UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

EVA VILLANUEVA, AS ADMINISTRATOR OF THE ESTATE OF HER BROTHER, HERMINIO VILLANUEVA,

Plaintiff,

– against –

THE CITY OF NEW YORK; CORRECTION OFFICER KENYATTA JONES, SHIELD NO. 2192; AND CORRECTION OFFICER TYIESHA COTTLE, SHIELD NO. 18386, and JOHN AND JANE DOES 1-11,

Defendants.

**No. 22 Civ. 9411**

**FIRST AMENDED COMPLAINT AND JURY DEMAND**

## PRELIMINARY STATEMENT

1. This is a civil rights action brought by Plaintiff Eva Villanueva, as administrator of the estate of her brother, Herminio Villanueva, a medically fragile man with chronic and disabling medical problems who died on June 21, 2020 in the Robert N. Davoren Center ("RNDC") on Rikers Island after being denied proper medical care and accommodations while incarcerated, and then suffering from a severe asthma attack without prompt medical response that could have saved his life.

2. Mr. Villanueva was arrested on March 2, 2020 on a technical parole violation for failing to register his address. He was 60 years old at the time and suffered from chronic obstructive pulmonary disease ("COPD"), severe asthma, liver disease, and other serious health conditions that were documented by and obvious to the New York City Department of Correction ("DOC"), an agency of Defendant the City of New York ("the City") that administers the Rikers Island jail complex, and to medical personnel of the NYC Health & Hospitals/Correctional Health Services ("CHS"), a division of the City's NYC

Health + Hospitals that provides health care in the City's jails.

3. Despite classifying Mr. Villanueva for "Medical Housing" during intake to Rikers Island, upon information and belief, DOC failed to hold Mr. Villanueva in a medical housing unit for 107 of the 111 days he was incarcerated.

4. While incarcerated at Rikers Island, DOC and CHS personnel provided Mr. Villanueva with haphazard and inconsistent medical care. DOC and CHS personnel failed to provide him with prescribed medications, failed to monitor and assess his health, failed to provide medical treatment, failed to completely and/or accurately document the care that he did receive, and failed to provide proper accommodations for his disabilities.

5. Upon information and belief, as a result of DOC's and CHS's indifference to Mr. Villanueva's medical disability and fragility—by failing to house him in an appropriate unit and failing to provide him with appropriate medical care—Mr. Villanueva's health precipitously declined while incarcerated at Rikers Island. Upon information and belief, DOC and CHS placed Mr. Villanueva at risk of further illness, a serious health episode, and/or death. Indeed, he contracted COVID-19 on or about May 31, 2020 while housed in a General Population unit. He was hospitalized at least twice, at Bellevue Hospital and Elmhurst Hospital. DOC's failures caused Mr. Villanueva unnecessary suffering, left him increasingly vulnerable, and were a proximate cause of his death on June 21, 2020.

6. As presaged by several days of worsening symptoms, on the evening of June 20, 2020, the night before his death, Mr. Villanueva was in "respiratory distress," and DOC personnel called for a "medical emergency" at 6:01pm. Medical staff were dispatched to Mr. Villanueva's housing unit to pick him up. However, at 6:25pm, a logbook entry from the Medical Clinic stated: "Medical Emergency stand down at this time." Upon information and belief, Mr. Villanueva never made it to the medical clinic, and received no medical care for his

medical emergency.

7. Approximately twelve hours later, on or about 7:00am on the morning of June 21, 2020, Mr. Villanueva woke up struggling to breathe. DOC Correction Officers, and in particular, Defendants Officers Kenyatta Jones and Tyiesha Cottle, responded without urgency. They failed to promptly summon medical assistance, failed to react when medical personnel did not respond to an initial call, and exhibited a wanton disregard for Mr. Villanueva's safety and well-being. DOC officers' and employees' lackadaisical approach to a life-and-death situation was captured on video.

8. Video footage also captured Defendant Officer Jones writing in the logbook that there was "Nothing to report" at 7:29am that morning, while Mr. Villanueva was in acute distress. Defendant Officer Jones broke the law when he failed to accurately report this significant incident.

9. Alarmed by the delay in medical response to Mr. Villanueva's dire condition, people incarcerated in Mr. Villanueva's housing unit desperately sought to attract attention from DOC personnel. They carried Mr. Villanueva in their arms to the door of the unit, trying to get him out to the nearby medical clinic. DOC Correction Officers turned them back. Mr. Villanueva's housing mates comforted him as he struggled to take his last breaths.

10. By the time medical staff finally arrived to Mr. Villanueva's housing unit, it was too late. Mr. Villanueva was pronounced dead that morning.

11. Following review of these events, the New York State Commission of Correction ("SCOC") found that as a result of DOC personnel's gross failure to adequately respond to an imminent medical emergency and failure to provide cardiopulmonary resuscitation, Mr. Villanueva was denied potentially life-saving medical attention for approximately 19 minutes. The SCOC also opined that if Mr. Villanueva had received medical

care on the night before his death, it may have saved his life.

