UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

BRONX COUNTY PUBLIC ADMINISTRATOR AS ADMINISTRATOR OF THE ESTATE OF JOSE MEJIA MARTINEZ;

Plaintiff,

-against-

THE CITY OF NEW YORK, CORRECTION OFFICER JONATHAN PADILLA, CORRECTION OFFICER SHAKEA SMITH, CORRECTION OFFICER LUIS HERNANDEZ, and CORRECTION OFFICER JASON DIXON,

Defendants.

Index No.

COMPLAINT AND JURY DEMAND

Plaintiff Bronx County Public Administrator as Administrator of the Estate of JOSE MEJIA MARTINEZ, by and through its attorneys, Emery Celli Brinckerhoff Abady Ward & Maazel LLP, for its Complaint, alleges as follows:

1. This is a civil rights action brought on behalf of the estate of 34-year-old Jose Mejia Martinez, who died on June 10, 2021 on Rikers Island after he experienced a drug overdose, and was left in his cell for many hours, never receiving the basic medical attention that could have saved his life.

2. When Mr. Mejia Martinez arrived at the City of New York's sprawling Rikers Island jail on May 13, 2021 for a non-violent parole violation, the City knew he was struggling with multiple mental health disorders and severe cocaine use disorder.

3. Weeks later, on June 10, 2021, Mr. Mejia Martinez walked into another incarcerated person's unlocked jail cell, retrieved a plastic cup likely containing methadone, and

proceeded to consume the cup's contents in the jail unit's dayroom—a common area that should have been under supervision of correction officers.

4. Mr. Mejia Martinez quickly became visibly intoxicated and began to stumble around the dayroom. For over 40 minutes, he staggered up the unit's staircase to the top tier, where he leaned on the railing in a stupor.

5. As Mr. Mejia Martinez grew increasingly and visibly incapacitated, no correction officers helped him. One correction officer—Defendant Officer Padilla—walked right past as Mr. Mejia Martinez stood slumped over the stairwell railing.

6. Eventually, other incarcerated people helped Mr. Mejia Martinez back to his cell, carrying him at times.

7. Mr. Mejia Martinez then slowly lost consciousness in his unlocked jail cell as he overdosed on methadone.

8. Correction officers stopped by occasionally to peer into his cell and observe him as he overdosed, but still no officer did anything to help Mr. Mejia Martinez.

9. No officers attempted CPR or gave him first aid. None administered naloxone, even though the life-saving drug was available. The officers assigned to Mr. Mejia Martinez's unit did not even bother to call for medical assistance.

10. After over three hours alone in his cell, slowly dying from methadone intoxication, another incarcerated individual discovered Mr. Mejia Martinez was unresponsive and summoned help. Only then did a correction officer finally call in a medical emergency.

11. Instead of administering CPR, first aid, or naloxone, correction officers then stood around Mr. Mejia Martinez's cell and waited for medical staff to arrive.

12. It was too late—Mr. Mejia Martinez was already dead and showing signs of rigor mortis by the time medical staff arrived at his cell.

13. Mr. Mejia Martinez's death was not only caused by individual correction officers' deliberate indifference to his serious medical needs—it was also the direct result of the City of New York's widespread and persistent policies, customs, and practices of deficient supervision in its jails, failing to provide emergency first aid to incarcerated people, and failing to train correctional staff to administer naloxone to individuals who are experiencing a drug overdose.

14. Mr. Mejia Martinez's hours of suffering and ultimate death were preventable and needless. Defendants' actions were contrary to law, contrary to sound correctional and medical practice, and contrary to the norms of a civilized society. This Complaint, arising from Mr. Mejia Martinez's tragic death, seeks to hold Defendants accountable for their violations of Mr. Mejia Martinez's constitutional rights.

PARTIES

15. Plaintiff is the Bronx County Public Administrator ("the Public Administrator"). The Public Administrator has duly applied to the Bronx County Surrogate's Court to be appointed the administrator of the estate of Jose Mejia Martinez for the purposes of bringing this action. On June 1, 2023, the Bronx County Surrogate's Court issued Temporary Letters of Administration for the estate of Jose Mejia Martinez to the Public Administrator.

16. Jose Mejia Martinez was a citizen of the Dominican Republic and resided at Rikers Island jail in Bronx County at the time these events occurred.

17. Defendant the City of New York (the "City") is a municipal corporation that, through the Department of Correction ("DOC"), operates a number of jails on Rikers Island

including the George R. Vierno Center ("GRVC"). DOC is responsible for the provision of medical care and services to prisoners confined in the City jails, including the jails in which Mr. Mejia Martinez was confined between May 13, 2021 to June 10, 2021.

18. DOC, through its senior officials at the central office and in each jail facility, promulgates and implements policies, including those with respect to the provision of healthcare, and access to medical and other program services mandated by local law and court orders. In addition, senior officials at DOC are aware of and tolerate certain practices by subordinate employees in the jails, including those that are inconsistent with formal policy. Because they are widespread, longstanding, and deeply embedded in the culture of the agency, these practices constitute unwritten DOC policies, customs, or practices. DOC is also responsible for the appointment, training, supervision, and conduct of all DOC personnel, including the individual Defendants referenced herein.

19. At all times relevant, Correction Officer Jonathan Padilla was employed by the DOC and assigned to the GRVC.

20. At all times relevant, Correction Officer Shakea Smith was employed by the DOC and assigned to the GRVC.

21. At all times relevant, Correction Officer Luis Hernandez was employed by the DOC and assigned to the GRVC.

22. At all times relevant, Correction Officer Jason Dixon was employed by the DOC and assigned to the GRVC.

23. At all times relevant, Defendants Officers Padilla, Smith, Hernandez, and Dixon (the "Individual Officer Defendants") were officers of the DOC, who participated in and/or had knowledge of and failed to intervene in the denial of prompt medical care to Mr.

Mejia Martinez on June 10, 2021. At all times relevant, the Individual Officer Defendants were acting under color of state law and within the scope of their capacities as agents, servants, and employees of Defendant City. The Individual Officer Defendants are sued in their individual capacities.

