Office of the New York State Attorney General Letitia James

Office of Special Investigation

September 10, 2024

Report on the Investigation into the Death of Michael Nieves

SUMMARY

New York Executive Law Section 70-b (Section 70-b) authorizes the Attorney General's Office of Special Investigation (OSI) to investigate and, if warranted, to prosecute offenses arising from any incident in which the death of a person is caused by a police officer or peace officer. When OSI does not seek charges, Section 70-b requires issuance of a public report. This is the public report of OSI's investigation of the death of Michael Nieves, who was incarcerated in a New York City Department of Correction (DOC) facility on Rikers Island.

OVERVIEW

Michael Nieves was incarcerated in the Anna M. Kross Center (AMKC), in a PACE unit, which a DOC employee described as a mental observation housing area and a therapeutic environment with intensive, specialized, multidisciplinary treatment, where medical and mental health clinicians provide care.

In the morning of August 25, 2022, Correction Officer Jalil Telemaque gave Mr. Nieves an institutional razor before he entered the showers. Later, when CO Telemaque asked Mr. Nieves to return the razor, Mr. Nieves said he had lost it. CO Telemaque notified Captain Mary Tinsley who responded to the housing area. She and CO Beethoven Joseph searched Mr. Nieves's cell but did not find the missing razor. They locked Mr. Nieves in his cell while they searched the cell of another person[1] who had been in the shower at the same time as Mr. Nieves, but did not find the razor there, either.

Capt. Tinsley told CO Joseph to take Mr. Nieves to the Intake unit for a body scan. According to video footage from CO Joseph's body worn camera (BWC), at 11:41 am CO Joseph went to Mr. Nieves's cell, opened the cell door, and saw Mr. Nieves leaning against a wall, bleeding heavily, but conscious. Capt. Tinsley called in a medical emergency. CO Joseph remained at the door of Mr. Nieves's cell, speaking with him as he continued to bleed. At various times while they awaited the arrival of medical staff, Capt. Tinsley, CO Joseph, and CO Jeron Smith offered a blanket and a shirt to Mr. Nieves, apparently for Mr. Nieves to put them on his wound, but he refused to take them. After watching Mr. Nieves for a few minutes, CO Joseph, apparently unsure where Mr. Nieves was bleeding, asked him if he was bleeding from the mouth or the neck; Mr. Nieves said he was bleeding from the neck.

During the wait for medical staff, neither Capt. Tinsley, nor CO Joseph, nor CO Smith, nor any other member of correction staff applied or attempted to apply pressure to Mr. Nieves's wound.

[1] In this report, any reference to a person is a reference to someone incarcerated at AMKC at the time of the incident, unless otherwise specified, such as a reference to a correction officer, a member of medical staff, etc.

Rikers medical staff arrived at 11:51 am and rendered aid. The first EMTs arrived at 12:30 pm; EMTs left the housing area with Mr. Nieves at 1:00 pm and took him to Elmhurst Hospital. On August 26, 2022, Mr. Nieves was declared brain dead and, on August 30, 2022, Mr. Nieves was removed from life support and declared dead.

The medical examiner who performed the autopsy of Mr. Nieves concluded in the written autopsy report that the cause of death was "incised wound of neck with injury of jugular vein" and that the manner of death was "suicide (cut self)." The medical examiner told OSI that the correction officers' failure to immediately render aid to Mr. Nieves before the arrival of medical staff by putting pressure on his neck wound contributed to his death. She said Mr. Nieves might have survived had someone applied pressure to his wound immediately after he was discovered with the injury. Such pressure could have closed the vein, causing the blood loss to cease earlier, increasing the chance that surgical intervention could have saved Mr. Nieves's life. However, the medical examiner said that survival would not have been guaranteed even with prompt medical intervention.

OSI concludes that the failure of Capt. Tinsley, CO Joseph, and CO Smith to render aid to Mr. Nieves was an "omission," meaning a failure to perform a duty imposed by law, pursuant to Penal Law Sections 15.00(3) and 15.10. Their omission contributed to Mr. Nieves's death, which brings the case within the scope of OSI's governing statute, Executive Law Section 70-b.[2] However, OSI concludes that a prosecutor would not be able to prove that the officers' omission caused Mr. Nieves's death beyond a reasonable doubt, and therefore closes the matter with this report rather than by seeking criminal charges.[3]

FACTS

Background

Mr. Nieves was arrested on April 9, 2019 for Burglary in the First Degree and remanded to the custody of DOC. According to court documents and Mid-Hudson Forensic Psychiatric Center (Mid-Hudson) orders, on March 2, 2022 Mr. Nieves was ordered to undergo an examination pursuant to Criminal Procedure Law Section 730 and, as a result of the examination, was deemed unfit to stand trial and committed to the custody of the New York State Office of

[2] Section 70-b states, in part, that OSI "shall investigate and, if warranted, prosecute any alleged criminal offense committed by [an officer, as defined] … concerning any incident in which the death of a person, whether in custody or not, is caused by an act or omission of such [officer] or in which the attorney general determines there is a question as to whether the death was in fact caused by an act or omission of such [officer] [emphasis added]."

[3] See also the New York City Board of Correction's "Report and Recommendations on 2022 Deaths in New York City Department of Correction Custody," which addressed the death of Mr. Nieves, here.

Mental Health at Mid-Hudson. Then, on June 1, 2022, Mr. Nieves was deemed fit to stand trial and was returned to the custody of DOC.[4]

During his re-admission to Rikers Island on June 8, 2022, a correction officer prepared an Arraignment and Classification Risk screening form and noted the following on Page 1:

- Medical Triage: "Normal"
- Do you have immediate medical needs? "No"
- Does Securing Order/Commitment Papers indicate medical/mental health attention is requested? "No"
- Physical condition as stated by inmate: "ok"
- Officer's observation, include any obvious indication of immediate medical needs or any display of extreme nervousness or depression, etc.: "Appears ok"
- Do you know of any reason why you may be at risk or need special security or protection from the General Inmate Population? "No"

The officer did not fill in answers to the questions on Page 2 of the Arraignment and Classification Risk screening form, which references suicide watch, special housing, gang affiliation, and other factors relevant to custody classification and housing.

The officer who prepared another form, the Suicide Prevention screening form, during the re-admission processing, noted that Mr. Nieves denied having or experiencing most of the risk factors listed in the "Personal Data" section; the officer noted that he answered yes to one risk factor question, "Detainee lacks support of family or friends in the community." The officer checked "No" for all risk factors in the "Behavior/Appearance" section of the form, made no written comments in the "Officer's Comments/Impressions" section, and did not indicate whether constant supervision was instituted or if Mr. Nieves was referred to medical or mental health.

According to DOC Forensic Investigator Ebony Thomas's preliminary investigative report, Mr. Nieves was evaluated by medical and mental health services upon re-admission to Rikers Island, recommended for Mental Observation Unit (MOU) housing,[5] and placed in a Program

[4] According to a supervising New York County Assistant District Attorney familiar with the case, Mr. Nieves was previously declared unfit to proceed to trial and committed to Mid-Hudson from October 16, 2019 through May 12, 2020, and found fit to proceed in October 2021 and November 2021.