12. The City and its senior officials are, and have been, aware that disabled, medically vulnerable individuals such as Mr. Villanueva housed at Rikers Island, particularly during the coronavirus pandemic, required high levels of care and, in certain cases, special housing. Nonetheless, Mr. Villanueva was denied adequate medical care, monitoring and assessment during his incarceration and housed in a general population unit, without onsite medical staff who could have saved his life. Mr. Villanueva's death is part of an egregious pattern of incidents whereby Defendant the City and its officers and employees display indifference to the serious medical needs of medically fragile incarcerated people at Rikers Island, which can lead to their serious injury and/or death, and where the City and its officers and employees failed to respond with urgency to medical emergencies by people held in its custody at Rikers Island.

13. Mr. Villanueva's suffering and ultimate death were preventable and needless. Defendants' actions were contrary to law, contrary to sound medical practice, and contrary to the norms of a civilized society. This complaint, arising from these tragic and unlawful acts, seeks compensatory and punitive damages, costs, disbursements, and attorneys' fees pursuant to applicable state and federal civil rights law.

## PARTIES

14. Herminio Villanueva was a citizen of the United States and resided at Rikers Island jail in Bronx County at all relevant times.

15. Mr. Villanueva was also known as "Hector Rodriguez" and was incarcerated on Rikers Island under that name.

16. At all relevant times, Mr. Villanueva was medically disabled by virtue of his serious, chronic health conditions.

17. At the time of his June 21, 2020 death, Mr. Villanueva was 61 years old.

18. Plaintiff Eva Villanueva is Mr. Villanueva's sister and statutory distribute. She has been duly appointed by the Queen County Surrogate's Court as the administrator of his estate for purposes of bringing this lawsuit. She is a citizen of the United States who resides in Bronx County, New York.

19. Defendant the City is a municipal corporation that, through DOC, operates a number of detention jails on Rikers Island, including the RNDC. DOC is responsible for the care, custody, and supervision of prisoners confined to Rikers Island, including the jails in which Mr. Villanueva was confined between his arrest on March 2, 2020 and death on June 21, 2020. The City acting through CHS is responsible for the provision of medical care and services to prisoners in its custody, and was at all relevant times responsible for the policies, customs, and practices of the DOC and CHS.

20. DOC and CHS, through their senior officials in its central office and in each jail facility, including Rikers Island, promulgates and implements policies, including those with respect to the provision of health care, and access to medical and other program services mandated by local law and court orders. DOC and CHS are also responsible for the appointment, training, supervision, and conduct of all DOC and CHS personnel, including the Defendants referenced herein, and for ensuring that its personnel adhere to its policies.

21. Senior DOC and CHS officials are aware of and tolerate certain practices by subordinate personnel in the jails, including those that are inconsistent with formal policy. Such practices at DOC facilities, and Rikers Island in particular, include the failure to provide adequate, appropriate, and timely medical care, monitoring and assessment, and lackadaisical response to medical emergencies. Because these practices are widespread,

long-standing, and deeply embedded in the culture of DOC and CHS, they constitute unwritten DOC and CHS policies or customs.

22. At all relevant times, Defendant the City was responsible for safeguarding and providing medical care to Mr. Villanueva, a medically fragile 61 year old. Instead, the City, via its policies and/or practices, was deliberately indifferent to his serious medical needs, placed him at risk of further illness and deterioration of his health, and failed to respond to his medical crisis on the day he died.

23. At all relevant times, City employees who provided or denied medical care to Mr. Villanueva were employees and agents of CHS and DOC, who participated in and/or had knowledge of the failures to provide appropriate medical care, monitoring, and assessment to Mr. Villanueva during his incarceration. At all relevant times, CHS and DOC employees were under color of state law and within the scope of their capacities as agents, servants, and employees of Defendant the City.

24. Upon information and belief, at all relevant times, Defendant Correction Officer Kenyatta Jones, Shield No. 2192, was a correction officer in the DOC assigned to the Mod 4 Lower B Post in RNDC.

25. Upon information and belief, at all relevant times, Defendant Correction Officer Tyiesha Cottle, Shield No. 18386, was a correction officer in the DOC assigned to the Mod 4 Lower A Post in RNDC.

26. At all relevant times, Defendants Jones and Cottle ("the Officer Defendants") participated in and/or had knowledge of and failed to intervene in the denial of prompt medical care to Mr. Villanueva on June 21, 2020. At all relevant times, the Officer Defendants were acting under color of state law and within the scope of their capacities as agents, servants, and employees of Defendant the City. Plaintiff sues the Officer Defendants in

their individual capacities.

27. Upon information and belief, at all relevant times, Defendant John and Jane Does 1-5 were employees or agents of Defendant the City who participated in, supervised, and/or had knowledge of and failed to intervene in the denial of prompt medical care required by Mr. Villanueva on June 20, 2021, when he was experiencing acute respiratory symptoms. They were assigned to, had supervisory responsibility for, were present at or responded to housing unit where Mr. Villanueva was confined. At all relevant times, they were under color of state law and within the scope of their capacities as agents, servants, and employees of Defendant the City.

