road Valhalla, NY 10595

M2015-1581



TOXICOLOGY REPORT

Deceased: Raynette Turner

Age: 42 Years Dr. Benjamin Bristol

Samples Submitted for Analysis

Blood (Site: Heart) Urine Vitreous Humor Liver Brain Gastric Contents
 Blood-Femoral

Received Date: 07/30/2015

Drug Screen (Confirmed and Unconfirmed)

<u>Specimen</u>	<u>Result</u>	<u>Technique</u>
Blood	7-aminoclonazepam, zolpidem, ecgonine methyl ester, levamisole, duloxetine and aripiprazole present	IA or TOF
Urine	7-aminoclonazepam, alphahydroxy-alprazolam, cocaine and morphine present	IA

All Confirmed Results Below

All documentation pertaining to this report is available in the laboratory.

Explanation of terms: www.criminaljustice.ny.gov/forensic/standardization/toxicology.html

Quantitative Results

<u>Specimen</u>	<u>Component</u>	<u>Result</u>	<u>Technique</u>
Blood (Heart)	Ethanol	Negative	GCFID
Blood (Heart)	7-aminoclonazepam	111 ng/mL	LCMSMS
Urine	7-aminoclonazepam	1370 ng/mL	LCMSMS
Blood (Heart)	Alpha-OH-alprazolam	Not detected at a concentration of 5ng/mL	LCMSMS
Urine	Alpha-OH-alprazolam	49 ng/mL	LCMSMS
Blood (Heart)	Alprazolam	Not detected at a concentration of 5ng/mL	LCMSMS
Urine	Alprazolam	Not detected at a concentration of 27ng/mL	LCMSMS
Blood (Heart)	Clonazepam	Not detected at a concentration of 5ng/mL	LCMSMS
Urine	Clonazepam	Not detected at a concentration of 27ng/mL	LCMSMS
Blood (Heart)	Zolpidem	Present less than 5 ng/mL	LCMSMS
Urine	Zolpidem	IQS for testing	LCMSMS
Blood (Heart)	Benzoylcegonine	Not detected at a concentration of 0.02ug/mL	GCMS
Urine	Benzoylcegonine	2.30 ug/mL	GCMS
Blood (Heart)	Cocaine	Not detected at a concentration of 0.02ug/mL	GCMS
Urine	Cocaine	Present less than 0.12 ug/mL	GCMS
Blood (Heart)	6-Monoacetylmorphine	Not detected at a concentration of 10ng/mL	GCMS

Signature:

Elizabeth Spratt
Elizabeth Spratt MS, P-ABFT (Director of Toxicology)

8/24/15 Report Date: 8/24/15



M2015-1581



TOXICOLOGY REPORT

Deceased: Raynette Turner

Age: 42 Years Dr. Benjamin Bristol

Urine	6-Monoacetylmorphine	Not detected at a concentration of 50ng/mL	GCMS
Vitreous Humor	6-Monoacetylmorphine	Not detected at a concentration of 10ng/mL	GCMS
Blood (Heart)	Codeine	Not detected at a concentration of 0.06ug/mL	GCMS
Urine	Codeine	Not detected at a concentration of 0.25ug/mL	GCMS
Vitreous Humor	Codeine	Not detected at a concentration of 0.06ug/mL	GCMS
Blood (Heart)	Morphine	Not detected at a concentration of 0.06ug/mL	GCMS
Urine	Morphine	0.28 ug/mL	GCMS
Vitreous Humor	Morphine	Not detected at a concentration of 0.06ug/mL	GCMS
Blood (Heart)	Duloxetine	Present less than 0.05 ug/mL	HPLC

Signature: _____

Elizabeth Spratt
 Elizabeth Spratt MS, F-ABFT (Director of Toxicology)

8/24/15

Report Date: 8/24/15



WESTCHESTER COUNTY
DEPARTMENT OF LABORATORIES AND RESEARCH
MICROBIOLOGICAL SERVICES
10 Dana Rd., Valhalla, NY 10595
John H. Wolk, M.D., Director
914-231-1610 FINAL

Patient : TURNER, RAYNETTE
Client : MEDICAL EXAMINER
Client MRN:

Lab MRN: MX00033757
Station:
DOB: [REDACTED] 1973 Age: 42 Sex: F

LABORATORY REPORT

Order#: B5290035
Source: Tissue
Spleen

Requested by: BRISTOL, BENJAMIN
Collected: 07/28/15 11:08
Received : 07/29/15 13:34

M2015-1581

GENERAL VIRAL CULTURE
08/19/15 Virus not isolated.

■ FINAL 08/19/15 15:52



WESTCHESTER COUNTY
DEPARTMENT OF LABORATORIES AND RESEARCH
MICROBIOLOGICAL SERVICES
10 Dana Rd., Valhalla, NY 10595
John H. Wolk, M.D., Director
914-231-1610 FINAL

Patient : TURNER, RAYNETTE
Client : MEDICAL EXAMINER
Client MRN:

Lab MRN: MX00033757
Station:
DOB: [REDACTED] 1973 Age: 42 Sex: F

LABORATORY REPORT

Order#: B5290034
Source: RECTAL

Requested by: BRISTOL, BENJAMIN
Collected: 07/28/15 00:00
Received : 07/29/15 13:34

M2015-1581
Collection time not specified.

GENERAL VIRAL CULTURE
08/19/15 ** Virus not isolated.

■ FINAL '08/19/15 15:51

CLIA #: 33D0857961 ELAP #: 11844 Legend: ■ - NEW RESULT ** - RESULT WAS MODIFIED AFTER FINAL STATUS

Patient : TURNER, RAYNETTE Lab MRN: MX00033757
Westchester County Department of Laboratories and Research - Microbiological Services



WESTCHESTER COUNTY
DEPARTMENT OF LABORATORIES AND RESEARCH
MICROBIOLOGICAL SERVICES
10 Dana Rd., Valhalla, NY 10595
John H. Wolk, M.D., Director
914-231-1610 FINAL

Patient : TURNER, RAYNETTE
Client : MEDICAL EXAMINER
Client MRN:

Lab MRN: MX00033757
Station:
DOB: [REDACTED] 1973 Age:42 Sex:F

LABORATORY REPORT

Order#: B5290036
Source: Lower respiratory
LUNG TISSUE

Requested by: BRISTOL, BENJAMIN
Collected: 07/28/15 11:10
Received : 07/29/15 13:34

M2015-1581

LOWER RESP VIRAL CULTURE
08/19/15 ** Virus not isolated.