24. By Decision and Order of the Supreme Court, Bronx County entered on November 17, 2022, Mr. Mejia Martinez's mother, Martha Martinez, acting as the putative administrator of Mr. Mejia Martinez's estate, was granted leave to serve a late Notice of Claim on the City on behalf of Mr. Mejia Martinez's estate, and subsequently served said notice of claim on December 22, 2022.

25. The City subsequently conducted an examination pursuant to General Municipal Law § 50-H on January 31, 2023.

26. At least thirty days have passed since the Notice of Claim was served on the City, and adjustment and payment thereof has been neglected or refused by the City.

JURISDICTION AND VENUE

27. This action arises under the Eighth and Fourteenth Amendments to the United States Constitution, 42 U.S.C. §§ 1983, and New York State law.

28. This Court has subject matter jurisdiction over Plaintiff's federal law claims pursuant to 28 U.S.C. §§ 1331 and 1343(a)(3)-(4) because Plaintiff's claims arise under the laws of the United States, namely 42 U.S.C. § 1983, and seek redress of the deprivation, under color of state law, of rights guaranteed by the Constitution of the United States.

29. This Court has supplemental jurisdiction over Plaintiff's state law claims pursuant to 28 U.S.C. § 1367(a).

30. Venue lies in this Court pursuant to 28 U.S.C. § 1391(b) because Defendant City of New York resides in this judicial district and the acts complained of occurred in this judicial district.

JURY DEMAND

31. Plaintiff demands trial by jury in this action.

STATEMENT OF FACTS

Jose Mejia Martinez Arrives at Rikers

32. On May 13, 2021, Jose Mejia Martinez was arrested for petit larceny, criminal possession of stolen property, and criminal possession of a controlled substance. He was sent to Rikers Island.

33. On information and belief, Mr. Mejia Martinez was detained in the custody, care, and control of the New York City Department of Correction ("DOC") at Rikers Island for 28 days until his death in custody on June 10, 2021.

34. When he was first admitted to DOC custody, Mr. Mejia Martinez was diagnosed with multiple mental health disorders and severe cocaine use disorder.

35. Mr. Mejia Martinez also tested positive for cocaine when he was first admitted to DOC custody.

36. Throughout his DOC incarceration, he disclosed a significant substance use history of K2, opioids, cannabis, alcohol, and cocaine.

37. On May 15, 2021, Mr. Mejia Martinez was referred to A Road Not Taken ("ARNT"), a substance abuse program operating at Rikers.

38. ARNT is not a medication-assisted treatment program.

39. On May 19, 2021, Mr. Mejia Martinez reported "low-level anxiety related to lack of access to cocaine use, after daily use of $100" of cocaine.

40. By June 8, 2021, Mr. Mejia Martinez's referral to ARNT still appeared as an open order.

41. Mr. Mejia Martinez was not prescribed methadone at any point during his DOC incarceration.

Mr. Martinez Slowly Overdoses on Methadone in Housing Unit Common Areas in Plain View of Correction Officers

42. On June 10, 2021, at approximately 10:09 a.m., while Mr. Mejia Martinez was detained in a housing unit at GRVC, he entered Cell #5—a cell which was not his own—and retrieved a white plastic cup.

43. On information and belief, at that time, Cell #5 was left unlocked by the correction officers supervising Mr. Mejia Martinez's housing unit.

44. DOC records concerning Mr. Mejia Martinez's death reflect that the GRVC's "Facility's Management Team acknowledges that keeping housing area cell doors unlocked for prolong [sic] periods of time is a constant issue."

45. According to a correction officer who worked on the unit where Mr. Mejia Martinez died and who was later interviewed by the New York City Board of Correction ("BOC"), "the cell doors in that unit did not lock," which was "an operational issue that went unaddressed prior to Mr. Mejia [Martinez's] death."

46. After retrieving the plastic cup, Mr. Mejia Martinez then walked back into the dayroom—the housing unit's common area—and ingested the substance in the plastic cup.

Fig. A – Mr. Mejia Martinez Ingests a Substance Contained in a Plastic Cup

47. At around 11:26 a.m. on that same day, Mr. Mejia Martinez began acting noticeably lethargic.

48. Mr. Mejia Martinez sluggishly walked around the dayroom, stopping frequently to place his hand on his head.

49. Incarcerated people present in the dayroom noticed that Mr. Mejia Martinez "seemed high."

50. A DOC civilian staff member observed Mr. Mejia Martinez sitting at a table in the dayroom and noticed that Mr. Mejia Martinez looked ill.

51. At approximately 11:46 a.m., Mr. Mejia Martinez walked up towards the top tier of the housing unit common area and nodded off while holding onto the stairwell railing.

52. Mr. Mejia Martinez spent approximately 40 minutes struggling to climb the stairs or stand upright. He repeatedly stopped, leaned over, and held his head.

