



DETAINED PERSON	DATE OF DEATH	CAUSE OF DEATH	ADAMS' ADMINISTRATION FAILURE(S)
<b>Chima Williams</b> <a href="#">READ MORE</a>	1/04/24	Unknown	Chima, 43, died after he collapsed playing basketball at the Eric M. Taylor Center on Rikers. This is the first jail death in 2024, following nine in 2023, 19 in 2022, and 16 in 2021.
<b>Manish Kunwar</b> <a href="#">READ MORE</a>	10/5/23	Unknown	<b>Likely Insufficient Safety Check*</b> : Manish Kunwar, 27, died in the Eric M. Taylor Center, where he had been <b>there for a week</b> . He spent about five months of 2023 in a psychiatric facility, and was picked up in Delaware after calling 911 saying he was suicidal.
<b>Donny Ubiera</b> <a href="#">READ MORE</a>	8/22/23	Unknown	<b>Delayed Medical Attention</b> : Donny Ubiera, age 33, was found unresponsive in his cell in the George R. Vierno Center at approximately 5:15 am on Tuesday. He was pronounced dead at approximately 5:51 am. <b>DOC Neglect</b> : Two detainees stated that correction officers didn't respond to Donny's cries for medical attention in the hours before he died.
<b>Curtis Davis</b> <a href="#">READ MORE</a>	7/23/23	Suspected Overdose	<b>Insufficient Safety Check</b> : An Assistant Deputy Warden signed the book but did not tour the area where Curtis died. There was also not a captain in the area due to a lack of staff. <b>Curtis did not have to die and should still be alive.</b>
<b>William Johnstone</b> <a href="#">READ MORE</a>	7/15/23	Suspected Overdose	<b>Likely Insufficient Safety Check</b> : William was found unresponsive in his cell and was taken to Mount Sinai Queens, where he died. Guards administered Narcan, suggesting <b>likely overdose</b> . This comes shortly after Commissioner Molina bragged under oath that zero overdose deaths had occurred under his watch because he's stopped drugs from coming into the jail. <b>William &amp; Felix's preventable deaths prove otherwise.</b>
<b>Ricky Howell</b> <a href="#">READ MORE</a>	7/6/23	Illness	<b>Unnecessary Detainment</b> : Ricky died of stage 4 cancer in Bellevue Hospital Prison Ward. He was arrested on Sept 2, 2022.
<b>Felix Taveras</b> <a href="#">READ MORE</a>	7/4/23	Suspected Overdose	<b>DOC Neglect</b> : Felix was taken to a clinic for medical care following complaints of chest pain, where he later died. <b>DOC has admitted to misconduct</b> —they have stated that <b>procedural violations were discovered</b> and therefore suspensions will be issued.
<b>Joshua Valles</b> <a href="#">READ MORE</a>	5/30/23	Autopsy Shows Skull Fracture (Under Investigation)	<b>Likely Foul Play &amp; Cover up by DOC</b> : DOC told the monitor that Valles "appeared to sustain a heart attack and that the Department does not suspect that any foul play occurred." <b>The autopsy shows a skull fracture.</b> We demand answers now as foul play and cover ups are clear in this case and many more by DOC.
<b>Rubu Zhao</b> <a href="#">READ MORE</a>	5/16/23	Fatal Injury (Under Investigation)	<b>Insufficient Medical Supervision</b> : Rubu was being held in Riker's most heavily staffed intensive-care psychiatric housing area, meant to have a higher degree of security and medical supervision. Clearly this supervision was lacking.
<b>Marvin Pines</b> <a href="#">READ MORE</a>	2/4/23	Seizure (Under Investigation)	<b>Insufficient Safety Check</b> : 7 Correction Officers were suspended as a result of Marvin's death—in large part because they failed to carry out their routine tours of the facility. Marvin should never have died, and was known to suffer from seizures.
<b>Edgardo Mejias</b> <a href="#">READ MORE</a>	12/11/22	Suspected Overdose	<b>Likely Insufficient Safety Check</b> : Correction Department sources said he was discovered by other detainees, who alerted staff. Several attempts were made to revive Mejias with Narcan but he did not respond, suggesting he was already too far gone by the time staff reached his side, the sources said.
<b>Gilberto Garcia</b> <a href="#">READ MORE</a>	10/31/22	Suspected Overdose	<b>Likely Insufficient Safety Check</b> : Almost 3 years to the day after he entered Rikers Island to await court date on robbery charge, 26-year-old Gilberto died of a suspected overdose and was found cold-and-blue, indicating that he had been dead for a long time.
<b>Erick Tavira</b> <a href="#">READ MORE</a>	10/22/22	Suicide (Hanging)	<b>Likely Insufficient Safety Check</b> : 28-year-old Erick was being housed in the mental health unit at the George R. Vierno Center (GRVC). This death surpassed the death count of 16 in 2021.
<b>Elmore Robert Pondexter</b> <a href="#">READ MORE</a>	9/22/22	Taken Off Life Support	<b>Potential Unstaffed Post in Understaffed Building</b> : Pondexter was intentionally granted "compassionate release" from detention, so that the Department of Corrections did not have to count his death as having occurred in their custody. This highlights the lengths to which Molina was willing to go to keep the death figures down—he specifically told his senior staff to ensure that a dying man was "off the Department's count."
<b>Gregory Acevedo</b> <a href="#">READ MORE</a>	9/20/22	Taken Off Life Support	<b>Potential Unstaffed Post in Understaffed Building</b> : 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?