28. Upon information and belief, at all relevant times, Defendant John and Jane Does 6-11 were employees or agents of Defendant the City who participated in, supervised, and/or had knowledge of and failed to intervene in the denial of prompt medical care required by Mr. Villanueva on June 21, 2021, when he was experiencing the medical emergency that led to his death. They were assigned to, had supervisory responsibility for, were present at or responded to housing unit where Mr. Villanueva was confined. At all relevant times, they were under color of state law and within the scope of their capacities as agents, servants, and employees of Defendant the City.

## JURISDICTION AND VENUE

29. This action arises under the Eighth and Fourteenth Amendments to the United States Constitution, under 42 U.S.C. §§ 1983 and 1988, the Americans with Disabilities Act, 42 U.S.C. § 1201 *et seq.*, and New York state common law.

30. This Court has jurisdiction pursuant to 28 U.S.C. §§ 1331, 1343(a)(3) and (4), 1367(a) and the doctrine of pendent jurisdiction. The acts complained of occurred in the Southern District of New York, and venue is proper pursuant to 28 U.S.C. § 1391(b).

## PLAINTIFF'S NOTICE OF CLAIM

31. Plaintiff has complied with the requirements of New York General Municipal Law Section 50-i. Plaintiff served a notice of claim on the municipal defendant City of New York on January 13, 2023, pursuant to a Stipulation permitting such claim. More than 30 days have passed since the service of the Notice of Claim.

## JURY DEMAND

32. Plaintiff demands trial by jury in this action.

## STATEMENT OF FACTS

33. Mr. Villanueva was arrested on March 2, 2020.

34. Mr. Villanueva was admitted to DOC custody on Rikers Island on March 2, 2020.

35. On March 4, 2020, Mr. Villanueva pleaded guilty to a parole violation for failure to register his address. He was sentenced to one-year in DOC custody. He would continue his detention at Rikers Island.

36. At the time of his arrest and initial confinement by DOC, Mr. Villanueva was 60 years old. He suffered from COPD, asthma, liver disease, and other serious medical conditions.

37. During the course of his incarceration, DOC medical records documented Mr. Villanueva's "active problem list" included COPD, hypotension, bronchitis, coronavirus, chronic obstructive airway diseased with asthma, Hepatitis C, thrombocytopenia, and other conditions.

**The City of New York Failed to Provide Medical Housing for Mr. Villanueva**

38. Give his age, disability, and medical fragility, Mr. Villanueva required specialized medical treatment and monitoring. He required reasonable modifications to reside at Rikers Island safely because he was at heightened risk of serious illness or death by virtue of his disabilities.

39. One such reasonable modification is that Mr. Villanueva required placement in a medical housing unit where he could receive monitoring of his serious health conditions. Another was heighted medical monitoring and treatment.

40. According to DOC IIS intake screen lists, Mr. Villanueva was classified for "Medical Housing," meaning, that DOC should house him in one of its designated medical units.

41. Medical housing units on Rikers Island at the time included the North Infirmary Command ("NIC") or the Communicable Disease Unit ("CDU") in the West Facility, both of which had greater medical infrastructure than the non-medical housing units, including, upon information and belief, more expedient access to medical providers and/or facilities.

42. Instead of being housed in one of the medical units, and in contravention of his intake classification, DOC housed Mr. Villanueva in the general population housing units for the vast majority of his incarceration, including the day of his death, which, upon information and belief, lacked dedicated medical providers/facilities and/or had lesser access to medical providers/facilities.

43. Upon information and belief, Mr. Villanueva was housed in a medical housing unit for only four of the 111 days incarcerated on Rikers Island.

**The City of New York Put Mr. Villanueva at Increased Risk of Exposure to COVID-19**

44. Upon information and belief, DOC put Mr. Villanueva at greater risk that his health would deteriorate when it failed to house him in an appropriate medical unit, and was on notice that its practices for separating and housing medically vulnerable prisoners in appropriate units were flawed and haphazard.

45. One such increased risk was contracting COVID-19, which was spreading throughout Rikers Island during the course of Mr. Villanueva's incarceration, and in the general housing units due to the lack of proper infection mitigation precautions and failure to monitor its spread.

46. On March 17, 2020, the New York City Board of Correction ("BOC") wrote to the then-Commissioner of the DOC and urged her and other leaders to take immediate reaction to release people from City jails as the COVID-19 pandemic erupted.

47. The BOC letter asked that the Commissioner prioritize the release of people from City jails who were at higher risk of infection, such as those over 50 or with underlying health conditions, both of which categories applied to Mr. Villanueva.

48. The first person in DOC custody tested positive for COVID-19 on March 18, 2020, approximately two weeks after Mr. Villanueva became incarcerated there. The number of incarcerated people and staff who tested positive climbed exponentially from that date. In a statement to Time Magazine on March 23, 2020, the DOC said that a total of 39 inmates and 21 DOC personnel had tested positive in City jails, with 58 others being monitored in special units. One week later, according to statistics from the Legal Aid Society, there were at least 180 cases of COVID-19 in New York City jails.