[5] Mental Observation Units (MOUs) are for people with serious mental illness and provide individualized care coordinated by social workers, psychologists, psychiatrists, and pharmacists. See https://www.health.ny.gov.

for Accelerated Clinical Effectiveness (PACE) unit.[6] FI Thomas wrote that Mr. Nieves had been on suicide watch four times in prior incarcerations and once during his present incarceration.[7]

DOC Staff Incident Reports

OSI reviewed the Incident Report Forms, Intradepartmental Memorandums, and handwritten statements of CO Telemaque, CO Joseph, Capt. Tinsley, and Assistant Deputy Warden Lanice Chappelle.

In his incident report, CO Telemaque said that on August 25, 2022, he was assigned to the "A Post" in AMKC MOD 1 Upper for the 6:00 am to 6:31 pm shift.[8] He said he gave out institutional razors to people in the housing area. He said that at 10:00 am he asked Mr. Nieves to return his razor, but Mr. Nieves said he lost it.[9] CO Telemaque told Mr. Nieves to find the razor and notified Capt. Tinsley. When Capt. Tinsley arrived in the housing area, she and CO Joseph searched Mr. Nieves's cell, searched another person's cell (KJ's cell, #5),[10] and when they returned to Mr. Nieves's cell they saw he had a self-inflicted wound. CO Telemaque said a medical emergency was called and Mr. Nieves refused the officers' help.

Rikers Island institutional razor.

[6] This unit was in AMKC MOD 1 Upper A. Mr. Nieves was assigned to cell #14. FI Thomas's report describes PACE as "a Mental Observation Housing cell area designed as a therapeutic environment which offers a program of intensive, specialized, multidisciplinary treatment. Medical and Mental Health clinicians provide care directly on the unit. On the PACE unit, all cells are single occupancy."

[7] Correctional Health Services records confirm Mr. Nieves was on suicide watch from June 10 to 29, 2022.

[8] The "A Post" officer is assigned to the control room, also referred to as "the Bubble," which is glass enclosed, at or near the entry point of a housing area, containing facility phones and controls for the entry door to the housing area. Officers assigned to the control room monitor the entry door and conduct supervision tours of the housing area.

[9] CO Telemaque's incident report does not indicate the time he distributed the institutional razors. In the MOD 1 Upper razor logbook CO Telemaque noted that Mr. Nieves was given a razor at 8:56 am.

[10] OSI does not publish names of civilians other than the decedent.

In his incident report, CO Joseph said that on August 25, 2022, he was assigned to the "C Post" in AMKC MOD 1 Upper for the 6:00 am to 6:31 pm shift.[11] He said that at 8:56 am Mr. Nieves was issued a departmental razor and that at 10:30 am he refused to return the razor, claiming he couldn't find it. CO Joseph secured all persons in their cells and notified the area supervisor. He said that at 11:30 am he and Capt. Tinsley "conducted a pat frisk" of Mr. Nieves and then searched his cell (#14), but did not find a razor.[12] He said that at 11:40 am Capt. Tinsley instructed Mr. Nieves to go to Intake for a body scan. CO Joseph wrote, "While waiting for PIC[13] Nieves, [I] observed blood coming from his facial area while standing in his cell." CO Joseph said he notified the medical staff, that at 11:50 am the medical staff arrived in the housing area, and that at 12:30 pm EMS arrived.

In her incident report, ADW Chappelle said that on August 25, 2022, she was the tour commander on the 6:00 am to 2:31 pm shift and that at 10:45 am Capt. Tinsley notified her that Mr. Nieves claimed he had lost his institutional razor. ADW Chappelle said she instructed Capt. Tinsley to search Mr. Nieves, his property, and his cell, and to have him escorted to Intake for a body scan. According to ADW Chappelle, Capt. Tinsley began her search of Mr. Nieves's cell at 11:10 am.

In her incident report and intradepartmental memorandum, Capt. Tinsley said that on August 25, 2022, she was the CAPS[14] supervisor during the 7:00 am to 3:31 pm shift and that at 10:30 am she was notified that Mr. Nieves had not returned his razor and claimed not to know what had happened to it. Capt. Tinsley said she secured the housing area, searched Mr. Nieves's cell, and pat frisked Mr. Nieves, but did not find the razor.[15] Capt. Tinsley said another person, KJ, was in the shower at the time the razor was lost and that, "due to there being only 1 officer on the floor and no dayroom officer[16] I utilized CO Joseph again to search" KJ and his cell, which had negative results. She said CO Joseph returned to Mr. Nieves's cell to escort him to Intake for a body scan and, when CO Joseph opened the cell door, he found Mr. Nieves bleeding from the "facial area." According to Capt. Tinsley, Mr. Nieves was conscious and said he did not want anyone to touch him. She said a medical emergency was activated by portable radio and that she telephoned Harts Island requesting medical assistance.[17] When the

[11] Security post officers, also referred to as the "B" or "C" post officers, are required to be in the housing area supervising inmates and conducting tours.

[12] Video does not show that either CO Joseph or Capt. Tinsley performed a pat frisk of Mr. Nieves.

[13] In DOC staff usage, "PIC" stands for person in custody.

[14] CAPS (Clinical Alternative to Punitive Segregation) is a housing unit for seriously mentally ill people who have committed infractions. See, NYC DOC CAPS and PACE Backgrounder.

[15] Video does not show that Capt. Tinsley performed a pat frisk of Mr. Nieves.

[16] Contrary to Capt. Tinsley's account, video surveillance shows other COs in the control room and housing unit.

[17] A review of the radio transmissions from August 25, 2022 shows a radio transmission at 11:42 am for a medical emergency in MOD 1 Upper, and another at 11:49 am, requesting an estimated time of arrival from Harts Island. Phone records for AMKC MOD 1 Upper show calls to Harts Island, at 11:40 am, 11:44 am, and 11:45 am. AMKC has two medical clinics, the main clinic and the Harts Island clinic, which provide the same level of care; the staff in the clinic nearest a medical emergency will be the responding staff.

medical staff arrived they began treatment and 911 was activated. At 1:00 pm Mr. Nieves was removed from the unit and transported to the hospital.