53. Mr. Mejia Martinez leaned over the stairwell railing and was visibly nearly unconscious and in physical pain.

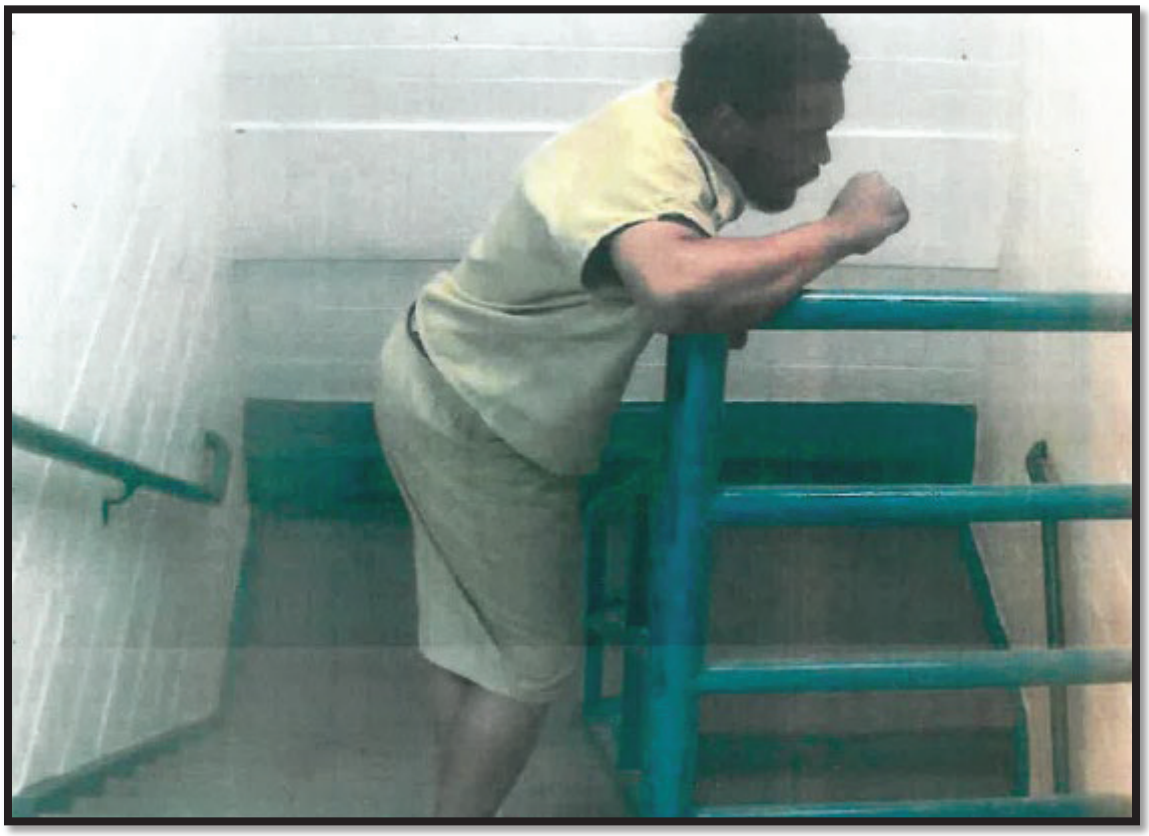

Fig. B – Mr. Mejia Martinez Leans Over the Stairwell Railing

54. Defendant Officer Padilla, who was one of the unit officers on duty on Mr. Mejia Martinez's housing unit, walked by Mr. Mejia Martinez at the stairwell and spoke to him.

55. Despite Mr. Mejia Martinez's obviously distressed state, Defendant Officer Padilla did not assist Mr. Mejia Martinez, summon medical help, or send him to the medical clinic, and instead continued walking downstairs past Mr. Mejia Martinez.

Fig. C – Officer Padilla Walks Downstairs Past Mr. Mejia Martinez at 11:57 a.m.

56. At that time, medical staff were nearby to Mr. Mejia Martinez.

57. Nearby medical staff could have immediately assisted Mr. Mejia Martinez if Defendant Officer Padilla summoned them.

58. At approximately 12:03 p.m., other incarcerated individuals helped Mr. Mejia Martinez walk back downstairs and sit down.

59. On information and belief, at this point, Defendant Officer Smith interacted with Mr. Mejia Martinez about a sick call but did not summon medical help or send him to the medical clinic.

60. At approximately 12:10 p.m., several incarcerated individuals helped Mr. Mejia Martinez to his cell, at times carrying him.

61. On information and belief, between 12:10 p.m. and 3:35 p.m., Mr. Mejia Martinez remained in his cell.

62. Between 12:10 p.m. and 3:35 p.m., Mr. Mejia Martinez experienced a methadone overdose in his cell.

63. Mr. Mejia Martinez became increasingly incapacitated as his condition deteriorated during this time period.

64. A methadone overdose is a life-threatening condition.

65. Between 12:10 p.m. and 3:35 p.m., correction officers, including Defendant Officer Padilla, repeatedly peered into Mr. Mejia Martinez's cell.

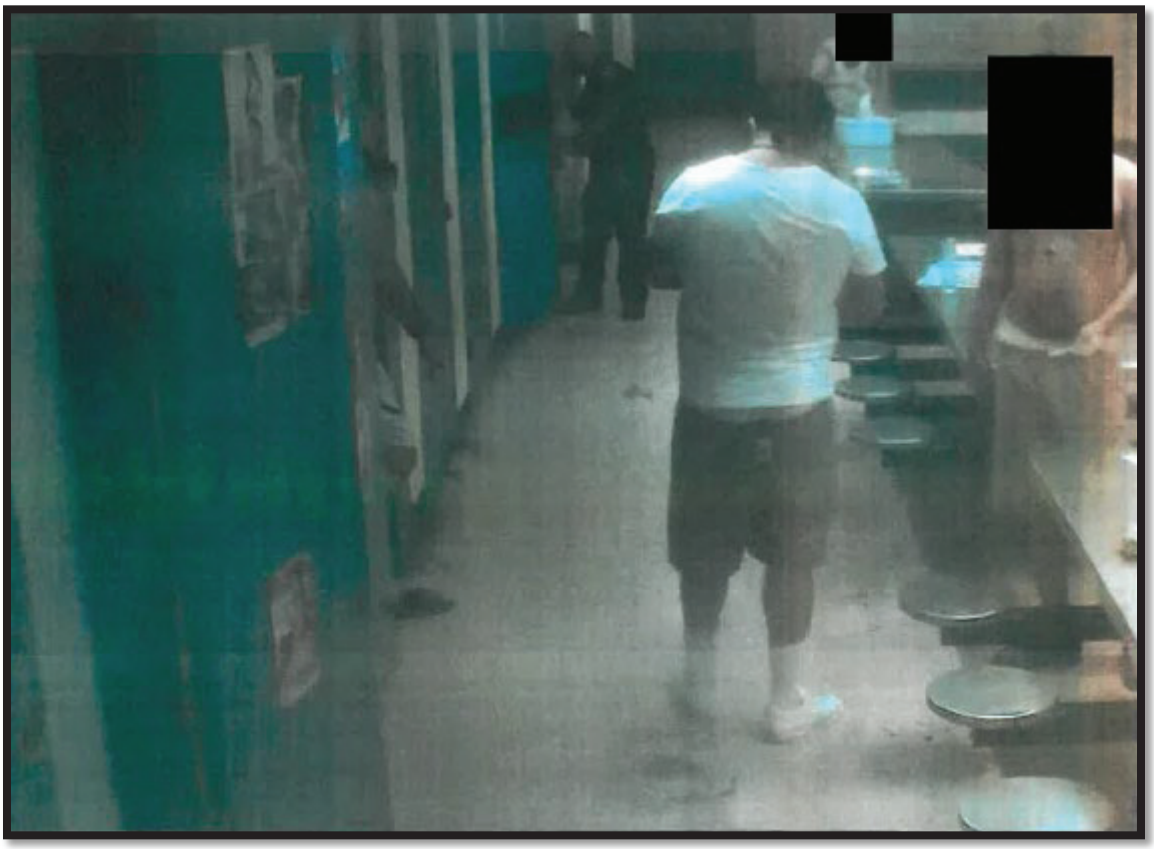

Fig. D – A Correction Officer Looks into Mr. Mejia Martinez's Cell to Observe Him at 2:32 p.m.