49. By March 30, 2020, the then-Chief Physician for Rikers Island, Dr. Ross McDonald, warned that there was a "public health disaster unfolding before our eyes" on

Rikers Island. Dr. McDonald called for the release of as many "vulnerable people" as possible. Mr. Villanueva was not released.

50. On or about April 4, 2020, Mr. Villanueva tested positive for COVID-19.

51. Upon information and belief, Mr. Villanueva was housed in a general population unit at the time.

52. According to the SCOC's Medical Review Board, following his COVID-19 diagnosis, City employees "fail[ed] to provide adequate monitoring of [Mr. Villanueva who had] a history of abnormal vital signs and a[n] underlying respiratory disease."

53. DOC and CHS personnel failed to provide adequate medical care to Mr. Villanueva during his bout with COVID-19, including failing to monitor his condition, failure to document medical visits and treatments, failure to ensure he received sufficient medical care, failure to ensure that he was receiving medication for his chronic conditions, and failed to accommodate his disability.

**The City of New York Was Indifferent to Mr. Villanueva's Precipitous Decline in Health in Its Custody**

54. Over the 111 days that Mr. Villanueva was in the care and custody of Defendant the City at Rikers Island, his health precipitously declined as result of Defendant the City's and its agents and employees' failure to provide with him with appropriate or timely medical care, and exposing him to health risks. Mr. Villanueva's decline was obvious to those who interacted with him and documented in his medical records.

55. For example, Mr. Villanueva was hospitalized multiple times over this period due to acute respiratory distress.

56. On or about May 9, 2020, medical staff responded to an emergency call from the housing unit where Mr. Villanueva was found standing near a window with inhalers in his hand with abnormal oxygen saturation levels.

57. EMS transported Mr. Villanueva to the Bellevue Hospital Prison Ward ("Bellevue") for evaluation after he reported to DOC medical staff that he was experiencing shortness of breath "refractory to inhalers" and wheezing. He was admitted to the hospital and remained at Bellevue for four days.

58. At Bellevue, Mr. Villanueva was diagnosed with asthma exacerbation due to COPD. He reported to doctors that his symptoms were similar but worse in intensity than prior asthma exacerbations. He was treated with antibiotics and Prednisone steroids.

59. Doctors at Bellevue noted Mr. Villanueva's multiple complex and overlapping medical problems including asthma, acute respiratory acidosis, NSTEMI type, suspected COVID-19 infection despite initial negative test, hypoxic and hypercapnic respiratory failure most likely in the setting of COVID-19, chronic lung disease, and hypoxia.

60. Mr. Villanueva's Bellevue discharge summary documented multiple ongoing health problems including elevated troponin, worsening hypoxia, and the need to monitor his oxygen saturation levels.

61. After Mr. Villanueva's discharge from Bellevue on May 13, 2020, he returned to Rikers Island.

62. That day, Rikers Island medical providers noted that Mr. Villanueva required "NIC level of care/monitoring."

63. On May 14, 2020, a Rikers Island doctor referred Mr. Villanueva to the CDU; the chief complaint was: "Pt with COPD and NSTEMI hospital return with negative

covid testing in hospital but with significantly elevated risk. Multiple co-morbidities." Mr. Villanueva was admitted to the CDU where medical personnel observed him to be "pale, thin, and frail." Mr. Villanueva was discharged from the CDU to General Population on May 18, 2020.

64. CHS and DOC staff responsible for treating and guarding Mr. Villanueva knew that Mr. Villanueva suffered from myriad complex medical problems that had required multiple recent hospitalizations and placed him a risk for future serious medical crises and knew that Mr. Villanueva required a higher-level of care and monitoring in his housing unit, such as NIC placement, but were deliberately indifferent to Mr. Villanueva's serious medical condition.

65. Mr. Villanueva's discharge from CDU to General Population was contrary to the recommendation of CHS medical staff several days earlier that he needed an "NIC level of care/monitoring."

66. Mr. Villanueva reported to medical staff on several occasions during May 2020 that he was experiencing symptoms of asthma including shortness of breath.

67. On May 24, 2020, Mr. Villanueva suffered an acute asthma attack which required a medical response to be called to the housing unit.

68. On June 3, 2020, for the third time in less than one month, another medical emergency was called in the housing unit in response to Mr. Villanueva's shortness of breath that was not responding to the inhaler. Mr. Villanueva was again taken in an ambulance from Rikers Island to the emergency room, this time at Elmhurst Hospital, for exacerbation of his asthma. He reported shortness of breath and was given oxygen.

69. Mr. Villanueva was returned to Rikers Island on June 4, 2020 with a recommendation for in-facility follow up. His medical records noted that he was experiencing

an "acute exacerbation" of his COPD.