In an addendum to her incident report, Capt. Tinsley said CO Telemaque told her that Mr. Nieves did not return his razor and that she told CO Telemaque to have CO Joseph, the floor officer, secure the housing unit. She said that when she arrived at the housing unit, CO Telemaque told her KJ had been in the shower area with Mr. Nieves when the razor went missing, and said he did not know which one of them had the razor. Capt. Tinsley said CO Joseph informed her that he searched Mr. Nieves and the shower area with negative findings. She said she and CO Joseph informed Mr. Nieves they were going to search his cell and property and told him to remove his mattress and stand in front of his cell to observe the search. Capt. Tinsley said they placed Mr. Nieves back in his cell after the search and that she and CO Joseph left to search KJ and his cell. After the search of KJ's cell, CO Joseph returned to Mr. Nieves's cell to escort him to Intake for a body scan; when he opened the cell door CO Joseph said, "he's leaking." Capt. Tinsley said she instructed CO Telemaque to see if the nurse was in the office on the landing, but he went to the office and no one was there. Capt. Tinsley said she radioed for a medical emergency, called the Harts Island clinic, and then returned to Mr. Nieves's cell where CO Joseph was standing in the doorway conversing with Mr. Nieves. She went to the "A" station, found a shirt, and gave it to CO Joseph to assist Mr. Nieves. Capt. Tinsley said she continued to request medical assistance through radio transmissions and calls directly to Harts Island until medical personnel arrived.

CO Jeron Smith, the PACE Escort officer on August 25, 2022, did not provide an incident report.

Witness Interviews

DOC Investigation Division investigators interviewed RB, who was housed in cell #8. RB said he did not see anything, that he was locked in his cell, and that CO Joseph was on the floor.

DOC ID investigators interviewed PD, who said Mr. Nieves was given a razor before 10:30 am. PD heard "no Nieves" and woke up. He said he did not see anything but heard the staff say, "stop doing that." PD said he saw Mr. Nieves's chest rising up when they took him out of his cell.

Medical Staff Interviews

OSI interviewed Dr. Carole Comas who said she was working in AMKC's main clinic when the correctional staff assigned to the clinic informed her of a medical emergency in the PACE Unit.[18] Dr. Comas said she was not informed of the nature of the emergency or the extent of

[18] According to Dr. Comas, correctional staff assigned to the clinic are responsible for answering calls made to the clinic and relaying the information to the medical staff.

any injuries. She said she retrieved the prepared "code cart" and stretcher and left the clinic. According to Dr. Comas, medical staff respond to all medical emergencies with the code cart and stretcher. She said the code cart is equipped with a blood pressure monitor, oxygen bag, cardiac monitor, and other medical tools, but is not typically stocked with gauze or bandages. Dr. Comas said when she arrived at the PACE housing unit she spoke with the correctional staff, asked them what happened, and told them they didn't provide any information when they called in the emergency; she said she did not recall if they responded to her comment as she was concentrating on Mr. Nieves. When asked if she had all the medical equipment she needed to provide Mr. Nieves with the care he required, Dr. Comas said she did, explaining that she used the cardiac monitor, the oxygen mask, and Mr. Nieves's blanket which she placed on his neck. Dr. Comas was asked if her response would have differed if she had been told the nature of the injury prior to leaving the clinic; she said she would have responded with gauze and additional staff. Dr. Comas said there is a medical clinic office next to the PACE unit and that a nurse is assigned to that clinic, but that she did not see the nurse when she arrived at Mr. Nieves's cell. Dr. Comas said she was the first to respond to the incident.

OSI interviewed Patient Care Associate (PCA) Nadege Josna who said that on August 25, 2022 she was working in the AMKC main clinic when the nurse in charge told her to respond to a medical emergency. PCA Josna said PCAs are not typically given specific details regarding an incident and that she was only told where to respond. She said she and Dr. Comas grabbed the medical equipment and the stretcher and left the clinic. When they arrived at Mr. Nieves's cell she asked the correctional staff if they had tried to stop the bleeding and they said Mr. Nieves did not want to be touched. PCA Josna said she went to the clinic office next to the PACE unit to get gauze, but that the nurse assigned to that office was not there or tending to Mr. Nieves. PCA Josna said she and Dr. Comas were the first to respond to Mr. Nieves's medical emergency.

Logbooks

According to the housing area's razor logbook, on August 25, 2022, at 8:56 am, CO Telemaque gave Mr. Nieves a razor.

In the MOD 1 Upper A logbook for August 25, 2022, CO Telemaque made the following entries:

- 10:40 am: Nieves still has a razor, captain notified
- 11:40 am: medical emergency announced to Harts Island, Nieves cut himself and is refusing aid from DOC staff
- 11:45 am: medical arrived on the scene
- 11:55 am: EMS activated
- 12:16 pm: EMS arrived in the building
- 12:27 pm: EMS at corridor
- 12:29 pm: EMS arrived on Post

- 12:44 pm: medical clinic called again for EMS ETA to building
- 12:46 pm: second EMS arrived on Post
- 1:01 pm: EMS departed

In the MOD 1 Upper C logbook for August 25, 2022, CO Joseph made the following entries:

- 10:30 am: Nieves refused to return institutional razor, area captain notified, all inmates secured in their cells in MOD 1 Upper A side
- 11:15 am: random search was conducted in Nieves cell to search for a razor
- 11:40 am: Nieves was given a direct order to go to intake to get a body scan
- 11:45 am: this writer observed blood leaking from Nieves' neck in his cell, all medical emergency was activated
- 11:50 am: medical emergency on post
- 12:30 pm: EMS on post
- 12:45 pm: additional EMS team arrived on post
- 1:00 pm: FDNY/EMS and all medical staff departed the housing area with Nieves

Video Surveillance

OSI reviewed video surveillance from Mr. Nieves's housing unit, which showed the housing unit and all the cell doors, but not the cells' interiors. The video did not have audio. Video showed the following on August 25, 2022, starting at 8:56 am:

- 8:56 am: Mr. Nieves went into his cell holding what looks like an institutional razor;

- 9:18 am: He came out of his cell;

- 9:21 am: A male CO and a female civilian employee approached Mr. Nieves's cell and appeared to look inside; the female employee sat at a table across from Mr. Nieves's cell;

- 9:29 am: Mr. Nieves returned to his cell;

- 9:32 am: He came out of his cell and sat with the female civilian employee at the table;

- 9:48 am: The female civilian employee left the unit;

- 9:52 am: CO Joseph opened Mr. Nieves's cell door; Mr. Nieves entered the cell while CO Joseph held the door open. CO Joseph then seemed to watch Mr. Nieves in the cell. A female CO came over and stood by the open cell door next to CO Joseph;

- 9:55 am: Mr. Nieves came out of cell with a large bag and documents and went to the table across from his cell; the female civilian employee returned to the unit and

exchanged documents with Mr. Nieves. CO Joseph stood beside them and spoke to the female employee. She left the unit;

- 10:03 am: Mr. Nieves made a phone call;[19]

- 10:30 am: Mr. Nieves appeared to conceal something in his left sock and paced back and forth throughout the unit while all the other people were locked in;

- 10:34 am: Mr. Nieves was at the on-site mental health clinic door speaking to a clinician, who gave him paper on which he began to write;

- 10:52 am: while still standing by the mental health clinic door, Mr. Nieves removed what appeared to be paper from his right sock, continued writing, placed the paper back in the right sock, and slid the other piece of paper he was writing on under the mental health clinic door;[20]

- 11:10 am: Mr. Nieves stood outside his cell with Capt. Tinsley as CO Joseph entered his cell;