66. On information and belief, when correction officers, including Defendant Officer Padilla, peered into Mr. Mejia Martinez's cell repeatedly between 12:10 p.m. and 3:35 p.m., Mr. Mejia Martinez was visibly distressed, incapacitated, unconscious, or otherwise in obvious need of immediate emergency medical attention.

67. None of these officers took any actions to assist him, summon medical help, or send him to the medical clinic.

68. At one point, an officer opened the door and allowed an incarcerated person to enter Mr. Mejia Martinez's cell.

69. At approximately 3:00 p.m., an incarcerated individual checked on Mr. Mejia and noticed that he felt cold to the touch.

Fig. E – An Incarcerated Person Individual Enters Mr. Mejia Martinez's Unsecured Cell

70. At approximately 3:40 p.m., an incarcerated individual entered Mr. Mejia Martinez's unsecured cell for at least two minutes.

71. Multiple other incarcerated people then entered and gathered around Mr. Mejia Martinez's cell.

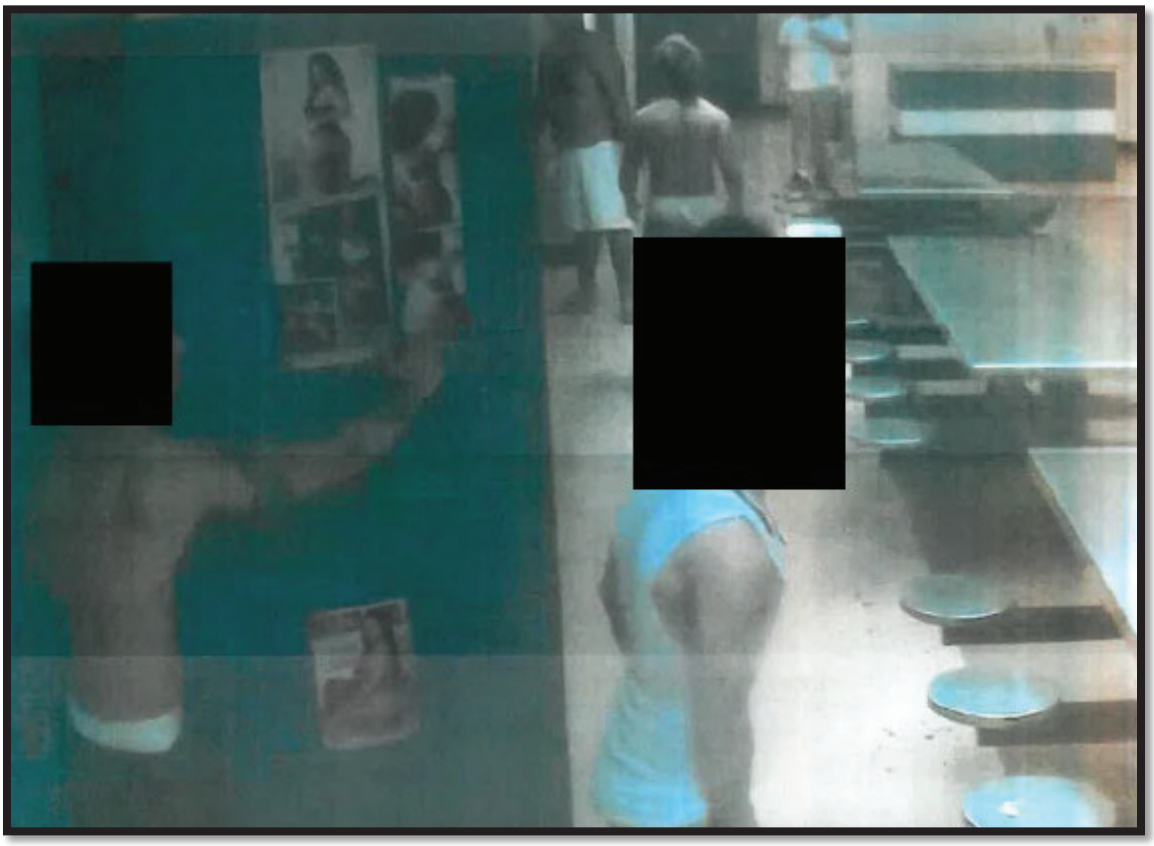

Fig. F – Multiple Incarcerated People Gather Around Mr. Mejia Martinez's Cell

72. The incarcerated individual who entered the cell saw that Mr. Mejia Martinez was unconscious and nonresponsive.

73. An incarcerated individual ran over to the unit control station to tell correction officers that there was a medical emergency.

74. In response, Defendants Officers Padilla, Dixon, and Hernandez went to Mr. Mejia Martinez's cell. They arrived at approximately 3:43 p.m.

75. Correction Officer Dixon then called for a medical emergency.

76. While Defendants Officers Padilla, Dixon, and Hernandez waited for medical clinic staff to arrive, none of the officers performed CPR on Mr. Mejia Martinez.

77. While Defendants Officers Padilla, Dixon, and Hernandez waited for medical clinic staff to arrive, none of the officers rendered any first aid to Mr. Mejia Martinez.

78. Medical clinic staff received the emergency call at 3:45 p.m.

79. On information and belief, this was the first time that medical staff were notified that day that Mr. Mejia Martinez required medical assistance.

80. When medical clinic staff finally arrived at Mr. Mejia Martinez's cell at approximately 3:51 p.m., nobody had yet initiated CPR.

81. Medical staff started CPR and applied an AED.

82. It was too little too late. Mr. Martinez was pale, cold, clammy, pulseless, and was already exhibiting early signs of rigor mortis evidenced by his stiff jaw, neck, and eyelids.