70. Upon his return to Rikers Island from Elmhurst, CHS medical records document that "pt well known COPD/hypoxia/hosp COVID April," and that the medical staff were concerned about his low oxygen saturation levels.

71. Mr. Villanueva was returned to his housing unit in the General Population on June 4, 2020 despite the concerns about his health.

72. Mr. Villanueva was told to follow up with primary care within the facility.

73. According to the SCOC's Medical Review Board, following his return from Elmhurst Hospital on June 4, 2020, City medical staff "failed to adequately assess a patient returning from the hospital for an acute respiratory episode prior to returning the patient to the housing unit."

74. Upon information and belief, DOC and CHS's haphazard attention to Mr. Villanueva's medical care caused him unnecessary suffering, and worsened his physical health, rendering him increasingly medically fragile and vulnerable.

75. Mr. Villanueva was confined on Unit M4SL in the RNDC on Rikers Island.

76. RNDC Unit M4SL was not a Medical housing unit.

77. RNDC Unit M4SL was a General Population unit.

78. Incarcerated people in RNDC Unit M4SL had to leave the housing unit to access medical care at the RNDC clinic located in a different part of the building.

79. On June 19, 2020, Mr. Villanueva was seen in the clinic and requested a refill of his albuterol pump.

80. Upon information and belief, when he returned to his housing unit, Mr. Villanueva told another incarcerated person that he had not been given the correct medicine.

81. Upon information and belief, on June 19, 2020, another incarcerated person reported to a DOC officer in the housing unit that Mr. Villanueva was audibly wheezing and sounded like he was "gasping for air," but they took no action.

**Mr. Villanueva is Denied Critical Medical Care the Day Before He Died**

82. Upon information and belief, Mr. Villanueva was in distress and visibly unwell on Saturday, June 20, 2020.

83. As presaged by several days of worsening symptoms, on the evening of June 20, 2020, Mr. Villanueva had acute difficulty breathing and DOC personnel called for a "medical emergency" at 6:01pm.

84. Upon information and belief, medical staff were dispatched to Mr. Villanueva's housing unit to pick him up and Mr. Villanueva left the housing block.

85. RNDC Unit M4SL had no medical staff on duty within the unit on June 21, 2020.

86. Upon information and belief, correctional staff who worked in the unit knew Mr. Villanueva was often sick and spent time in the hospital.

87. However, at 6:25pm, a logbook entry from the Medical Clinic stated "Medical Emergency stand down at this time."

88. There is no record of Mr. Villanueva receiving medical care in the Medical Clinic on June 20, 2020.

89. Upon information and belief, Mr. Villanueva was transported to the medical clinic on June 20, 2020, but received no medical care for his medical emergency.

90. According to the SCOC's Medical Review Board's analysis of the events of June 20, 2020, Mr. Villanueva "had presented again with acute respiratory symptoms but was not provided with proper medical attention." It opined that "had [Mr. Villanueva] been provided timely medical care on the evening on [sic] 6/20/20, his terminal event during the morning hours of 6/21/20 may have been prevented."

91. Upon information and belief, Defendants John and Jane Doe 1-5 were or should have been aware of Mr. Villanueva's acute respiratory distress, failed to provide medical care, participated in, supervised, and/or had knowledge of and failed to intervene in the denial of prompt medical care he required.

**June 21, 2020: Mr. Villanueva Suffers a Severe Asthma Attack, Is Denied Prompt Medical Attention, and Dies**

92. Approximately twelve hours later, on or about 7:00am on the morning of June 21, 2020, Mr. Villanueva woke up struggling to breathe.

93. Mr. Villanueva began wheezing and coughing.

94. Mr. Villanueva used an asthma inhaler several times.

95. Several incarcerated people noticed Mr. Villanueva's distress and went over to Mr. Villanueva's bed.

*Figure 1: Another incarcerated person responded to Mr. Villanueva's distress.*


96. Defendant Jones was one of the officers on duty in Mr. Villanueva's housing unit on the morning of June 21, 2020.

97. Defendant Jones observed and heard Mr. Villanueva's breathing distress.

98. Defendant Jones observed that several incarcerated people responded to Mr. Villanueva's bedside.

99. Even as he observed Mr. Villanueva being assisted by other incarcerated persons, Defendant Jones did not contact the medical department to request medical attention for Mr. Villanueva.

100. Prompt intervention with acute episodes of asthma is essential and can prevent death.

101. After observing for several minutes, Defendant Jones approached Mr. Villanueva's bed.

102. Upon information and belief, one of the incarcerated people assisting Mr. Villanueva told Defendant Jones that Mr. Villanueva had pre-existing health conditions and that Mr. Villanueva "shouldn't be here."

103. Defendant Jones again observed that Mr. Villanueva was struggling to breathe.

104. Defendant Jones walked over to the A-Post Station and asked Defendant Cottle to call for medical assistance.

105. Upon information and belief, Defendant Cottle called the Medical Clinic by phone.

106. Defendant Jones wrote in the housing logbook that there was "Nothing to report," while Mr. Villanueva was in acute distress.