■ FINAL 08/19/15 15:53

Medical Examiner's Autopsy Report 018

Office of the Medical Examiner
 COUNTY OF WESTCHESTER
 Examination of Body

Page 2

15-1581

Turner

3a. Date of Death:	Month <u>7</u> Day <u>27</u> Year <u>15</u>	3b. Hour: <u>3:08</u>	<u>AM</u> <u>PM</u>
4c. Place of Death: Hospital or institution (if neither, give address):	<u>Muncat Vernon Police Department</u>		

I (autopsied) (examined) the body of Ragnette Turner on the 28th day of July '15 at 10⁰⁰ AM PM.

27. Manner of death:						
Natural	Accident	Homicide	Suicide	Undeter. Circum.	Unclassified	<u>Pending Investigation</u>
30. Death was caused by:						
PART I.						
PFS						
PART II. Other Significant Conditions:						
31a. If injury, Date:			Hour	31b. Locality: (City, Town, County, State)		
Month	Day	Year	M			
31c. Describe how injury occurred:						
31d. Place:					31e. At work:	
					Yes	No
32d. Was decedent hospitalized in last 2 months?				32e. If female, was pregnant in last 6 months?:		
<u>Yes</u>	No	Unknown		Yes	No	<u>Unknown</u>
33b. Date of Delivery: Month Day Year						

Report to police: Yes No Photo by: HP

Reported to: _____ at _____ by: _____

Signed: Bruce Bristol, MD Medical Examiner
 (OVER)

Medical Examiner's Autopsy Report 019

Description of Body

Approximate Age:

Sex:

Color of Skin:

Development:

Height (est.meas.):

Weight (est.):

Body Build :

Nutrition:

Hair:

Scalp:

Pubic:

Face:

Other:

Eyes:

Color:

Conjunctivae:

Mouth:

Teeth:

Breasts:

External Genitalia:

Skin (Inc. scars, tattoos, anomalies, etc.):

External Pathology (Incl. trauma):

Rigidity:

Lividity (

Body Heat

OTHER

NAME RAYNETTE TURNER
 FUNERAL DIRECTOR R. STEVEN LOGGILL F.H.
 IDENTIFIED TO - OFFICE OF MR. VERNON P.D.
 REMOVED BY Medical #108 TIME 5:00 DATE 7/27/15
 AGE 42 CLOTHING YES
 JEWELRY NO
 RETURNED BY Sharon K. TIME 12:00 DATE 7-30-15

ME. 15-1587
 CASE NO.

(M)

Westchester County
Dept. Labs/Research
Yalhalla, NY

For Investigational
Purposes Only

SEX AGE

COMMENT

PRINT 08/06/2015 14:53
S.ID A10CELET, H15-1581.3

vit, dx diather

Test	Result	Flag	Unit		
glu	4		mg/dL	0	0
creat	0.1		mg/dL	0.0	0.0
BUN	0		mg/dL	0	0
Na	69		mmol/L	0	0
K	3.9		mmol/L	0.0	0.0
Cl	57		mmol/L	0	0

Medical Examiner's Autopsy Report 021

Westchester
gov.com

GIVE NO INFORMATION ON THE CASE. REFER TO P.D. OR D.A

PRINTED
7/27/2015
10:43

Office of the Medical Examiner
Valhalla, New York 10595

REPORT OF DEATH

REPORT RECEIVED BY Inv. Sean Mc Donnell		DATE 07/27/2015	TIME 3:11pm	M.E. CASE NO M2015-1581	
REPORTED BY PO Allen		(Signature)			POLICE JURISDICTION/INCIDENT # Mount Vernon PD
NAME OF DECEASED Raynette Turner		D.O.B. 1973 [REDACTED] 1971	AGE 44 42	SEX F	RACE Black
				RELIGION ?	
					OCCUPATION
PRONOUNCED BY Medic Bookstein	DATE 07/27/2015	TIME 3:08pm	ARRIVED VIA	DATE	TIME
PLACE OF DEATH 2 Roosevelt Square N. (Mount Vernon Police Department)				IF IN HOSPITAL	
HOSPITAL MR#	NEXT OF KIN			TEL. NO.	
LAST SEEN ALIVE 07/27/2015 ~1:00pm	BY WHOM Jailer	TIME FOUND 2:45pm	BY WHOM Jailer		
IF INJURY	DATE OF INJURY	TIME OF INJURY	INJURY AT WORK		
DESCRIBE HOW INJURY OCCURRED					
LOCATION (STREET ADDRESS, TOWN OR CITY, COUNTY, STATE)					
CIRCUMSTANCES AND MEDICAL HISTORY (INCLUDE DOCTOR'S NAME AND WHEN LAST SEEN DECEASED)					
<p>Reported that the dec was being held in police station jail Taking into custody on 7/25/2015 at 2:39pm. Stated she was checked on regularly. Today she was seen throwing up around 1:00pm and again around 2:00pm. At 2:45pm the jailer check and noted her unresponsive in the cell. He contacted his supervisor first who instructed them to call EMS. Medics arrived and provided no resuscitation attempt (unknown why). She was pronounced and left on scene [REDACTED].</p> <p>[REDACTED] No signs of trauma, foul play, drugs or ETOH. Police state the dec did not request any medical aide. ADA Jean Priscoe notified by police. Inv Mc Donnell to the scene</p>					
DISPOSITION <input checked="" type="checkbox"/> Accepted <input type="checkbox"/> No Case	POLICE NOTIFIED <input type="checkbox"/> Yes <input type="checkbox"/> No	TIME	M.E. ON DUTY	TIME NOTIFIED	
BODY MOVED TO			ADMISSION BLOOD AVAILABLE <input type="checkbox"/> Yes <input type="checkbox"/> No		

GIVE NO INFORMATION ON THE CASE. REFER TO P.D. OR D.A

Westchester
[redacted] .com

Department of Laboratories and Research
Office of the Medical Examiner
10 Dana Road, Valhalla, NY 10595
914-231-1600

REPORT OF DEATH INVESTIGATION

MRW #: 15-1581

DATE: 7/27/15

POLICE JURISDICTION: Mt. Vernon

M.D. MEDICAL EXAMINER: P.B. M.D.