83. Medical staff then notified EMS, which arrived at 4:35 p.m.

84. At 4:39 p.m., Dr. Adam Litroff announced Mr. Mejia Martinez's time of death.

85. The official cause of Mr. Mejia Martinez's death as determined by the New York City Office of Chief Medical Examiner ("OCME") was acute methadone intoxication.

The Board of Correction Investigates Mr. Mejia Martinez's Death

86. The New York City Board of Correction ("BOC") is the City agency that regulates, monitors, and inspects City correctional facilities.

87. The BOC is required by statute to investigate the circumstances of all in-custody deaths at City correctional facilities.

88. The BOC investigated Mr. Mejia Martinez's death.

89. As part of its investigation, BOC staff interviewed people in custody and staff, and reviewed video footage, DOC records, medical records, OCME records, and press coverage.

90. On September 12, 2022, the BOC published its Report and Recommendations on 2021 Suicides and Drug-Related Deaths in New York City Department of Correction Custody (the "2022 BOC Report").

91. According to the BOC report, sixteen people died in DOC custody in 2021, including six by suicide, four by acute drug intoxication, and six as a result of medical complications.

92. The 2022 BOC report included the BOC's findings regarding Mr. Mejia Martinez's in-custody death.

93. The BOC concluded that correctional staff failed to intervene to assist Mr. Mejia Martinez, even as he "visibly struggled to move and stand upright within view of correctional officers."

94. The BOC further noted that the doors in Mr. Mejia Martinez's unit did not lock:

> A uniformed DOC staff member stated that the cell doors in that unit did not lock, an operational issue that went unaddressed prior to Mr. Mejia's death. On the issue of unsecured cell doors, DOC records reflect: 'The Facility's Management Team acknowledges that keeping housing area cell doors unlocked for prolong [sic] periods of time is a constant issue. A memo to be read for 21 consecutive roll

> calls will be reissued, as well [as] continued disciplinary actions for Staff members found in violation of such.

95. The BOC also concluded that "[t]he prevalence of drugs [at Rikers], often laced with fentanyl, combined with deficient supervision and reduced staffing, threatens the lives of those in custody and on a daily basis."

96. The BOC cited the City's own reporting, which noted that "banned drugs were seized within the [City's] jails more than 2,600 times between April 2020 and May 2021, more than double the seizures from April 2018 and May 2019, when the [jail population] was higher."

97. Consistent with this finding, the BOC noted that Mr. Mejia Martinez, who "was not prescribed methadone during his incarceration . . . died of acute methadone intoxication after ingesting a substance from two cups given to him by others in custody. A search of his belongings uncovered approximately 30 pills."

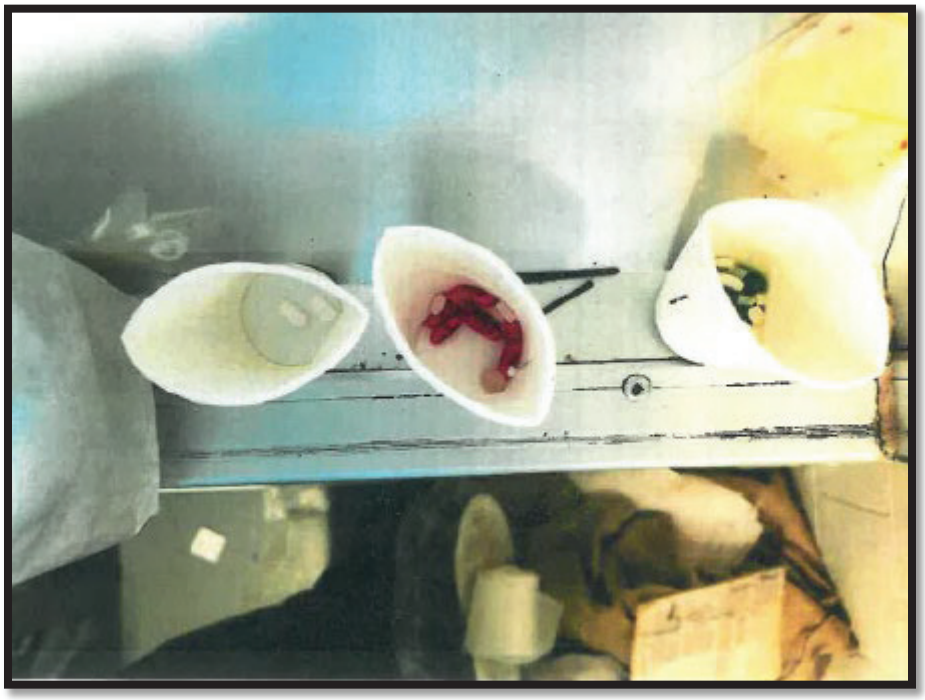

Fig. G – Cups of Pills Found in Mr. Mejia Martinez's Cell After His Death

The City's Widespread and Persistent Practice of Failing to Provide Emergency First Aid to Incarcerated People

98. In case of an emergency requiring CPR or first aid, formal DOC policy requires correction officers to render such aid until the arrival of medical personnel.

99. Formal DOC policy instructs DOC staff members trained in CPR and currently certified in CPR administration to administer CPR.

100. Formal DOC policy states that DOC personnel who are not CPR certified shall limit their resuscitation efforts to rescue breathing.

101. DOC's Correction Academy teaches DOC staff how to perform CPR and first aid, and how to use automated external defibrillators.

102. In practice, DOC staff, including correction officers, do not follow these formal policies and training when responding to incarcerated people's serious medical needs.

103. At the time of Mr. Mejia Martinez's death, the widespread and persistent practice among DOC staff, including correction officers, was to *not* provide CPR or first aid in response to incarcerated people's medical emergencies, including drug overdoses.

104. Prior to Mr. Mejia Martinez's death, the City had notice of the DOC staff's widespread and persistent practice of failing to provide timely first aid or CPR, and of the DOC's staff chronic inaction in the face of medical emergencies.

105. According to data gathered and maintained by the DOC, the DOC's in-custody mortality rate sharply increased during the years leading up to Mr. Mejia Martinez's death in 2021.

106. The City's own data shows that the DOC's in-custody mortality rate was 0.65 in 2017, 0.96 in 2018, and 0.41 in 2019.