- 11:20 am through 11:28 am: a female CO and CO Jeron Smith were visible in the unit;

- 11:27 am: CO Joseph came out of Mr. Nieves's cell; Mr. Nieves entered the cell and was locked in;

- 11:32 am: CO Joseph and CO Smith entered another person's cell as that person stood outside the cell with Capt. Tinsley;

- 11:38 am: CO Joseph returned to Mr. Nieves's cell, appeared to say something to Mr. Nieves through the cell door and walked away;

- 11:41 am: CO Joseph returned to Mr. Nieves's cell and opened the door; Capt. Tinsley walked over to the cell, appeared to look inside, and walked to the control room;

- 11:45 am: CO Smith arrived at the cell with what appeared to be a shirt, stood at the doorway for a few seconds and left with the shirt;

- 11:46 am: CO Joseph picked up what appeared to be a blanket from a table nearby, stood at the threshold of Mr. Nieves's cell holding the blanket with his arm extended

[19] DOC Call Detail Report shows Mr. Nieves was on the phone from 10:03 am through 10:15 am. According to DOC ID Investigator Cesaire Smith the call was an "attorney blocked call" and therefore DOC was not authorized to access the recording.

[20] DOC ID did not obtain the paper Mr. Nieves slid under the clinic door.

into the cell and dropped the blanket on the ground; CO Smith and Capt. Tinsley approached the cell door and left;

- 11:50 am: CO Joseph walked to the mental health office, appeared to look inside and then returned to Mr. Nieves's cell; medical staff arrived.

CO Joseph's Body Worn Camera (BWC)

CO Joseph was equipped with a BWC, which he activated at 11:11 am, 11:32 am, and 11:41 am.[21]

At 11:11 am CO Joseph's BWC footage showed that Mr. Nieves walked out of his cell holding his mattress as CO Joseph entered the cell and started searching it; Capt. Tinsley stood at the cell door next to Mr. Nieves. At 11:20 am Mr. Nieves said something inaudible to Capt. Tinsley and Capt. Tinsley told him he is not supposed to put the razor down and that he is supposed to return it after he uses it. At 11:28 am CO Joseph finished searching the cell and Capt. Tinsley told him to take Mr. Nieves to Intake for a body scan.[22] At 11:29 am Capt. Tinsley and CO Joseph locked Mr. Nieves in his cell and went to the control room. At 11:31 am CO Joseph turned off his BWC.

From 11:32 am through 11:36 am CO Joseph's BWC footage showed that CO Joseph and CO Smith searched KJ's cell. At 11:38 am Capt. Tinsley told CO Joseph to get Mr. Nieves for his body scan. CO Joseph approached Mr. Nieves's cell and told him he had to go to the body scan; the footage showed Mr. Nieves through the cell door windows pacing inside his cell. At 11:39 am CO Joseph walked to the control room and turned off his BWC.

At 11:41 am CO Joseph's BWC footage showed that Mr. Nieves was leaning against a wall in his cell, hunched over and bleeding from his upper body, surrounded by a large amount of blood on the floor. The BWC captured Capt. Tinsley in the background saying, "I have a medical emergency in Mod 1 Upper." CO Joseph repeatedly told Mr. Nieves to sit down but he remained standing, leaning against the wall. CO Joseph asked Mr. Nieves what happened; Mr. Nieves said the state and federal government forced him to commit suicide over his inventions, litigation, and class action lawsuit, and that they were going to send him to a satanic torture chamber. At 11:45 am CO Smith walked over to the cell holding a shirt and CO Joseph told Mr. Nieves to put it on; Mr. Nieves said, "No. This is where the buck stops." CO Joseph asked Mr. Nieves if he was bleeding from the neck or the mouth, and Mr. Nieves said his neck. At 11:47 am Capt. Tinsley and CO Smith approached the cell, and Capt. Tinsley told CO Joseph to throw a blanket in the cell. Mr. Nieves said, "No." Capt. Tinsley asked Mr. Nieves if he did not want them to help him, and he said, "No." At 11:48 am, CO Joseph asked CO

[21] CO Joseph's BWC timestamp was incorrectly set twelve hours ahead; the correct times are used in the text.
[22] After the incident a hazmat team cleaned the cell and destroyed all the property in the cell; the team did not report finding a razor during the cleanup.

Smith, who was standing near the control room, what was taking medical so long. At 11:50 am, CO Joseph walked over to the mental health office and appeared to look inside; someone sitting at a desk in the office did not come out of the office or speak with CO Joseph. CO Joseph returned to Mr. Nieves's cell; Mr. Nieves was sitting on the floor in a large amount of blood. At 11:51 am the first medical responders arrived. Medical personnel said no one told them what the emergency was and they did not have anything, including gauze. At 11:52 am medical staff yelled for someone to call EMS and the clinic. Medical staff repeatedly asked why 911 was not called. At 11:53 am CO Joseph turned off his BWC.

CO Joseph's BWC, from 11:41 am to 11:51 am, redacted according to the Attorney General's published video release policy, may be viewed here.

Officer Discipline

DOC summarily suspended Capt. Tinsley and CO Joseph on August 26, 2022, and CO Smith on August 27, 2022, for 30 days, "due to an on-going confidential investigation."[23] When they returned to work they were placed on modified duty prohibiting inmate contact. On May 24, 2023, a memorandum of complaint (MOC) was filed against CO Joseph and CO Smith citing the following Rules and Regulations:[24]

> 2.30.010: Correction Officer shall be held responsible for the safety, sanitation, and security of their posts, for the proper care, custody, control and treatment of inmates, and the enforcement of the Rules and Regulations of the Department and the command;
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> 3.05.120: Members of the Department are responsible for the efficient performance of their duties and for the proper supervision of any inmates under their direction;
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> 3.20.030: Members of the Department found guilty of any of the following offenses may be dismissed from the Department or suffer such punishment as the Commissioner may direct: 1. Violation of the rules and regulations, 4. Conduct unbecoming of an officer or employee;
>
> 3.20.300: Though not specifically mentioned in these rules and regulations, all behavior which threatens the good order and discipline and all conduct of a nature to bring discredit upon the Department shall be acted upon by the Department according to the nature and degree of the offense and punished at the discretion of the Commissioner;

[23] CO Smith's suspension was delayed by one day because he was not home when DOC ID attempted to serve him the suspension notice.

[24] Disciplinary charges are not pending against Capt. Tinsley as she has resigned from her employment with DOC.