MEDICAL INVESTIGATOR: S. McDonnell

REPORT BY: Ben Bristol, MD

DATE/TIME OF ARRIVAL AT SCENE: 7/27 4:30 PM

NAME OF DECEASED: Turner

LAST KNOWN RESIDENCE: Mt. Vernon

BODY FOUND AT: Police jail, Mt. V.

DOB/AGE: 4/4/24 [redacted] 1973 SEX: F

RACE: BLACK

PRONOUNCED DEAD BY: Bookstein

DATE OF PRONOUNCEMENT: 7/27 TIME: 308

AM
PM

FACILITY WHERE PRONOUNCED: Mt. Vernon PP

INFORMANTS: Sexton, P.O. - HANDLING CASE
Allen, P.O.

NEXT OF KIN: [redacted]
PHONE #: [redacted]

PRESENT AT SCENE: Pat Murphy, ADM
Lt. Kennedy, Det. Div.

Herman Turner [redacted]

CIRCUMSTANCES OF DEATH: No trauma

44 y/o ♀ [redacted] found dead in cell on bench. H/O vomiting,
not feeling well. To hospital on 25th for HTN.

MEDICAL HISTORY: HTN, [redacted]

PMD: [redacted] (B)
PHONE #: [redacted]

AK PMD
No 4 s
(psychiatrist)

↑
not
PMD

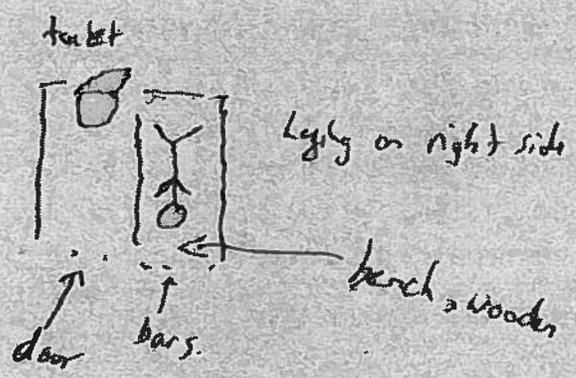
MEDICATIONS: Clonazepam, Enalapril

AMBIENT TEMPERATURE: 70's - 80's

DESCRIPTION/CONDITIONS:

SCENE DIAGRAM:

Clean cell; toilet paper in bowl



CLOTHING LIST: Floral pattern dress, bra, panties, sandals. all clean/dry/intact

BODY DESCRIPTION: Well developed f.

PHYSICAL FINDINGS:

No trauma white sclera normal eyes
 Facial Lividity flabby abdomen
 No petechiae
 Cornea intact
 No oral trauma

RIGOR: **ABSENT** SLIGHT / MODERATE / FULL / RECEDING

LIVOR: COLOR: Purple-red
 SITE: face
 BLANCHING: N

ALGOR: Slightly cool

PERSONAL EFFECTS: (INDICATE THOSE FOUND ON BODY BY ME INVESTIGATOR AND THEIR DISPOSITION)

JEWELRY: Ring to police

WALLET/POCKET BOOK None

KEYS None

FUNERAL DIRECTOR'S STATEMENT OF AUTHORITY

This statement is made for the purpose of inducing the hospital or health care facility to release the death certificate and/or the remains of the deceased below named and with the knowledge that the hospital or health care facility will rely on the truth of the statements made herein.

Medical Examiner's Autopsy Report 024
THE CITY OF NEW YORK

DEPARTMENT OF HOSPITALS

No death certificate and/or body will be released by the hospital to a funeral director until a copy of this form properly executed is on file.

IT IS HEREBY CERTIFIED THAT THE UNDERSIGNED HAS BEEN AUTHORIZED TO TAKE CHARGE OF

The remains of: (Name of deceased) <i>Kaynette K Turner</i>	who died at:	on: (date) <i>7/27/15</i>
by: (Name of person granting authority) <i>Herman Turner</i>		and who is to: (relationship) <i>Husband</i>
Remains to be removed from: (Name of hospital, health care facility or mortuary) <i>Westchester ME</i>	to: (Name of residence, funeral chapel or cemetery) <i>R. Steven LeGALL F/H</i>	at: (address) <i>169 Empire Blvd Brooklyn NY 11225</i>

THIS AUTHORIZATION HAS NOT BEEN THE RESULT OF ANY SOLICITATION BY OR ON BEHALF OF THE UNDERSIGNED

Signature: (Funeral Director) <i>[Signature]</i>	New York State Funeral Director's Lic. No.: <i>11887</i>
Representing the firm of: <i>R. Steven LeGALL F/H</i>	Address of firm: <i>169 Empire Blvd Brooklyn NY 11225</i>

Medical Examiner's Autopsy Report 025

Westchester
 R2015-1581
 Raynette Turner

Department of Laboratories & Research
 Office of the Medical Examiner
 10 Dana Road, Valhalla, New York 10885
 Tel: (914) 231-1800 Fax: (914) 231-1772

Date: 7/27/2015

PROPERTY SHEET

Name of Deceased: RAYNETTE TURNER MEWA: 2015-1581

Clothing: YES Received with body: YES Brought In by Police: _____

Belt _____	Jacket _____	Suspenders _____
Blouse _____	Pants/Slacks _____	Sweater _____
Boots _____	Scarf _____	Sweatpants _____
Coat _____	Shirt _____	Sweatshirt _____
Dress <u>X</u>	Shoes _____	Thermal Bottom _____
Gloves _____	Shorts _____	Thermal Top _____
Handkerchief _____	Skirt _____	Tie _____
Jeans _____	Slippers <u>X</u> pair	Vest _____
Hat _____	Sneakers _____	

