15 DETAINED PERSON DEATHS ON RIKERS ISLAND IN 2022

DETAINED PERSON	DATE OF DEATH	CAUSE OF DEATH	ADAMS' ADMINISTRATION FAILURE(S)
Tarz Youngblood READ MORE	2/27/22	Overdose	**Insufficient Touring:** Did not complete tours every 30 minutes; did not check Youngblood's cell for over 3 hours. **Security & PREA Violation:** Cell window was obstructed by sheet. **Insufficiently-Staffed Post:** "A" Post Officer was not allowed detainee contact.
George Pagan READ MORE	3/17/22	Sepsis	**Missed Medical Appointments:** DOC failed to produce Pagan to **9** medical appointments in the **6** days leading to his death; Pagan did not receive necessary medication. **Delayed Medical Response on Date of Death:** No one responded until **47 minutes** after detainees alerted Officers to Pagan's medical emergency. **Unstaffed Post:** No Officer on Post until 2:30pm. **No Tours Completed:** "B" Post Officer did not tour; instead hung out with fellow CO on a different post.
Herman Diaz READ MORE	3/18/22	Choked on Orange	**No Medical Aid Performed by DOC:** The "A" Post Officer refused to perform CPR or Heimlich. **Unstaffed Post:** No Floor Officer on Post. **Insufficiently Staffed Post:** "A" Post Officer was not allowed detainee contact so he watched Mr. Diaz die while detainees begged the Officer to help. **Medical Was Not Called:** DOC claims the "A" Officer called medical but no record exists and Correctional Health Services denies any calls for help; detainees carried Mr. Diaz to the clinic.
Dashawn Carter READ MORE	5/7/22	Suicide (Hanging)	**No "Mental Health Designation":** Mr. Carter had just returned from a 9-month stay in a psychiatric facility and had previously been placed on suicide watch. **Possible Lack of Mental Health Treatment:** Waiting for final report on this; possibly did not receive meds. **Possible Delayed Medical Attention:** Waiting for final report on this; detainees performed CPR but unsure how long delay was before DOC/CHS stepped in.
Mary Yehudah READ MORE | READ MORE	5/18/22	Suspected Diabetic Ketoacidosis	**Possible Deficient Medical Care:** Correctional Health Services failed to do urinalysis; DOC failed to provide medical checkup. **Insufficient Touring:** DOC staff did not tour every 30 minutes as required; Ms. Yehudah was not checked for 90 minutes—she died during that time. **Molina Reversed Decision to Move Women off Rikers Island:** Awaiting further details; this is still under investigation. DOC originally claimed she died of an overdose but Ms. Yehudahs' family's lawsuit contained evidence that she had no illicit drugs in her system and that she died from complications from untreated diabetes.
Emanuel Sullivan READ MORE	5/28/22	Unknown	**Found dead in bed with blood dripping from nose; still under investigation.**
Antonio Bradley READ MORE	6/18/22	Suicide (Hanging)	**Delayed Response:** Mr. Bradley was hanging for 6-9 minutes before anyone assisted. **Cover-Up by DOC:** DOC compassionately released a brain-dead Mr. Bradley so that when he officially died, DOC would not have to report it; DOC did not report his death, although they were aware he died, which delayed and tarnished the Attorney General and DOI investigations.
Anibal Carrasquillo READ MORE	6/20/22	Overdose	**Insufficient Tours** **Understaffed Posts** **Closure of OBCC:** Days before his overdose, Mr. Carrasquillo was detained at OBCC. Upon closing OBCC, he was moved to GRVC, where drugs & violence are rampant.
Albert Drye READ MORE	6/21/22	Unknown	**Still no solid details here yet.**
Elijah Muhammad READ MORE	7/11/22	Suspected Overdose	**Likely Delayed Medical Attention:** Preliminary evidence that Mr. Muhammad was suffering earlier in the day with symptoms of overdose, but was ignored by staff. **Likely Insufficient Tours:** Rigor mortis had already set in by the time Muhammad's body was found.
Michael Lopez READ MORE	7/15/22	Suspected Overdose	Awaiting details but **likely neglect by corrections staff, who did not intercede in drug use.**
Ricardo Cruciani READ MORE	8/15/22	Suicide (Hanging)	**Negligence:** The DOC was directed by a judge to place Cruciani in protective custody and under suicide watch, however this was **not complied with.** **Understaffed Building:** detainee was placed in understaffed Eric M. Taylor Center with the general population.
Michael Nieves READ MORE	8/25/22	Suicide (Slit His Throat)	**Security Violation:** Mr. Nieves slit his throat with a razor that officers gave him on Rikers Island. **Negligence:** Instead of saving him, 3 Officers watched him for 10 minutes as he bled out. He was transferred to hospital and put on life support, but was pronounced brain dead. **Cover up by DOC:** DOC failed to report the incident to elected officials who toured the island later that day.
Kevin Bryan READ MORE	9/14/22	Suicide (Hanging)	**Potential Unstaffed Post in Understaffed Building:** Mr. Bryan hung himself in a locked staff bathroom after he was jumped by other detainees.
Gregory Acevedo READ MORE	9/20/22	Taken Off Life Support	**Potential Unstaffed Post in Understaffed Building:** Acevedo climbed the towering fence on the roof of the city's floating jail barge, over barbed wire, and jumped into the East River. How did the Department of Corrections enable this?

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