> 7.05.010: It shall be the duty of members of the Department supervising inmates to look after the inmate's welfare and to ensure that the inmates receive proper food, clothing, and medical treatment.[25]

On August 31, 2023, formal charges and specifications were filed against CO Joseph and CO Smith. Both officers were charged with violating the Rules and Regulations listed in the MOC, as well as Directive 4521R-A, Suicide Prevention and Intervention, a directive established to assist correction officers to identify and respond to suicidal incarcerated persons and addresses "identification, referrals, monitoring/reporting, housing, communication, intervention, and training."[26]

DOC Directive 4508R-E, "Control of and Search for Contraband"

The purpose of DOC Directive 4508R-E is "to establish policy and procedures for the control of and search for contraband." The Directive regulates "inspections and searches of an inmate's person, living quarters, property and any areas in or around any New York City Department of Correction (DOC) facility." It further states, "Contraband includes items that may disrupt the safety, security, good order and discipline of the facility," including "any article which could reasonably be considered capable of causing physical injury by being used as a weapon."

A pat frisk is defined as "a search of an inmate's person and his/her clothing while the inmate is clothed. However, an inmate may be required to remove his/her coat, hat, shoes and socks and turn his/her pockets inside out. The search shall include searching into the inmate's clothing. The pat frisk is conducted to determine whether the inmate is in possession of concealed weapons or contraband secreted under or within the inmate's clothing, and it's not to be conducted to harass or punish an inmate." The directive states, "Pat Frisks shall be conducted on inmates: a. Whenever they leave or enter a housing area; b. When there is suspicion that an inmate is in possession of contraband; c. When entering court facilities; and d. At any other time it is necessary for reasons of facility security."

The directive further states, "the Department also utilizes a number of non-intrusive electronic search devices to detect contraband on a person or his/her clothing." Examples of electronic searches include the Body Orifice Scanning System (BOSS Chair), magnetometers, transfriskers, fluoroscope machines, and ion scans.[27]

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[25] A memorandum of complaint initiates the departmental disciplinary proceedings against DOC uniformed staff members. Once an MOC is filed, attorneys with the DOC Trials and Litigation Division are responsible for filing the formal charges against the uniformed staff members, and for the prosecution.

[26] As of the date of this report, the disciplinary proceedings against CO Joseph and CO Smith are still pending.

[27] The Directive also defines a strip search without body cavity search and a strip search with body cavity search and the ways they must be authorized.

Appendix B, "Isolation of Inmates Suspected of Concealing Contraband," requires a person to be isolated from other people when they are suspected of possessing contraband and refuse to surrender the suspected contraband. Once a supervisor is notified of the incident, the person "shall be escorted to a search location" where the staff "shall conduct the following searches: a. magnetometer; b. BOSS chair, and Ion Scan if necessary; c. Strip Search Without a Visual Body Cavity Search; and d. Cellsense." Afterward the person is to be placed in a jumpsuit with flex-cuffs.

DOC Training on Medical Intervention

Capt. Tinsley and COs Joseph and Smith completed DOC training for CPR-AED-First Aid.[28] The description provided in their training transcript says, "Officers must be prepared to provide CPR and First Aid to their fellow officers, staff, inmates and visitors in sudden life-threatening events. This course introduces medical emergency situations that can occur at NYC DOC and emphasizes the role and responsibility of Correction Officers in recognizing and immediately responding to such emergencies, including situations involving self-injurious behavior. During this training, Officers practice CPR and rescue breathing techniques on mannequins. They also learn the Heimlich maneuver and dressing and bandaging wounds and injuries. CPR-AED-First Aid training is mandated by State Commission of Correction."

According to DOC records, Capt. Tinsley received the CPR-AED-First Aid training in 2003, 2007, 2010, 2014, and 2018. CO Joseph received CPR-AED-First Aid training in 2017, 2020, and 2022. CO Smith received CPR-AED-First Aid training in 2014, 2017, and 2019.

OSI interviewed DOC ID Investigator Cesaire Smith who said that in the event of a medical emergency COs are instructed to contact the medical staff and await their arrival unless the person who needs aid requires CPR or is hanging from a ligature; COs must perform CPR if they are trained in the procedure and must cut any ligature used in an apparent suicide attempt.

OSI interviewed DOC Academy First-Aid Instructor Christopher Hennessey who said that COs are given eight hours of first-aid training while in the academy, provided a first-aid manual,[29] and shown a training video; a refresher course is given every two years after recruits graduate from the academy. Instructor Hennessey said if a person is bleeding significantly the CO must contact the medical staff and monitor the person until the medical staff arrives. He said the COs are not mandated to provide wound care themselves and any wound care by a CO to an inmate is discretionary. He said if a person suffers a minor cut they are to be segregated from the other people while they wait for the medical staff to arrive, but the unit supervisor may instruct a CO to transport a person to the clinic if the person is ambulatory and there is

[28] See training transcripts.

[29] OSI obtained a copy of the first-aid manual given to CO recruits. It is not specific to correctional institutions.

sufficient staff to safely secure the unit. Instructor Hennessey said the housing units are not regularly equipped with first-aid equipment or personal protective equipment (PPE).

Instructor Hennessey said COs are not trained to provide wound care. The first-aid manual given to recruits and the training video contain sections on severe bleeding, though not on bleeding from the neck. When asked about this section, Instructor Hennessey said the manual and training video are created by an outside vendor, not DOC, and, though they include wound care, the COs do not practice or train on wound care.

Instructor Hennessey said COs are trained to always call medical in a medical emergency. The only time COs are instructed to render medical aid is when a person is unresponsive; in that situation the CO is to perform CPR and administer Narcan.

OSI interviewed DOC Deputy Commissioner of Training and Development, Robert Gonzalez,[30] whose statements differed materially from Instructor Hennessey's. Deputy Commissioner Gonzalez said DOC correction officer recruits and in-service correction officers receive basic first-aid training, inclusive of wound care, bandaging and the application of pressure on open wounds. The training consists of in-class instruction, a manual, and a video. According to Deputy Commissioner Gonzalez, recruits in the academy receive practical training on wound care where they practice applying pressure on a wound and bandaging; in-service members do not repeat the practical training but are shown applicable videos on wound care. Deputy Commissioner Gonzalez said all correction officers are given a manual on basic and secondary first aid and are expected to be familiar with the lessons in the manual. Deputy Commissioner Gonzalez said if a correction officer observes a person bleeding from an open wound, the correction officer is required to apply pressure on the wound to stop or slow the bleeding while they wait for medical staff to arrive.

Text of DOC Rules on Medical Intervention

The following paragraphs are the actual text of DOC rules and regulations. The underlined phrases are emphases added by OSI.

6.15.10: In the event that an officer observes an inmate who appears to be attempting to commit suicide, the officer who first observes the inmate shall immediately summon assistance by notifying any uniformed staff member on duty in the vicinity or by communicating with any other uniformed staff member.

> 1. An officer shall take precautions against a possible attack by an inmate who may be feigning suicide, especially when there are no other officers in the vicinity. The officer

[30] Dr. Gonzalez held the position of Deputy Commission of Training and Development from December 2022 through January 2024.

shall immediately activate his/her personal body alarm or summon help via radio transmission or telephone, then take action to stop the inmate from committing suicide.

a. If an officer observes an inmate with a ligature around his/her neck that is attached to another object, the uniformed staff member shall not wait for assistance to arrive. The officer shall immediately remove or cut the ligature or, if unable to remove it, disable it, e.g. loosening it, to stop the inmate from hanging/strangling himself/herself.