107. There was a sharp increase in in-custody deaths in 2020, when the mortality rate increased to 2.42. That number increased yet again in 2021 to 2.87—the highest in over a decade.

108. According to an October 28, 2022 Special Report filed by the independent monitor appointed by a judge of this Court to oversee the City's compliance with its Consent Judgment in *Nunez v. City of New York* concerning conditions of confinement at Rikers (the "*Nunez* Independent Monitor"), the DOC's "practice failures," including "poor security practices," "staff mismanagement," and "potential staff inaction" contributed to this increase in in-custody deaths

109. Even though the City has long had notice of the DOC staff's widespread and persistent practice of failing to provide first aid or CPR to incarcerated individuals, it did nothing to improve its supervision or training of its staff regarding first aid or CPR.

110. The DOC staff's widespread and persistent practice of failing to provide first aid or CPR, and its deliberate indifference towards the same, had predictably deadly consequences for people incarcerated at DOC correctional facilities.

111. In 2021 alone, six incarcerated individuals, including Mr. Mejia Martinez, died after DOC correction officers followed this widespread and persistent practice and failed to provide timely first aid or CPR, or take any action at all, in response to an incarcerated person's medical emergency.

112. On April 19, 2022, Thomas Braunson, who had recently arrived at Rikers, was found unresponsive on his bed, yet correction officers did not perform CPR or chest compressions, and instead stood idly by for at least ten minutes until medical clinic staff arrived. Mr. Braunson had consumed a large quantity of heroin and died of a drug overdose.

113. On September 7, 2021, Esias Johnson was found unconscious in his cell, where he had been lying incapacitated in his bed for more than four hours after other incarcerated people woke up for breakfast. No DOC staff performed first aid on Mr. Johnson. Instead, other incarcerated individuals tried to revive him. Like Mr. Mejia Martinez, Mr. Johnson's official cause of death was acute methadone intoxication.

114. On November 14, 2021, the sole correction officer assigned to William Brown's Rikers housing unit stood by for at least nine minutes while multiple incarcerated individuals vomited and Mr. Brown became unresponsive, before the officer finally performed chest compressions on Mr. Brown. Minutes later, he died from a drug overdose.

115. On August 30, 2021, two correction officers and a captain entered Segundo Guallpa's cell and discovered that he was unresponsive with a ligature made from socks wrapped around his neck and the bedframe. The three officers stood by his bedside, talking and looking at Mr. Guallpa, instead of performing first aid. Mr. Guallpa was pronounced dead nearly 20 minutes later.

116. Likewise, when correction officers found Tomas Carlo Camacho unresponsive in his cell at Rikers on March 2, 2021, they did not render any first aid while awaiting the arrival of medical clinic staff. When medical staff later arrived, Mr. Camacho still had a pulse. He died at the hospital two weeks later.

117. In the 2022 BOC Report, the BOC explicitly recommended that the DOC "should reevaluate and strengthen its . . . CPR training for staff as several officers with such training failed to intervene in multiple instances" in 2021.

118. The City's widespread practice of failing to provide emergency first aid to incarcerated people persists today.

119. According to the *Nunez* Independent Monitor's October 28, 2022 Status Report "the number of in-custody deaths [in October 2022] ha[d] already surpassed the number of deaths in 2021 and [was] the highest number of deaths in a single year since 2013."

120. The *Nunez* Independent Monitor stressed that, as of October 2022, "access to critical services" at Rikers, including "access to medical treatment" is still "frequently delayed and/or canceled."

121. As a result, the *Nunez* Monitoring Team wrote that it "is alarmed and disturbed by the number of deaths among individuals in custody" and noted that "[t]he number of deaths, particularly those due to suicide and drug overdoses, are deeply troubling."

The City's Failure to Train Staff to Provide Lifesaving Naloxone to Incarcerated People Who Are Experiencing a Drug Overdose

122. Naloxone, also known by its brand name, Narcan, is a nasal spray designed to help reverse the effects of a known or suspected opioid overdose.

123. Naloxone can be administered to reverse a methadone overdose.

124. Naloxone is an easy-to-use nasal spray that does not cause adverse effects if used on someone who is not overdosing.

125. Beginning in 2014, the New York City Department of Health and Mental Hygiene trained hundreds of visitors to Rikers Island on overdose rescue and naloxone use.

126. In 2020, the National Commission on Correctional Healthcare issued a position statement supporting increased access to Naloxone in correctional facilities and

recommended that people who work in correctional facilities should receive education on overdose and naloxone use.[1]

127. On information and belief, at the time of Mr. Mejia Martinez's death, DOC staff, including the Individual Officer Defendants, had access to naloxone.

128. However, according to the BOC, at the time of Mr. Mejia Martinez's death, DOC correction officers "had not yet been trained" to use naloxone and some officers "incorrectly believe[d] that people in custody cannot request naloxone."

129. A departmental directive for correction officers to use naloxone when an overdose is suspected became effective on June 30, 2022, long after four suspected overdoses in DOC custody in 2022 alone.

130. On information and belief, the DOC did not start training its staff, including correction officers, on how to administer naloxone until August 2022—over a year after Mr. Mejia Martinez died of an overdose in DOC custody.

131. In the 2022 BOC Report, the BOC noted that it was still "unclear when all DOC staff will complete this vital training" and recommended that the DOC "must increase its naloxone training efforts and aim to finish training all uniformed staff within the next month."

132. Consistent with the BOC's findings, none of the Individual Officer Defendants administered naloxone to Mr. Mejia Martinez at any point on June 10, 2021.

133. The DOC first approved a pilot program to train people in custody on how to use naloxone in November 2021.

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[1] https://www.ncchc.org/position-statements/naloxone-in-correctional-facilities-for-the-prevention-of-opioid-overdose-deaths-2020/.

134. At the time of Mr. Mejia Martinez's death, the DOC did not track overdoses that did not result in death, even though it had the ability to do so.

The City's Widespread and Persistent Practice of Insufficient Supervision By Jail Staff

135. According to formal DOC policy, correction officers are required to conduct rounds in jail housing units every 30 minutes.

136. In reality, DOC officers routinely fail to conduct rounds every 30 minutes or otherwise adequately supervise incarcerated people.