Bedclothes: Bathroba _____ Housecoat _____ Nightgown _____ Pajamas _____
 Underclothes: Bra X Girdle _____ Panties X Pantyhose/Stockings _____
 Slip _____ T-Shirt _____ Shorts/Briefs _____ Socks _____

Other _____
 Wallet: (Contents i.e., credit cards, license) _____
 (Money present, how much?) _____

Handbag: (Contents) NONE

Jewelry: (Describe) _____

Listed by: J. McDermott #108

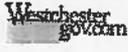
Received all items as listed above: _____

Police Department

NEW YORK STATE

[Signature]
 Funeral Home
R. Stearn Leggett F/H

Medical Examiner's Autopsy Report 026

	DEPARTMENT OF LABORATORIES AND RESEARCH Division of Forensic Sciences Valhalla, NY 10595	LAB NO: F2015-1485 Report #: 1
---	---	---

SOURCE OF REQUEST: Medical Examiner (W.C.) NY AGENCY NO. M2015-1581
DELIVERED BY: Aux Asst Alex Collado DATE & TIME: 8/4/2015 @ 11:47 hrs.
DECEASED: RAYNETTE TURNER

SPECIMEN:

The following items were received from and previously described by Kevin MacLaren of the Forensic Biology section:

- 1.4. fingernail clippings- left hand
- 1.5. fingernail clippings- right hand

For information regarding other items in this case, please refer to a report by Kevin MacLaren.

REQUEST:

Examine for trace evidence.

RESULTS / INTERPRETATIONS:

Gross and stereomicroscopic examinations were conducted and the following observations were made:

- 1.4) Five (5) clippings are present. One (1) clipping has a small amount of reddish-brown material adhering. Trace evidence was observed and was collected. The collected trace evidence consists of fibers, minerals, a gray colored paint-like chip and other trace materials.
- 1.5) Five (5) clippings are present. Trace evidence was observed and was collected. The collected trace evidence consists of fibers, minerals, two dark colored hair-like fragments (without roots) and other trace materials.

The fingernail clippings were transferred to Kevin MacLaren for possible additional analysis. Please refer to his report for results.

The collected trace evidence will be retained at the Forensic Laboratory pending possible future analysis and/or comparison to other submissions.



Daniel Rothenberg
Forensic Science Specialist
9/3/2015

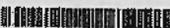
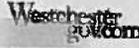
This report does not constitute the entire case file. Copies of notes, worksheets, and other supporting materials related to this case are available upon request. For definitions of standardized terms used in reporting, go to www.criminaljustice.ny.gov/forensiclaboratorystandards.htm

Medical Examiner's Autopsy Report 027

NEW YORK STATE DEPARTMENT OF HEALTH CERTIFICATE OF DEATH		STATE FILE NUMBER
<p style="text-align: center;">Raynette K. Turner</p>		<p>07 27 2015 3:08 P</p>
<p>2 ROOSEVELT SQUARE N. M2015-1581</p>		<p>POLICE DEPT. MOUNT VERNON WESTCHESTER</p>
<p>1973 42 Stamford, Connecticut</p>		
<p>Home maker New York Westchester</p>		<p>Herman Turner</p>
<p>unknown</p>		<p>Season Carol</p>
<p>Herman Turner</p>		
<p>08 02 2015 The Woodlawn Cemetery Bronx, New York</p>		
<p>R Steven LeGall Funerals 169 Empire Blvd Brooklyn, New York 11205</p>		<p>0419</p>
<p>Quddus Saaduddin Singh</p>		<p>13166</p>
<p>ISSUED AS THIS IS COMPLETED BY CERTIFIED PHYSICIAN - OR - CORONER/DEPUTY CORONER'S PHYSICIAN OR MEDICAL EXAMINER</p>		
<p>25A. CERTIFICATION: To the best of my knowledge, death occurred at the time, date and place and due to the cause stated.</p>		
<p>246152 Benjamin Bristol, MD, Westchester County Medical Examiner's Office, Yonkers, NY</p>		
<p>07 27 2015 3:08 P</p>		
<p>SEE INSTRUCTIONS SHEET FOR COMPLETING CAUSE OF DEATH.</p>		
<p>SEE INSTRUCTIONS SHEET FOR COMPLETING CAUSE OF DEATH.</p>		
<p>PENDING FURTHER STUDY</p>		

3:08 PM 07/27/15
 RAYNETTE TURNER
 CHIEF OF DEATH

Medical Examiner's Autopsy Report 028

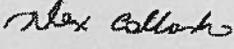
	Department of Laboratories and Research Division of Forensic Science 10 Dann Rd. Valhalla, New York 10595 Phone: (914) 231-1630	 Lab No. F2015-1405 Submission # 1	
---	---	---	--

REQUEST FOR EVIDENCE EXAMINATION

Submitting Agency: <u>Medical Examiner (W.C.) NY</u> Jurisdiction: <u>Mount Vernon</u> Recovery/Collection Date: <u>7/28/14</u> Name(s): (D): RAYNETTE TURNER (B) Business / (D) Deceased / (E) Elimination / (H) Hosp Subm / (J) Subject / (M) ME Subm / (O) Other / (S) Suspect / (V) Victim / (X) Defendant	Agency ID#/M/EW#: <u>M2015-1581</u> Case Type: <u>Death Investigation</u> Investigator Name: <u>Dr. Bristol</u> Telephone #: <u>231-1600</u> Fax#: _____ Cross reference#: _____
---	--

Brief Description and Agency Item #/Property #.
Item # 1-containing MB Kit-One labeled and sealed plastic bag containing: Nails, Nail clipper, Head hair, Pubic-hair, and Blood-Agency# 001

To be Completed Upon Submission

Submitter: <div style="text-align: center;">  Auth: Alex Collado </div>	Receiver: <div style="text-align: center;">  Susan M. Tecca </div>
--	---

By signing this document the submitter agrees that the most appropriate test method(s) will be selected at the discretion of the laboratory.