2. If the inmate appears to have stopped breathing, uniformed staff shall immediately commence emergency first-aid procedures and continue performing them until medical assistance arrives

7.05.010: It shall be the duty of members of the Department supervising inmates to look after the inmate's welfare and to ensure that the inmates receive proper food, clothing, and medical treatment.

7.10.040: Whenever an inmate complains or appears to be injured or sick, prompt action shall be taken to ensure that the inmate is examined by authorized medical personnel. In instances where there are no authorized medical personnel within the facility, an ambulance shall be summoned. In the event that the urgency of the situation precludes first notifying a supervisor because a delay in obtaining medical treatment could cause a worsening of the inmate's condition, the member of the Department shall take action to ensure that the inmate is examined by authorized medical personnel and shall notify the supervisor as soon as possible, either while the inmate is being treated or immediately thereafter. In an emergency situation, when time is of the essence, the member of the Department shall contact authorized medical personnel or, where there are no authorized medical personnel within the facility, an ambulance. (Emergency health care is defined as any circumstance, other than the standard sick call or follow-up, necessitating a face-to-face encounter between medical staff and an inmate patient, to prevent loss of life, disfigurement and/ or placing of an inmate in imminent danger.)

7.10.070: In cases of an emergency requiring cardio-pulmonary resuscitation (CPR), the use of an automated external defibrillator (AED) or first aid, all qualified staff members have a responsibility to render such aid until the arrival of medical personnel. (Note: Only personnel trained and certified in CPR AED shall offer assistance. Prior to administering emergency first aid CPR/AED, certified personnel shall always use personal protective equipment (PPE) as a protective barrier. At no time, should an inmate participate in the delivery of first aid, CPR or operate an AED.)

DOC Directive 4516R-D, Injury to Inmate Reports: When an inmate complains of injury, the correction officer or any employee who received the complaint shall, as soon as possible, notify the area supervisor and apprise him/her of the inmate's complaint. In the event that the urgency of the situation precludes such notification because a delay in obtaining medical treatment could cause a worsening of the inmate's condition, the notification shall be made as soon as possible, while the inmate is either being treated or immediately thereafter….Inmates who appear to have any of the following conditions or complain of any of these conditions must be brought directly to the Clinic location for medical attention and shall not be escorted to any intake location:

a. Loss of Consciousness
b. Respiratory or Breathing Issues
c. Seizures
d. Fractures
e. Swelling and/or Bruising to the Head or Face
f. Bleeding from the Head or Face
g. Bleeding from Eyes or Ears
h. Any bleeding that appears excessive to a reasonable person
i. Disorientation
j. Any other Class A injury as defined in Directive 5006R-D, "Use of Force."

DOC Directive 4517R, Inmate Count Procedures: …. If, at any time, an officer deems an inmate is not exhibiting any signs of life or may be in need of medical attention, the officer will immediately alert the other officer(s) on post (or the nearest officer), who shall immediately notify the control room captain and request medical assistance. The counting officer shall remain in close proximity to the inmate's cell or bed, keep the inmate under close observation, and render emergency first aid as appropriate. Officers must be alert for any indication that the inmate may be attempting to lure him/her to open the cell as a ploy to injure a staff member or another inmate. The control room captain shall ensure immediate notification is made to facility medical staff and then the area's direct supervisor to report to the area. The control room captain shall then immediately notify the tour commander.

Medical Records[31]

According to Mr. Nieves's Correctional Health Services (CHS)[32] records he was seen by a unit nurse on August 24, 2022 who wrote, "Patient verbalized no health concerns or complaints. Patient ambulated with a steady gait. Patient denied pain, hallucinations, and suicidal ideations. Patient maintained displayed unkept personal hygiene [sic], and cell was clean in

[31] OSI limits the publication of medical and mental health information to the information necessary to understand the circumstances of the case.

[32] CHS is a division of the New York City Health and Hospitals Corporation and provides medical and mental health services in DOC facilities.

appearance. Patient remained largely independent from peers. Patient remains non-compliant with Lithium medication. Patient remained stable and in no sign of distress."

On August 25, 2022 Mr. Nieves was seen by a clinician for his 730 Restoration Support Team follow up who wrote, "Mr. Nieves was in the shower and met with Writer in the day area after he finished. He presented as more anxious, paranoid, and delusional during this encounter. Patient had rapid, pressured speech, intense eye contact, and tangential [*sic*]. He was difficult to interrupt. Patient was preoccupied about his inventions, the government, and legal lawsuits. He stated that he spoke with investigations yesterday sharing information about the government (stating that he 'blew the whistle') and that he feared for his life. Patient denied any suicidal ideation, intent, or plan. He also denied any homicidal ideation, intent or plan. Writer and Patient were unable to discuss legal updates as he was preoccupied about conspiracies. However, Mr. Nieves is aware of legal updates as he speaks with his attorney regularly. Patient asked Writer to make a copy of his list of inventions and legal documents. Once Writer exited the office, 2 officers stated that he had a razor that he did not return. Mr. Nieves stated he left it in his cell and seemed fearful and anxious. Writer attempted to de-escalate the situation, however, Writer was told to leave the unit."

Observation Aide Program

Pursuant to Directive 4017R-C, DOC has an Observation Aide Program in which certain incarcerated persons are designated observation aides, or suicide prevention aids, who conduct "vigilant patrols" six times per hour at irregular intervals. Observation Aide logbooks are to be maintained in the "A post" station in all housing areas where observation aides are assigned. The directive requires the "A post" officer to write the assigned observation aide's name in the Housing Area logbook. If no aide is available, the officer is to notify the housing area supervisor, who will instruct the security post officer to commence fifteen-minute tours of inspection and will assign a second correction officer to the housing area until an observation aide is available.

OSI requested the Observation Aide logbook and roster for Mr. Nieves's housing unit from August 24 and 25, 2022; according to CO Julius Johnson, the archives officer at Rikers Island, he was unable to locate the logbook for these dates. OSI was provided with the "AMKC Suicide Prevention Aide Roster," which shows that one observation aide was assigned to Mr. Nieves's housing area during the 10:00 pm – 6:00 am tour, August 24-25, which did not include the time period of the incident.

Autopsy

Dr. Kristen Landi, Medical Examiner with the NYC Office of Chief Medical Examiner, performed the autopsy of Mr. Nieves. The autopsy report states the cause of death was "incised wound of neck with injury of jugular vein" and that the manner of death was "suicide (cut self)." Dr.

Landi's report states that a small "fragment of orange plastic" was found in Mr. Nieves's stomach.

Autopsy photo of plastic removed from Mr. Nieves's stomach.