137. The City's widespread practice of inadequate supervision of incarcerated individuals and insufficient rounding plagued DOC correction facilities for years leading up to Mr. Mejia Martinez's death.

138. During the time period leading up to Mr. Mejia Martinez's death, the City was aware that DOC staffing levels were dropping precipitously because of widespread failures by DOC staff to report to work, resulting in what the Independent *Nunez* Monitor described as a "staffing crisis" in Summer 2021.

139. In January 2019, before the COVID-19 pandemic, an average of 6% of employees were out sick on a given day.

140. By April 2020—over a year before Mr. Mejia Martinez's death—an average of one third of the DOC's workforce—over 3,000 officers—was out sick on a given day.

141. According to the *Nunez* Independent Monitor's October 18, 2022 Status Report, the City's failure to address staff attendance at DOC facilities "reached an apex in 2021" and caused DOC's jails to be left "without sufficient staff to provide adequate safety and access to services."

142. By September 2021, an average of 21% of DOC staff were on sick leave on a given day.

143. Even when they are present, DOC staff failed to adequately monitor or supervise housing areas and individuals in their custody.

144. The DOC's widespread and persistent practice of insufficient supervision has repeatedly led to the deaths of individuals incarcerated at DOC correctional facilities.

145. In 2021 alone, the DOC's widespread and persistent practice of insufficient jail supervision contributed to the deaths of at least eight incarcerated people, including Mr. Mejia Martinez.

146. According to the BOC, in the following cases, the "DOC failed to adequately maintain the care, custody, and control of [DOC] housing areas by not actively supervising those in their custody according to their own policies, leading to tragic results."

147. During the seven hours Thomas Carlo Camacho was in the DOC's Hart Island Clinic pen after his medical appointment, correction officers did not check on him for approximately two hours before he was found unresponsive. Due to this lack of supervision, Mr. Camacho was able to put his head through the cuffing port and asphyxiate without any intervention by DOC staff, causing his death. Correction officers did not find him until at least 20 minutes later.

148. Javier Velasco, Thomas Braunson. Segundo Guallpa, and Esias Johnson each died while in custody at DOC correctional facilities after correction officers failed to conduct routine rounds and/or failed to verify that people in custody under their supervision were alive and breathing in their cells.

149. Anthony Scott was placed in a pen directly across from a correction officer's desk. Despite this, Mr. Scott fashioned a ligature from his clothing and jammed the holding pen's locking mechanism with paper, while an officer was present but failed to supervise the pen. Mr. Scott then wrapped the ligature around his neck and tied it to a fixture within the pen when correction officers left the area unattended, causing his death.

150. William Brown's housing unit at Rikers was unsupervised from 6:10 p.m. to 10:33 p.m. on November 14, 2021. During that time he and other people in custody smoked a synthetic cannabinoid and were in the dayroom past 9:00 p.m. against DOC policy. Minutes after smoking the synthetic cannabinoid, Mr. Brown and other incarcerated individuals slouched over and vomited. A correction officer arrived at the unit at 10:33 p.m. but did not render any aid to Mr. Brown until nearly ten minutes later. Mr. Brown was pronounced dead at 10:46 p.m.

151. The City's widespread practice of inadequate supervision of incarcerated individuals and rounding, persists—years after Mr. Mejia Martinez's death.

152. According to a March 16, 2022 Special Report filed by the *Nunez* Independent Monitor, the DOC's "staffing-related problems are directly linked to its deficient security practices" and "a significant portion" of DOC staff continue to "either . . . not report to work or are on a modified status that does not allow them to work directly with incarcerated individuals."

153. The Monitor noted that staffing problems "have also contributed to grave operational deficiencies that lead to unnecessarily high levels of stress, frustration, violence, and injury among incarcerated individuals and staff."

154. The Monitor also warned that "[w]ithin the [DOC's] facilities, on a daily basis, some housing unit posts continue to not have any staff assigned to them (known as

'unmanned posts') and staff regularly work overtime (at least double, if not *triple shifts*), both of which occur due to the dysfunction in the [DOC's] staff management practices. Furthermore, due to poor staff supervision, assigned staff at times abandon their housing unit posts."

155. The *Nunez* Independent Monitor concluded that the DOC's "staffing issues are . . . driven by deeply ingrained patterns of mismanagement and dysfunction" and noted that "[d]espite the bloated size of its workforce and its extraordinary budget, the [DOC] has not seen an appreciable improvement in the appalling conditions of confinement that are at the heart of the [2015 *Nunez*] Consent Judgment."

COUNT ONE
42 U.S.C. § 1983
(Against the Individual Officer Defendants)

156. Plaintiff repeats and realleges the foregoing paragraphs as if the same were fully set forth at length herein.

157. By reason of the foregoing, and by denying Mr. Mejia Martinez access to adequate medical care, failing to promptly summon medical treatment, and/or failing to provide medical treatment, the Individual Officer Defendants acted with deliberate indifference to Mr. Mejia Martinez's serious medical needs, thereby depriving him of his rights, privileges, and immunities guaranteed to every citizen of the United States in violation of 42 U.S.C. § 1983, including, but not limited to, rights guaranteed by the Eighth and Fourteenth Amendments to the United States Constitution.

158. The Individual Officer Defendants acted at all relevant times willfully, wantonly, maliciously, and/or with such reckless disregard of consequences as to reveal a conscious indifference to the clear risk of death or serious injury to Mr. Mejia Martinez that shocks the conscience.

159. The Individual Officer Defendants acted at all relevant times under pretense and color of state law and in their individual and official capacities and within the scope of their respective employments as officers, agents, employees, and/or contracted personnel of Defendant City. Said acts by the Individual Officer Defendants were beyond the scope of their jurisdiction, without authority of law, and in abuse of their powers.

160. The Individual Officer Defendants acted willfully, knowingly, and with the specific intent to deprive Mr. Mejia Martinez of his constitutional rights secured by 42 U.S.C. § 1983 and by the Eighth and Fourteenth Amendments to the United States Constitution.

161. As a direct and proximate result of these violations of Mr. Mejia Martinez's constitutional rights, he suffered the damages hereinbefore alleged.