107. Defendant Jones did not interact further with Mr. Villanueva.

108. Other people incarcerated in Mr. Villanueva's housing unit attempted to assist Mr. Villanueva.

109. Several more minutes elapsed, and no medical team arrived.

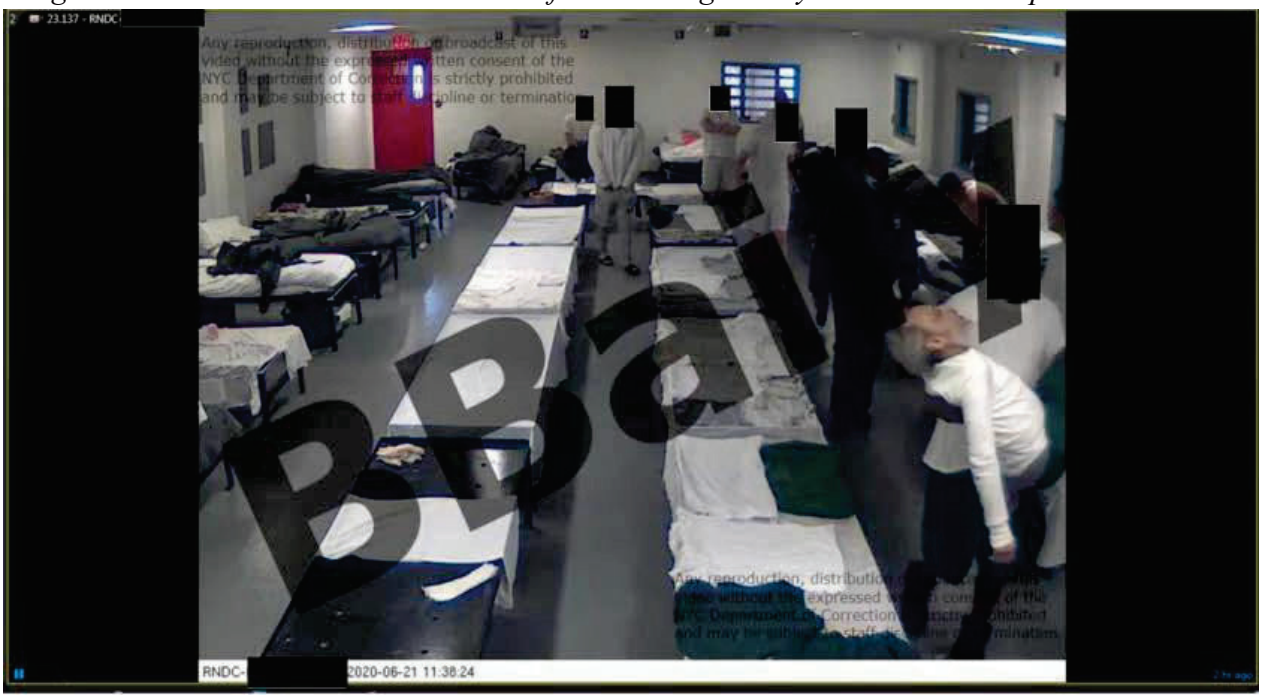
110. After about 10 minutes had elapsed from Mr. Villanueva's initial signs of distress, medical response had still not arrived.

111. Another incarcerated person on the housing unit picked up Mr. Villanueva intending to transport Mr. Villanueva to medical attention.

112. Upon information and belief, only at that juncture did Defendants Jones and/or Cottle use a radio to report a medical emergency.

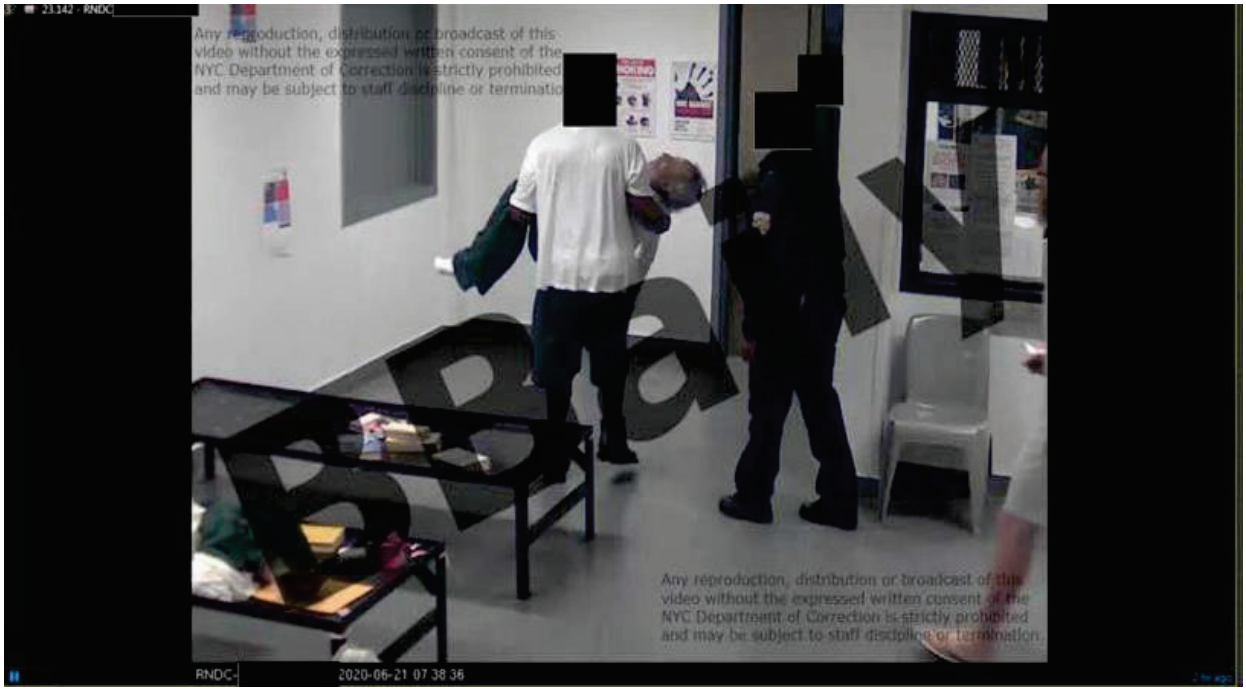
113. An incarcerated person started to carry Mr. Villanueva out of the housing area towards the vestibule area.