OSI interviewed Dr. Landi, who said that Mr. Nieves might have survived his injury had someone applied pressure on his neck immediately after he was discovered with the injury, but survival was not guaranteed even with prompt medical intervention.[33] According to Dr. Landi, Mr. Nieves required immediate surgical repair of the jugular vein; without surgery he would not have survived his injury, and applying pressure on his neck would have stopped or slowed the bleeding until he was transported to the hospital. Dr. Landi said, based on her review of the BWC, Mr. Nieves was conscious, speaking, and aware of his surroundings when he was discovered bleeding in his cell. Dr. Landi told OSI that, based on the autopsy and her review of the BWC, the officers' failure to put pressure on Mr. Nieves's wound contributed to his death.

Dr. Landi noted that medical staff arrived within ten minutes, but that the treatment Mr. Nieves needed was to be transported to the hospital for surgery. Dr. Landi said the correction officers did not give the medical staff sufficient information about Mr. Nieves's injury in the initial call, which in turn delayed his getting to the hospital. She said the response of DOC medical staff to the initial emergency call was slow and uncoordinated; even upon arrival at the cell, the medical staff did not immediately put pressure on Mr. Nieves's wound. Dr. Landi

[33] Dr. Landi said if the COs attempted to apply pressure on Mr. Nieves's neck and Mr. Nieves physically resisted, the nature and degree of any resulting struggle might have increased Mr. Nieves's blood pressure, resulting in increased blood flow and blood loss. Dr. Landi said that how the COs attempted to render aid and whether and how Mr. Nieves resisted would affect whether the COs' intervention would have aggravated or mitigated the injury.

told OSI that, based on the autopsy and her review of the BWC, the medical staff also contributed to Mr. Nieves's death.[34]

Request for CO Interviews

OSI contacted Joey Jackson, Esq., of the Joey Jackson Law Firm, which represents members of the Correction Officers' Benevolent Association (COBA), requesting an interview of CO Joseph and CO Smith. After consulting with his clients, Mr. Jackson advised OSI that the officers declined to be interviewed by our office.

OSI contacted James Frankie, Esq., of Frankie and Gentile, P.C., which represents members of the Correction Captains' Association, requesting an interview of Capt. Tinsley. After consulting with his client, Mr. Frankie told OSI that the captain declined to be interviewed by our office.

LEGAL ANALYSIS

Under Penal Law Section [PL] 125.10, "A person is guilty of criminally negligent homicide when, with criminal negligence, he causes the death of another person."

"Criminal negligence" is defined in PL 15.05(4): "A person acts with criminal negligence with respect to a result [in this case, death] … when he fails to perceive a substantial and unjustifiable risk that such result will occur …. The 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."

A person can be convicted of criminally negligent homicide for an omission when the person (1) fails to perform an act as to which a duty of performance is imposed by law;[35] (2) the failure of performance was blameworthy conduct in that it created or contributed to a substantial and unjustifiable risk that a person's death would occur;[36] (3) the blameworthy conduct was in fact a contributory cause of the person's death;[37] (4) the person's death was a reasonably foreseeable result of the conduct;[38] and (5) and the defendant's failure to

[34] Dr. Landi noted that the medical staff's failure to provide prompt medical treatment may have also contributed to Mr. Nieves's death. However, Section 70-b does not give OSI jurisdiction over the medical staff, and their conduct is not the subject of this investigation.

[35] Penal Law Section 15.00(3)

[36] N.Y. Crim. Jury Instr. 2d Penal Law § 125.10; *People v. Cabrera*, 10 NY3d 370, 376 (2008).

[37] *People v Fitzgerald*, 45 NY2d 574, 579 (1978).

[38] *People v Stan XuHui Li*, 34 NY3d 357, 369 (2019)

perceive the risk of death was a gross deviation from the standard of care of a reasonable person.[39]

Duty

An omission is conduct defined as a "failure to perform a duty imposed by law." PL 15.00(3), 15.10. The Court of Appeals has held that the state and its agents have a duty of care to the persons in their custody. *Sanchez v State of New York*, 99 NY2d 247, 250 (2002) ("having assumed physical custody of inmates, who cannot protect and defend themselves in the same way as those at liberty can, the State owes a duty of care to safeguard inmates"). This duty of care is found in the Correction Law, which explicitly states that the chief administrator of a jail has a duty to "receive and safely keep…each person lawfully committed to his custody." Correction Law Section 500-c. The Correction Law also requires that each facility must be established and maintained with "due regard to the health and safety of every person in the custody of the department" and "the right of every person in the custody of the department to receive humane treatment." Correction Law Section 70. The duty of care is further defined in the regulations established by the local correctional facilities. As described above, DOC Rules and Regulations 7.05.010 states, "It shall be the duty of members of the Department to look after the inmate's welfare and to ensure that the inmates receive proper food, clothing, and medical treatment," and 7.10.040 states, "Whenever an inmate complains or appears to be injured or sick, prompt action shall be taken to ensure that the inmate is examined by authorized medical personnel." DOC Directive 4516R-D, "Injury to Inmate Reports," noted above, requires COs to transport incarcerated people experiencing specified medical conditions directly to a clinic for medical attention.

The scope of the duty of care is limited to protecting incarcerated people from risks of harm that are reasonably foreseeable, "those that [correction officers] knew or should have known." *Vasquez v State*, 68 AD3d 1275, 1276 (3d Dept 2009), citing *Sanchez*, 99 NY2d 247, 255. The duty of care does not make a correction officer "an insurer of inmate safety." *Sanchez*, 99 NY2d 247, 253. The courts look to a facility's regulations, policies, past experience, and expertise to determine whether a harm was foreseeable. The duty of care includes providing reasonable care that an inmate showing signs of suicidal ideation does not take his or her own life, *Gordon v. City of New York*, 70 NY2d 839, 840 (1987), and providing timely and adequate medical care to an inmate who personnel are aware is experiencing a medical emergency, *Kagan v State*, 221 AD2d 7, 16 (2d Dept 1996) ("it is beyond cavil that the State owes a duty to provide medical care and treatment to its prisoners").

Blameworthy Conduct and Causation

[39] *People v. Cabrera*, 10 NY3d 370, 376 (2008)

Criminally negligent homicide requires proof the defendant engaged in "'blameworthy conduct' so serious that it creates or contributes to a substantial and unjustifiable risk that another person's death will occur," NY Criminal Jury Instructions 2d Penal Law Section 125.10; see *People v. Cabrera*, 10 NY3d 370, 376 (2008). The blameworthy conduct must cause a person's death to sustain a conviction for criminally negligent homicide. *People v Fitzgerald*, 45 NY2d 574, 579 (1978). A person causes the death of another person when "(1) that defendant's actions were an actual contributory cause of the death, in the sense that they forged a link in the chain of causes which actually brought about the death; and (2) that the fatal result was reasonably foreseeable." *People v Stan XuHui Li*, 34 NY3d 357, 369 (2019), quoting *People v. Davis*, 28 NY3d 294, 300, (2016) (internal quotation marks omitted). The defendant's actions need not be the only cause of death; "it is enough that the defendant's conduct set in motion" or continued in motion the events which ultimately resulted in death. *People v Matos*, 83 NY2d 509, 511 (1994).