COUNT TWO
42 U.S.C. § 1983
(Against Defendant City of New York)

162. Plaintiff repeats and realleges the foregoing paragraphs as if the same were fully set forth at length herein.

163. At the time of Mr. Mejia Martinez's incarceration and death in DOC custody, Defendant City permitted, tolerated, and was deliberately indifferent to a widespread and persistent policy, custom, or practice of medical neglect, deliberate indifference, and negligence by DOC officers, agents, and employees towards the serious medical needs of incarcerated people, including incarcerated people who are experiencing a drug overdose.

164. At the time of Mr. Mejia Martinez's DOC incarceration and death in DOC custody, Defendant City also permitted, tolerated, and was deliberately indifferent to the DOC's widespread and persistent policy, custom, or practice of mismanaging staffing levels in DOC correctional facilities, which caused insufficient supervision of incarcerated individuals and

rounding. This widespread and persistent policy of insufficient staffing exacerbated the deadly effects of the DOC's policy, custom, or practice of medical neglect, deliberate indifference, and negligence by DOC officers, agents, and employees towards the serious medical needs of incarcerated people, including incarcerated people who are experiencing a drug overdose.

165. At the time of Mr. Mejia Martinez's DOC incarceration and death in DOC custody, Defendant City also permitted, tolerated, and was deliberately indifferent to the DOC's widespread and persistent policy, custom, or practice of DOC staff failing to adequately monitor or supervise housing areas or conduct sufficient rounds to monitor the safety and security of the incarcerated individuals in custody. This widespread and persistent policy of inadequate supervision of housing areas and insufficient rounding exacerbated the deadly effects of the DOC's policy, custom, or practice of medical neglect, deliberate indifference, and negligence by DOC officers, agents, and employees towards the serious medical needs of incarcerated people, including incarcerated people who are experiencing a drug overdose in their custody.

166. Defendant City exhibited deliberate indifference to the serious medical needs of incarcerated people, including incarcerated people who are experiencing a drug overdose, by, among other things:

a. Failing to supervise DOC officers, agents, and employees who were responsible for treating or responding to the serious medical needs of incarcerated people;

b. Failing to train DOC officers, agents, and employees to provide CPR and first aid facing medical emergencies, including incarcerated people who are experiencing a drug overdose;

c. Failing to train DOC officers, agents, and employees to provide appropriate medical care to incarcerated people with serious medical needs, including incarcerated people who are experiencing a drug overdose; and

d. Failing to train DOC officers, agents, and employees to promptly administer naloxone to incarcerated people who are experiencing a drug overdose.

167. The City's permitting, tolerance of, and deliberate indifference towards DOC officers, agents, and employees' medical neglect, deliberate indifference, and negligence towards the serious medical needs of incarcerated people constituted a municipal and corporate policy, custom, or practice. This policy, custom, or practice was a direct and proximate cause of Mr. Mejia Martinez's mistreatment and death, and plaintiff's resultant damages, hereinbefore alleged.

168. By permitting, tolerating, and acting with deliberate indifference towards DOC officers, agents, and employees' medical neglect, deliberate indifference, and negligence towards the serious medical needs of incarcerated people, the City deprived Mr. Mejia Martinez of rights, remedies, privileges, and immunities guaranteed to every citizen of the United States, secured by 42 U.S.C. § 1983 and the Eighth and Fourteenth Amendments to the United States Constitution.

COUNT THREE
Negligence
(Against All Defendants)

169. Plaintiff repeats and realleges the foregoing paragraphs as if the same were fully set forth at length herein.

170. At all relevant times, the City, through its officials, employees, agents, servants, and/or representatives, including the Individual Officer Defendants, owed a duty to Mr.

Mejia Martinez to meet the standard of care owed to incarcerated people. The standard of care required, among other things, prompt and immediate treatment of Mr. Mejia Martinez's emergency medical condition.

171. At all relevant times pursuant to this Complaint, the Individual Officer Defendants failed to uphold this duty to Mr. Mejia Martinez.

172. By denying Mr. Mejia Martinez access to adequate medical care, failing to promptly summon medical treatment, and/or failing to provide medical treatment, the Individual Officer Defendants demonstrated a complete disregard for Mr. Mejia Martinez's life and safety, and thereby breached the duty owed to Mr. Mejia Martinez.

173. The actions of the Individual Officer Defendants represent a gross deviation from the actions a reasonable individual would have taken in their position, given their knowledge and employment.

174. The Individual Officer Defendants were at all times relevant to this Complaint acting in their capacities as DOC officers and employees, and within the scope and course of their employment by the DOC, an agency of the City.

175. A private employer would otherwise be liable for the negligence of the Independent Officer Defendants. The City is therefore liable for the Individual Officer Defendants' negligence under the doctrine of *respondeat superior*.

176. Defendants' breach of their duty of care to Mr. Mejia Martinez was the proximate cause of Mr. Mejia Martinez's serious and unnecessary injuries, including severe pain and suffering and death.

177. As a direct and proximate result of Defendants' acts and omissions detailed above, Mr. Mejia Martinez suffered physical injury, severe pain and suffering, emotional distress, monetary damages, and death.

COUNT FOUR
Wrongful Death
(Against All Defendants)

178. Plaintiff repeats and realleges the foregoing paragraphs as if the same were fully set forth at length herein.

179. As a direct and proximate result of the Individual Officer Defendants' acts and omissions detailed above, Mr. Mejia Martinez suffered physical injury, severe pain and suffering, and death.

180. As a direct and proximate result of the Individual Officer Defendants' acts and omissions detailed above, the statutory distributees of Mr. Mejia Martinez's estate sustained pecuniary and non-economic loss resulting from the loss of Mr. Mejia Martinez's love, comfort, society, attention, services, income, support, and life.

PRAYER FOR RELIEF

WHEREFORE, Plaintiff respectfully requests judgment against Defendants as follows:

a. Awarding compensatory damages in an amount to be determined at trial;

b. Awarding punitive damages against the Individual Officer Defendants in an amount to be determined at trial;

c. Awarding Plaintiff reasonable attorneys' fees and costs under 42 U.S.C. § 1988; and

d. Directing such other and further relief as the Court may deem just and proper, together with attorneys' fees, interests, costs, and disbursements of this action.

Dated: New York, New York
June 9, 2023

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