*Figure 2: Mr. Villanueva is carried out of the housing unit by an incarcerated person.*




114. Defendant Jones followed the incarcerated person carrying Mr. Villanueva but took no steps to assist him.

*Figure 3: Defendant Jones followed behind the incarcerated person assisting Mr. Villanueva.*




115. One of the incarcerated people assisting Mr. Villanueva carried Mr. Villanueva's inhaler with him.

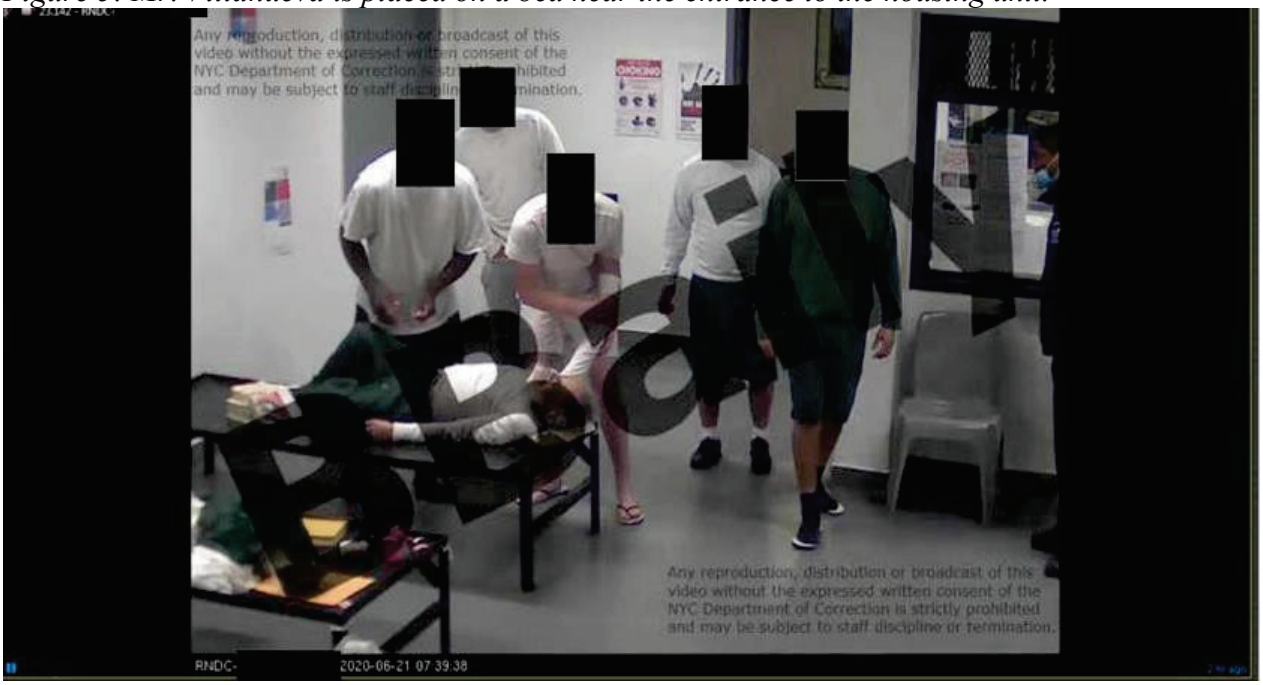
116. The incarcerated people carrying Mr. Villanueva were attempting to transport Mr. Villanueva to the Medical Clinic which lay outside the housing unit.