If the decedent could not have been saved with prompt medical intervention, failure to seek medical care does not cause or contribute to causing death. *See People v. Dlugash*, 41 NY2d 725, 730-31 (1977) (defendant not guilty of homicide because the People did not prove beyond a reasonable doubt that the victim was alive at the time defendant shot him). Proof on this issue is usually provided by physicians. In *People v Henson*, 33 NY2d 63, 71 (1973), for example, the Court of Appeals cited a doctor's testimony that "the injuries suffered by [the decedent], even complicated, as they were…could have been treated almost up to the last moment of his life."

Failure to Perceive

To convict a person of criminally negligent homicide, a prosecutor must prove that the defendant had the mental state of criminal negligence.

The Court of Appeals described the mental state as "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." *People v Haney*, 30 NY2d 328, 334 (1972). What separates negligence from criminal negligence is the magnitude of the failure to perceive the risk, in that "the carelessness must be such that its seriousness would be apparent to anyone who shares the community's general sense of right and wrong." *Cabrera*, 10 NY3d 370, 376.

To determine whether the defendant's failure to perceive the risk was criminally culpable, courts look to the training, experience, and expertise of the defendant, as what would be obvious to a doctor may be imperceptible to a parent with no medical training, *People v Wong*, 81 NY2d 600, 608 (1993). In *Wong*, two caregivers were contracted to care for a three-month-old infant; the evidence showed that one of the caregivers forcefully shook the infant, leading to the baby's death. There were no external injuries, and it was unclear which defendant shook

the baby. As an initial matter, the Court held that the defendants had a duty of care, arising out of their contract with the parents. *Wong*, 81 NY2d 600, 608. The court then overturned the convictions for manslaughter and dismissed the indictments. The court found that the evidence did not demonstrate whether the "passive" (i.e. non-shaking) defendant was aware the other defendant had shaken the baby. Further, the court observed that while "there are situations where the need for prompt medical attention would be obvious to anyone—a child bleeding profusely, for example," that was not the case in *Wong*, where the baby had no external injuries and the baby's symptoms of a coma could be mistaken for ordinary sleep to someone without medical training. Id. at 608, quoting *People v Steinberg,* 79 NY2d 673, 681 (1992).

In *People v. Mayo*, 4 AD3d 827, 828 (4th Dept 2004), the court sustained the conviction of a mother who was found guilty of criminally negligent homicide for failing to seek medical care for her child, who had suffered a broken rib, puncturing his intestines; the child would have exhibited signs of excruciating pain, which would have worsened as peritonitis set in. In *People v Goddard*, 206 AD2d 653, 655 (3d Dept 1994), the court dismissed an indictment charging a babysitter with criminally negligent homicide because his failure to perceive that a baby was severely dehydrated and needed medical attention was not a gross deviation from the standard of care of a reasonable person, considering that the babysitter had no medical training and limited knowledge of the baby's medical condition.

Analysis and Conclusion

Duty

Based on the New York Correction Law and case law, the correction officers in the PACE Unit on August 25, 2022, including Capt. Tinsley, CO Joseph, and CO Smith, were legally responsible for the care of Mr. Nieves, and they had a duty to render aid to him immediately when they observed him bleeding from the neck. Their duty to render aid extended beyond calling the medical staff for assistance, as they knew the medical staff's arrival would not be instantaneous. The officers' duty was to render basic first aid, by applying pressure to Mr. Nieves's wound. However, the officers' specific duty to apply pressure to Mr. Nieves's wound without waiting for the arrival of medical staff is based primarily on the widely shared general knowledge that pressure should immediately be applied to a severely bleeding wound, as the evidence that such treatment was specifically taught or required by DOC in cases like Mr. Nieves's case is weak and conflicting.

As set forth above, Instructor Hennessey and Deputy Commissioner Gonzalez provided conflicting information as to whether DOC officers are trained in wound care beyond receiving a manual containing wound care instructions, and provided conflicting information as to whether their DOC training makes clear that officers are to treat serious wounds themselves without waiting for medical staff to arrive.

Moreover, the DOC rules and regulations quoted above generally require correction officers to respond to an injury or a medical emergency by notifying medical or bringing a person to a clinic; the only specifically described emergencies which the rules tell officers to address without waiting for medical staff are the use of a ligature in a suicide attempt, which officers are instructed to cut or disable, and the cessation of breathing, in which case officers are instructed to render first aid, which, given the context and the officers' training, clearly refers to CPR. The rules and regulations do state that officers are to use "first aid" in cases of "injury," but, in the only specific reference to severe bleeding, the rules tell officers to bring the person to the medical clinic (see above, quoted segment of DOC Directive 4516R-D).

Causation

According to Dr. Landi, the officers' failure to apply pressure on Mr. Nieves's neck contributed to his death. Mr. Nieves was conscious, breathing, and speaking when CO Joseph discovered him bleeding in his cell. Dr. Landi said that if someone had applied continuous pressure on his neck, that could have lessened the bleeding while they got him to a hospital, increasing the chances of survival. However, Dr. Landi said that survival was not guaranteed, even with prompt medical intervention.

Dr. Landi also pointed out that the response of the medical staff contributed to death. Although medical's inadequate response was partly caused by the correction officers' failure to properly inform them of the situation, medical staff still failed to put pressure on the wound immediately after they arrived, when they would have seen for themselves that pressure was the necessary action.

Conclusion

OSI concludes that the correction officers had a duty under the law to render immediate aid to Mr. Nieves by applying pressure to his wound as soon as they discovered him bleeding in his cell. However, OSI also concludes that, although the correction officers' failure to render aid to Mr. Nieves contributed to his death, a prosecutor would not be able to prove beyond a reasonable doubt that the correction officers' failure to aid Mr. Nieves caused his death.

OSI therefore will not seek charges against the correction officers and closes the matter with the issuance of this report.

RECOMMENDATION

DOC should require that officers render immediate wound care to incarcerated people experiencing severe bleeding, without waiting for the arrival of medical staff, and DOC should train all officers in wound care and provide them with the equipment needed for such care.

As already described, there is conflicting information as to whether DOC trains correction officers in wound care, and DOC rules and regulations do not clearly require officers to render care to people with severely bleeding wounds. Although we cannot know what was in the minds of the officers involved in this case, the lack of clarity in their training and in the rules may well have been a factor in their failure to render immediate aid to Mr. Nieves, which, in turn, contributed to his death.

Therefore OSI recommends:

- that DOC amend its rules and regulations to make clear that correction officers are required to treat severe bleeding without waiting for the arrival of medical staff, as the rules and regulations already make clear with respect to other life-threatening situations (use of ligatures, cessation of breathing), and
- that DOC train all officers on care of severe bleeding and provide them with the equipment needed for the job, such as personal protective equipment (PPE) and gauze and bandages, as DOC now does for other life-threatening situations (availability of, e.g., Narcan and AEDs).

Dated: September 10, 2024