Received: 08/04/2015 1147

Contents of packaging are not inventoried at time of receipt.

Medical Examiner's Autopsy Report 029

Prelog for receipt #1

Page 1 of 1

Westchester Laboratory Analysis Electronic Packing Slip

Case Information

Sent electronically to Lab: (08/04/2015 @ 11:22)
 Division of Forensic Sciences



Department Case: M2015-1581 Submission # 1

- Department: Medical Examiner (W.C.), NY [8059] / User Name: Alexander Collado
- Department Case: M2015-1581
- Submission Number: 1
- Case Officer Pick: Dr. Bristol
- Officer Name: Dr. Bristol
- Officer Phone: 231-1600
- Recovery Date: 07/28/2014
- Offense Location: Mount Vernon Police Department..2 Roosevelt Square N
- Juris.: Mount Vernon
- Case Type: Death Investigation
- Has Prev Evid Been Submitted: No
- Case Comments: Doc was being held in police station jail

F2015-1485

Case Type: Death Investigation
 Received: 08/04/2015 by SNTS
 Inv Agency: Medical Examiner (W.C.)
 Agency Case #: M2015-1581
 Sub. By: Aut Rest Alex Collado

Submission Information

- Delivery Type: Hand Delivered
- Comments: None
- Date Sent: 08/04/2015
- Telephone#: 231-1600
- Is The Evidence Sealed: Yes
- Are The Seals Initialed: Yes

Name Information

Name Type	Full Name	Date Of Birth	Sex	Race
Deceased	TURNER, RAYNETTE	1973	Female	Black

Analysis Request Information

Item #	Package	Item Type Code	Item Description	Serial Number	Exam Requests	Evidence Recovered From
001	plastic bag	[MEKIT] ME Kit	One labeled and sealed plastic bag containing: Nails, Nail clipper, Head hair, Pubic hair, and Blood.		DNA-DNA Analysis	Victim

Medical Examiner's Autopsy Report 030



Robert F. Astorino
County Executive

Department of Laboratories and Research

Kunjetez Ashur, M.D.
Pathologist/Medical Examiner

Memorandum

Department of
Laboratories and Research

July 28, 2015

Mount Vernon Police Dept.
John Roland, Chief
2 Roosevelt Square
Mount Vernon, NY 10550

M2015-1581

This office has investigated the death of Raynette Turner, who lived at 409 South 2nd Avenue Mount Vernon, NY and died at Mount Vernon Police Department, on 07/27/2015.

Based on an investigation and a postmortem examination (with/without) autopsy, the cause of death has been certified as:

PENDING FURTHER STUDY

Signed: , M.D.
Associate Medical Examiner

Please furnish this office with a copy of the Police Report

10 Court Road
Valhalla, New York 10595
Tel. (914) 231-4215
Fax (914) 231-1772

(Rev. 12-7-05/c)

Medical Examiner
Tel. (914) 231-1600
Fax (914) 231-1772

Forensic & Toxicology
Tel. (914) 231-1630
Fax (914) 231-1798

Public Health
Tel. (914) 231-1610 (Microbiology)
Tel. (914) 231-1620 (Environmental)
Fax (914) 231-1772



Robert P. Astorino
County Executive

Department of Laboratories and Research

Kunjlata Ashar, M.D.
Pathologist/Medical Examiner

October 5, 2015

Mt. Vernon Police Department
John Roland, Chief
2 Roosevelt Square
Mt. Vernon, NY 10550

M2015-1581

This office has investigated the death of Raynette Turner 42 year old black female , who lived at 409 South 2nd Avenue Mount Vernon, NY and died at Mount Vernon Police Department, on 7/27/2015.

Based on an investigation and a postmortem examination (~~with~~ without) autopsy, the cause of death has been certified as:

CARDIOMEGALY WITH MYOCARDIAL FIBROSIS; CHRONIC USE OF COCAINE AND MORPHINE

NATURAL

Signed: Ben Binstel, M.D.
Associate Medical Examiner

10 Dana Road
Valhalla, New York 10595
Tel. (914) 231-1715
Fax (914) 231-1772

(Rev.12-7-05/c)

Medical Examiner
Tel.: (914)231-1600
Fax (914) 231-1772

Forensic & Toxicology
Tel. (914) 231.1630
Fax (914) 231-1798

Public Health
Tel. (914) 231-1610 (Microbiology)
Tel. (914) 231-1620 (Environmental)
Fax (914) 231-1772

Raynette Turner

M2015-1581

CHART AND HOSPITAL SUMMARY:

42 year old black female with [REDACTED]
 [REDACTED]
 [REDACTED] died in jail on 7/27/15 at 3:08 pm. [REDACTED]
 [REDACTED]

PT	PTT	HCG	WBC	HEMATOCRIT	PLATELET COUNT	POLYS	ELECTROLYTES SODIUM - 141 POTASSIUM - 3.9	BUN	CREATININE	AST	ALT	BILIRUBIN	IRON
10.0	25.7	N	11.2	41.0	261	63%	CHLORIDE - 110 CO2 - 29	13	0.72	16	10	0.2	58

Tests on B12 and iron were normal, thyroid tests were normal, urine analysis was unremarkable. [REDACTED]

[REDACTED]

7/26/15 - While in jail she was taken to Montefiore/Mt. Vernon hospital which is adjacent to the jail. Her chief complaint at the ER was "needs medications." Her outpatient medicine regimen is noted as follows: Cymbalta (orally 2x day), Enalapril (orally 1x day), Abilify (7 mg, orally 1 x day), Ambien (10 mg, orally 1 x day), and Xanax (2 mg, orally 2x day). She was also prescribed Clonazepam (Klonopin, 1 mg orally 1 x day) and Duloxetine (60 mg, orally 1 x day). Her vitals

Office of the Medical Examiner
COUNTY OF WESTCHESTER, N.Y.
Report of Investigation

MEW #

- Page 3 -

were normal. Temperature was 97.9 degrees Fahrenheit. Her heart rate was 65 beats per minute. Respiration is 18. Systolic and diastolic is 122/82 and pulse oximeter is 100%. No current laboratory information was available at Montefiore Mt. Vernon hospital.