<b>Kevin Bryan</b> <a href="#">READ MORE</a>	9/14/22	Suicide (Hanging)	<b>Likely Insufficiently Staffed Post</b> : Kevin hung himself in a locked staff bathroom after he was jumped by other detainees.
<b>Michael Nieves</b> <a href="#">READ MORE</a>	8/25/22	Suicide (Slit His Throat)	<b>DOC: Neglect</b> : Michael slit his throat with a razor that officers gave him on Rikers Island. 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.
<b>Ricardo Cruciani</b> <a href="#">READ MORE</a>	8/15/22	Suicide (Hanging)	<b>Likely Insufficient Safety Check</b> : The Department of Correction was directed by a judge to place Ricardo in protective custody and under suicide watch, however this was not complied with, and instead he was placed in understaffed Eric M. Taylor Center with the general population.
<b>Michael Lopez</b> <a href="#">READ MORE</a>	7/15/22	Suspected Overdose	<b>Likely DOC Neglect</b> : Awaiting details but <b>likely neglect by corrections staff, who did not intercede in drug use.</b>
<b>Elijah Muhammad</b> <a href="#">READ MORE</a>	7/11/22	Suspected Overdose	<b>Likely Delayed Medical Attention</b> : Preliminary evidence that Mr. Muhammad was suffering earlier in the day with symptoms of overdose, but was ignored by staff. <b>Likely Insufficient Safety Check</b> : Rigor mortis had already set in by the time Muhammad's body was found.
<b>Albert Drye</b> <a href="#">READ MORE</a>	6/21/22	Unknown	<b>Likely Delayed Medical Attention</b> : Albert had been hospitalized for a serious and unspecified illness for several weeks prior to his death. He was sent to hospital only 6 days after entering Rikers.
<b>Anibal Carrasquillo</b> <a href="#">READ MORE</a>	6/20/22	Overdose	<b>Delayed Medical Attention</b> : Anibal had complained of chest pain, but was ignored by DOC. <b>Cover up by DOC</b> : An officer was fired in relation to this incident, but there has been no official statement as to why. Sources say that the officer failed to intervene as he was overdosing. <b>Closure of OBCC</b> : Days before his overdose, Mr. Carrasquillo was detained at OBCC. Upon closing OBCC, he was moved to GRVC, where drugs & violence are rampant.
<b>Antonio Bradley</b> <a href="#">READ MORE</a>	6/18/22	Suicide (Hanging)	<b>Delayed Response</b> : Mr. Bradley was hanging for 6-9 minutes before anyone assisted. <b>Cover-Up by DOC</b> : 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.
<b>Emanuel Sullivan</b> <a href="#">READ MORE</a>	5/28/22	Unknown	<b>Likely Insufficient Safety Check</b> : Emanuel was found dead in his bed with blood dripping from nose. He was 20 years old. We still know very little about his death.
<b>Mary Yehudah</b> <a href="#">READ MORE</a>   <a href="#">READ MORE</a>	5/18/22	Suspected Diabetic Ketoacidosis	<b>Possible Deficient Medical Care</b> : Correctional Health Services failed to do urinalysis; DOC failed to provide medical checkup. <b>Insufficient Safety Check</b> : DOC staff did not tour every 30 minutes as required; Ms. Yehudah was not checked for 90 minutes—she died during that time. <b>Molina Reversed Decision to Move Women off Rikers Island</b> : Awaiting further details; this is still under investigation. DOC originally claimed she died of an overdose but Ms. Yehudah's family's lawsuit contained evidence that she had no illicit drugs in her system and that she died from complications from untreated diabetes.
<b>Dashawn Carter</b> <a href="#">READ MORE</a>	5/7/22	Suicide (Hanging)	<b>No "Mental Health Designation"</b> : Mr. Carter had just returned from a 9-month stay in a psychiatric facility and had previously been placed on suicide watch. <b>Possible Lack of Mental Health Treatment</b> : Waiting for final report on this; possibly did not receive meds. <b>Possible Delayed Medical Attention</b> : Waiting for final report on this; detainees performed CPR but unsure how long delay was before DOC/CHS stepped in.
<b>Herman Diaz</b> <a href="#">READ MORE</a>	3/18/22	Choked on Orange	<b>No Medical Aid Performed by DOC</b> : The "A" Post Officer refused to perform CPR or Heimlich. <b>Unstaffed Post</b> : No Floor Officer on Post. <b>Insufficiently Staffed Post</b> : "A" Post Officer was not allowed detainee contact so he watched Mr. Diaz die while detainees begged the Officer to help. <b>Medical Was Not Called</b> : 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.
<b>George Pagan</b> <a href="#">READ MORE</a>	3/17/22	Sepsis	<b>Missed Medical Appointments</b> : DOC failed to produce Pagan to 9 medical appointments in the 6 days leading to his death; Pagan did not receive necessary medication. <b>Delayed Medical Response on Date of Death</b> : No one responded until 47 minutes after detainees alerted Officers to Pagan's medical emergency. <b>Unstaffed Post</b> : No Officer on Post until 2:30pm. <b>No Tours Completed</b> : "B" Post Officer did not tour; instead hung out with fellow CO on a different post.
<b>Tarz Youngblood</b> <a href="#">READ MORE</a>	2/27/22	Overdose	<b>Insufficient Safety Check</b> : Did not complete tours every 30 minutes; did not check Youngblood's cell for over 3 hours. <b>Security &amp; PREA Violation</b> : Cell window was obstructed by sheet. <b>Insufficiently-Staffed Post</b> : "A" Post Officer was not allowed detainee contact.