7/27/15 - The ambulance service Transcare records the death note. Ms. Turner was found lying supine on her bench. No sign of trauma was visible. Lividity was noted to the back. There was no rigidity. Time of death was 15:02.

Ben Bristol, MD
Benjamin Bristol, M.D.

Pathologist/Associate Medical Examiner

BB/dmk

August 17, 2015

ME8b/6-78

Detention and Transportation Procedures - TC-1 2006 - 02/27/06

Transport

AM Procedures: Check Westchester County Department of Corrections Court List against Cell block Prisoner Log Book for any prisoners missing from said County Jail List that we have scheduled for pickup or transport. The County faxes a daily list of prisoners that are to be produced on Mondays through Fridays during regular court days; this list should be found in the fax machine located near the heat sealer in the cell block. This list is faxed to our facility between 0100 & 0400 hrs.

Contact County Jail Personnel to have them determine why there is a discrepancy and the reason for them not being produced that day... such as Prisoner has been bailed out or incorrect court date was entered.

Check all transport equipment... don't forget the chains.

All Prisoner Property is to be bagged and tagged or it will not be accepted.

****Verify that all Prisoner Forms have been completed - See Forms Section

PM Procedures: All prisoners that are to be transported to County Jail must be accompanied by a County Court Commitment, Hold or any other Court Ordered document in order to be accepted by County Jail.

All prisoner valuables and property must accompany prisoner at time of transport, said property will not be accepted by County Jail after transport.

There is no storage area at HQ/Cell block for prisoner property.

****Verify that all Prisoner Forms have been completed - See Forms Section

Detention

Start of Tour: Debrief previous Jailer/Officer on Cell Block conditions and Prisoner welfare.

Physical check of cell block - condition of cells, holding area, interview room, all locking doors including entry/egress. elevator - note all defects in cell block.

Check cell sheets against prisoners. (City of Mount Vernon Police Department Jail Form). Check number of prisoners and their condition, monitoring status. medica' needs. meals received or needed as necessary.

Complete Jail "Day Book." Physically check that jail equipment is present and operational.

Monitoring: Refer to and note on Cell Sheets
(City of Mount Vernon Police Department Jail Form)

Routine - Note prisoner activity every 30 minutes... lying down, sitting...
Also note any other activity upon occurrence... such as, meals,
Printing/photo's, legal aide. brought to court, hospital.. etc.

Active - Note prisoner activity every 15 minutes... same as above

Constant - Steady, uninterrupted watch... same as above.

***** Document any special conditions briefly....such as, medical condition(s)
and treatment received... erratic behavior/injury... damage to cell
and corresponding notification and report number(s).

Forms: Prisoner Transport & Meal Report (MV-88)

This form is to begin at the start of each day, (Midnight Tour), and is to be used
throughout each tour.

Midnight Tour starts sheet by filling out -

Date: Today's date then skip to bottom section.

Bottom section - From: Arrest (or if they came from County Jail and were held by us overnight put
"CJ"note this is not a common occurrence).

To: Left blank at start of tour

Status: Either - Routine / Active / Constant or write in the word Medical if
special meal or medical attention may be required.

Prisoners Name: Last, First

Sex: M for Male, F for Female

Warrant: Outside agency(ies) acronym, i.e., NYPD

Meals: Check appropriate boxes as completed, B for breakfast, L for Lunch, D
for dinner.

Cell #: Cell prisoner placed into.

Day and Evening Tour's complete sheet as appropriate -

Top section - Meals Served By: Name of person serving prisoner meals

Desk Officer: Print name of Desk Boss

Transport Section: Every box to be completed including departure and return time

Bottom section - From: Prisoners that come in from County Jail put "CJ."

To: As appropriate, i.e., "CJ." "DAT" for Desk Appearance Ticket, "Baj." "

"Bonded" released via Bondsman procedures, "ROR" for Released or Own
Recognizance.



ORGANIZATION

Article No. XII

PRISONER ATTENDANT			Page 1 OF 1
Date Issued 1/4/93	Effective 1/18/93	History OPS-92-03	Revised 1/4/93

SUBJECT: PRISONER ATTENDANT

PURPOSE:

To establish a position within the Department structure responsible for escorting, care and safekeeping of prisoners while incarcerated in cells at the Mount Vernon Police Headquarters/Court Facility lockup.

1. The Prisoner Attendant shall be under the jurisdiction of the Support Services Division

PRISONER ATTENDANT:

2. Generally the duties of the Prisoner Attendant shall be:

- A. Maintenance of Department Jail Form;
- B. Maintenance of Prisoner Transportation and Meal Report;
- C. Maintenance of Cell Block Damage and Equipment Log Book;
- D. Escorting, Care and safekeeping of prisoners;
- E. Care and safekeeping of prisoner's property within cell block area.
- F. Serve meals to prisoners;
- G. Maintain record of visitors in Transportation Log Book.
- H. Periodically make inspections of prisoners:
Responsible for the good order of the cell area keeping corridors and cells clear of obstruction.
- J. Responsible to report any and all damage or non- functioning equipment in cellblock area.
- K. Render first aid treatment to prisoners;
- L. Assist Desk Officer on booking procedures and any related duties.
- M. Any other duties as designated by the Police Commissioner.



OPERATIONAL PROCEDURES

Procedure No. 3.050

PRE-ARRAIGNMENT BAIL			Page 1 OF 2
Date Issued 1/4/93	Effective 1/18/93	History	Revised 1/4/93

SUBJECT: PRE-ARRAIGNMENT BAIL

PURPOSE:

To establish procedures, to act as a guide for Desk Officers fixing pre-arraignment bail.

Section 150.30 of the Criminal Procedure Law authorizes a Desk Officer "In Charge at a Police Station or Police Headquarters" to fix pre-arraignment bail and, upon the posting thereof, to issue and serve an Appearance Ticket upon the arrest person.

Also to establish procedures for Desk Officers releasing prisoners on Appearance Tickets by when Court is not in session and such release requires processing (fingerprints/photos).

NOTE: Section 150.30 reads that desk Officers "MAY" fix such bail. They are not mandated to do so.

POLICY:

1. The pre-arraignment bail, fixed by Desk Officer, will be as follows;
 - A. Class "E" Felonies - Not to exceed \$ 750.00, NO bail to be given on the following charges:
 - (1) Section 130.25 - Rape 3rd degree
 - (2) Section 130.40 - Sodomy 3rd degree
 - (3) Section 205.10 - Escape 2nd degree
 - (4) Section 205.17 - Absconding from temporary release 1st degree
 - (5) Section 205.19 - Absconding from community treatment facility
 - (6) Section 215.56 - Bail Jumping 2nd degree
 - B. Class "A" Misdemeanor - Not to exceed \$500;
 - C. Class "B" or Unclassified Misdemeanor - Not exceed \$200;
 - D. Violations (Disorderly Conduct, Harassment, etc.) - Not to exceed \$100.

Note: The Desk Officer may refuse to set bail in all cases except Unlawful Possession of Marijuana 221.05 (Violation). In this instance, the defendant must be released on an Appearance Ticket. See section 150.75 of the Criminal Procedure Law.

2. No Appearance Tickets may be issued while Court is in session.
3. No Appearance Tickets for Class A, B, C, or D Felony Arrest and Class E Felony Arrest listed in Section 1A above.
4. No Appearance Tickets for Arrested by Warrant.

5. No Appearance Tickets for Loitering 240.35 P.L. (Sub.3)
6. No appearance Tickets for Loitering 240.37 P.L. (Sub. 2)
7. The Desk Officer will not set bail if the offense for which the defendant is arrested is drug related, involving cocaine, heroin, barbiturates, amphetamines or possession of a hypodermic needle or possession of a large quantity of marijuana (over two {2} ounces).
8. No Appearance Tickets for Prostitution charges.

DESK OFFICER

9. Shall order the duty Detective to promptly process (finger print) any prisoner eligible for an Appearance Ticket.
10. No Appearance Ticket shall be issued until the prisoner has been fingerprinted and a record check for outstanding warrants has been completed.
11. With respect to charges involving Class "A" and Class "B" misdemeanors, Non-County residents shall not be released without bail.
12. The Desk Officer may not set bail on persons arrested on warrants.



OPERATIONAL PROCEDURES

Procedure No. 3.064

PRISONERS - MEDICAL ATTENTION

Page 1 OF 2

Date Issued 1/4/93

Effective 1/18/93

History OPS-85-10

Revised 1/4/93

SUBJECT: PRISONERS - MEDICAL ATTENTION

PURPOSE:

To obtain necessary medical and/or psychiatric treatment for prisoners in police custody.

POLICY:

Prisoners who are apparently in need of medical and/or psychiatric care shall promptly receive first aid if necessary, and then be transported to the proper treatment facility. All prisoners in need of psychiatric care will be kept under extremely close supervision to prevent them from harming themselves, others, or damaging property.

PROCEDURES:

ARRESTED PERSONS - MEDICAL TREATMENT

1. Prisoners in medical treatment shall be taken to the nearest medical facility, either by patrol car or ambulance, as is appropriate.

POLICE OFFICER:

2. The officer will remain with the prisoner until a preliminary diagnosis and medical treatment is rendered.
 - A. If the prisoner is not admitted, normal arrest processing procedures will be resumed. The prisoner will be transported back to Headquarters where he will be placed in the holding cell for processing.
 - B. If the prisoner is admitted, the officer will immediately notify the Desk Officer to make the necessary guard arrangements. Where the nature of the charges, and other circumstances permit, a supervisor may direct that an Appearance Ticket be issued as alternative to maintaining a guard.
3. Prisoner, to be handcuffed, hands in rear, before transporting to the hospital or Headquarters.
4. Remain with prisoner at all times in the hospital.
5. Request room change if security is adequate.
6. Do NOT remove handcuffs, unless requested by attending physician.

- A. If requested to remove handcuffs, inform physician of circumstances of arrest prior to removal, remove handcuffs if physician still requests, and replace handcuffs at completion of examination.
- B. Make appropriate entries in Official Department Memorandum Book and request attending physician to sign entries; also indicate physician's refusal to sign any entries.

ARRESTED PERSONS - PSYCHIATRIC TREATMENT

- 7. If the pending charges are a violation or misdemeanor:
 - A. The Desk Officer shall summon the Crisis Intervention Service of the Psychiatric Institute, Westchester County Medical Center, to evaluate the prisoner to determine if hospitalization is necessary. The local Mobile Crisis Unit is available twenty-four (24) hours a day. They will respond to the scene (place of occurrence), or to Headquarters.
 - B. If the Crisis Intervention Center Staff determines that the individual is to be hospitalized, the officer shall take the following action:
 - (1) Supervisor shall issue a Desk Appearance Ticket, if possible. (Note: if the subjects only unlawful conduct is disorderly conduct which is the result of a possible mental condition, the subject should not be charged, but brought to the Psychiatric Institute as per established Department Procedures.
 - C. If the Crisis Intervention Service Staff determines that the subject does not require hospitalization, arrest processing will continue.
- 8. In cases where the charge is a felony or an Appearance Ticket is inappropriate, the prisoner must first be arraigned and then committed by the Judge to the County Jail Forensic Unit. The Jail cannot accept a prisoner without a commitment document.



OPERATIONAL PROCEDURES

Procedure No. 3.067

PRISONER SUICIDE PREVENTION SCREENING

Page 1 OF 3

Date Issued 1/4/93

Effective 1/18/93

History OPS-86-22

Revised 1/4/93

SUBJECT: PRISONER SUICIDE PREVENTION SCREENING

PURPOSE:

To identify and reduce the incidence of suicides among the local prisoner population.

POLICY:

The Mount Vernon Police Department shall attempt to identify potential suicide risks and/or serious mental health problems among newly incarcerated prisoners. When such conditions are identified, the prisoner shall be kept under constant observation as long as he is in custody or appropriate aid is provided.

PROCEDURE:

1. The Desk Officer shall question arresting/transporting officers as to the mental condition of the prisoner and whether or not the prisoner displayed and depression and/or behavior that would indicate suicidal tendencies.
2. Examine prisoner's property in an effort to determine current or prior psychiatric care (Appointment cards, prescription bottles, etc.)
3. Only Desk Officers that are N.Y. State certified shall conduct the screening interview and prepare the Suicide Prevention Screening Guidelines for all prisoners lodged in the lockup at Headquarters.
4. If, after the completion of the screening interview it is determined that the prisoner:
 - A. Answers YES to question 1, 8, 9, 11, Or 16a and 16b; or
 - B. Scores in the High Risk (eight (8) or higher), then this prisoner will be considered HIGH RISK, AND the Desk Officer shall place prisoner under constant supervision.
 - C. Although prisoner may NOT have scored in those High Risk areas outlined above, the Desk Officer, in his judgment, may order a prisoner to be placed under Active Constant Supervision.

CONSTANT - ACTIVE - NORMAL SUPERVISION:

DEFINITIONS:

CONSTANT SUPERVISION: *Uninterrupted personal visual observation of prisoners by Member responsible for care and custody of prisoners.*

ACTIVE SUPERVISION: *Immediate availability to prisoners by Member responsible for care and custody of prisoners including but not limited to:*

1. *Supervisory visits to be conducted at a minimum of fifteen (15) minute intervals, and:*

2. *The ability of a Member to communicate orally with prisoner and respond.*

NORMAL SUPERVISION: *Condition of prisoner checked, by actual visits to cells at intervals not to exceed thirty (30) minutes.*

5. Any prisoner who displays signs of drinking, although not considered intoxicated, shall be placed under ACTIVE SUPERVISION, at least for as long as it takes for condition to improve.
6. If, at anytime, a prisoner is identified as suicidal or displaying serious mental health problems, his name shall be entered in the HIGH RISK ROLODEX FILE maintained behind main Desk. Also included shall be his DOB, DCJS, NCIC numbers or any other information which may be useful for future identifications. This shall be pursued every prisoner is placed into a cell.
7. A thorough search of every prisoner shall be conducted by the arresting officer in the presence of the Desk Officer. All property shall be removed, appropriately vouched and stored. Arresting Officer will be sensitive to and always remove neckties, scarves, belts, shoelaces, etc. and store with other property. Appropriate entry shall be made on property receipt.
8. If a prisoner, although under CONSTANT SUPERVISION attempts to harm himself or clearly displays paranoia or hallucinates, it will be necessary to have individual examined by a psychiatrist at the Westchester County Medical County.
9. Should Court be in session, the Judge shall immediately be notified, the prisoner arraigned and immediately transported to the Westchester County Forensic Unit along with Commitment papers, and the pink copy of the Suicide Prevention Screening Guideline Form (#330-ADM). If court is not in session, the Judge will be contacted, at home if necessary, Commitment Papers prepared, taken to the Judge for signature and previous procedure, outlined above, followed.
10. If, in the judgment of the Desk Officer, it is necessary to restrain this individual, the ambulance will be contacted and the appropriate restraining equipment applied under the supervision of medical personnel; and if necessary, transported to the Westchester County Medical Center by ambulance.
11. If it is impossible to conduct the screening because of a language barrier, prisoner will be placed on CONSTANT supervision.
12. If any changes in a prisoner's condition is detected, it shall be noted on the FORM #330-ADM. Should these changes constitute or result in a change of designation, this should also be noted. Date and time will preface these entries.
13. The pink copy shall always accompany the prisoner when being transferred from Headquarters lockup. Designated Risk prisoners will be kept under CONSTANT SUPERVISION during transportation. White copy of FORM #330-ADM will be forwarded to the Bureau of Administration, yellow copy will remain at Main desk. In addition, the Bureau of Administration, yellow copy will remain at Main Desk. In addition, the Bureau of Administration will provide a Rolodex File of "High Risk" persons for the Desk Officer's reference at each and every booking as part of the screening process. Desk Officer shall ensure that every "High Risk" prisoner is entered in the "High Risk" prisoner is entered in the "High Risk" Rolodex.
14. If a Designated Risk prisoner is released, the Desk Officer will review the form, evaluate the prisoner and determine if the prisoner might be a danger to himself or others after release. If it is determined that he might be risk or the answer to question #9 remains YES, Crisis Intervention Services will be notified and the Desk Officer guided by their directions. If they decide to respond, the prisoner will not be released until their arrival. If Crisis Team decides to commit individual, pink copy of FORM #330-ADM will be supplied. If the prisoner is released, pink copy to be destroyed. White and yellow copy will be filed as in paragraph 13.

PROCEDURE NO. 3.067

Page 3 of 3

15. The Detention Officer is responsible for the correct entries on the Jail Form and will be aware of the designation of each prisoner under his control. He will be especially watchful for verbal and behavioral indications of suicidal intent or serious mental health problems. These observations will be routinely made during regular security checks. Note worthy indications include, but are not limited to:
- A. Semiconscious or unconscious state;
 - B. Depressed state, indication of withdrawal, periods of crying, insomnia, sluggishness;
 - C. Extreme restlessness, pacing up and down;
 - D. Sudden drastic change in mood, eating or sleeping habits;
 - E. Signs of drug or alcohol withdrawal or intoxication; and
 - F. Signs of serious mental health problems such as health problems such as hallucinations and delusions.

NOTE: *It shall be the duty of the Desk Officer to properly screen each prisoner, properly complete FORM #330-ADM and to ensure proper performance of Detention Officer.*

16. Desk Officers shall notify their relief of any DESIGNATED RISK prisoners in custody when reporting for duty. The Desk Officer will examine the FORM #330-ADM of each prisoner under his control and familiarize himself with the backgrounds of all prisoners in custody.
18. Should it be necessary to administer First Aid, while awaiting the arrival of medical personnel and an ambulance, personnel may utilize the First Aid Kit behind the Main Desk.