*Figure 4: A different incarcerated person took Mr. Villanueva in his arms in the vestibule.*


117. Upon information and belief, Defendant Cottle ordered the incarcerated people who were trying to obtain medical care for Mr. Villanueva to return to the housing unit and wait for the medical team to arrive.

118. The incarcerated people returned into the unit and placed Mr. Villanueva on a bed.

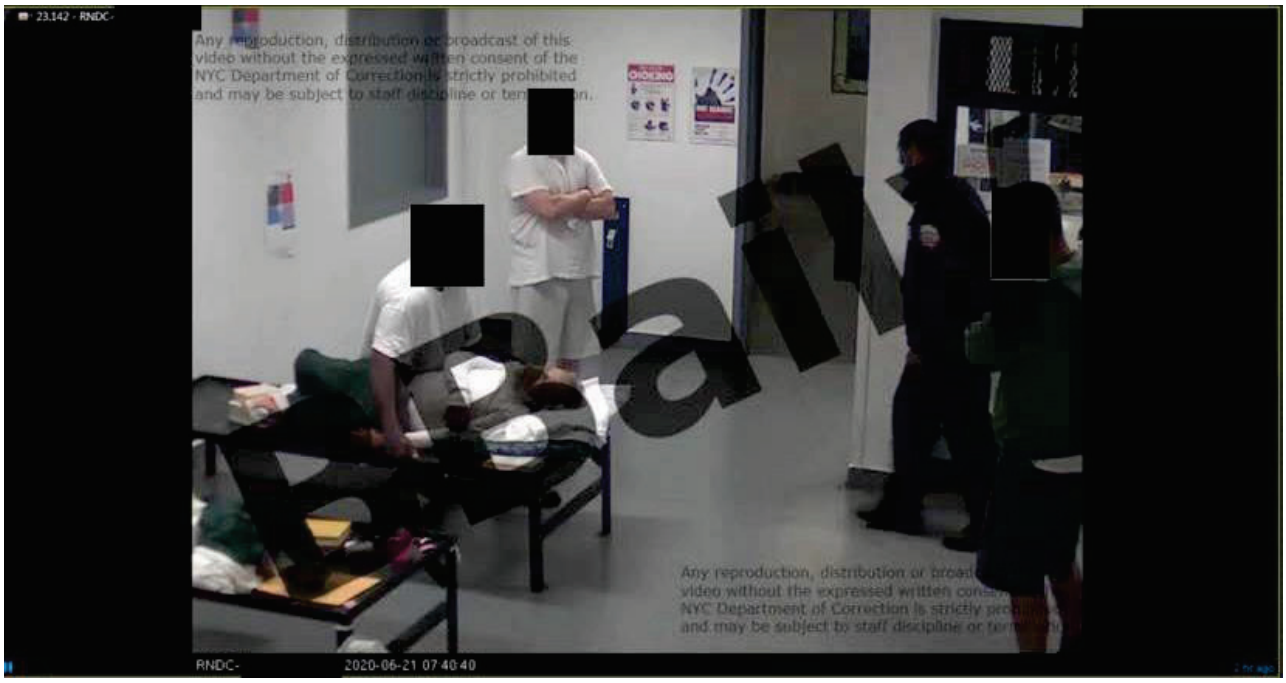
*Figure 5: Mr. Villanueva is placed on a bed near the entrance to the housing unit.*




119. Defendant Jones continued to stand by and do nothing to help Mr. Villanueva or summon medical attention.

120. As Mr. Villanueva lay dying on a bed, an incarcerated person sat down next to him to comfort him.

*Figure 6: Mr. Villanueva is comforted by another incarcerated person.*




121. While they waited for the medical staff to arrive, Defendants Jones and Cottle did not initiate CPR or make any efforts to resuscitate Mr. Villanueva.

122. Approximately 19 minutes after Mr. Villanueva sat up and exhibited visible distress, the first medical clinician arrived at the unit.

123. Medical staff then began chest compressions.

124. Defendants Jones and Cottle failed to promptly call for emergency medical assistance.

125. Defendants Jones and Cottle failed to timely use their radios to notify the medical department that there was an emergency.

126. Had Defendants Jones and Cottle acted swiftly and in accordance with sound correctional practice, Mr. Villanueva might have survived. But they did not.

127. Upon information and belief, Defendants John and Jane Doe 6-11 were

or should have been aware of Mr. Villanueva's acute respiratory distress, failed to provide medical care, participated in, supervised, and/or had knowledge of and failed to intervene in the denial of prompt medical care he required.

128. According to the SCOC's Medical Review Board, "there was a gross failure to adequately respond to an imminent medical emergency."

129. According to the SCOC's Medical Review Board, Defendant Jones "failed to provide first aid to an incarcerated person with difficulty breathing and failed to provide cardiopulmonary resuscitation to a incarcerated person in her care."

130. According to the SCOC's Medical Review Board, Defendant Jones's failures delayed cardiopulmonary resuscitation "by approximately 19 minutes."

131. Mr. Villanueva was pronounced dead at 8:10am on June 21, 2020.

132. Following an autopsy on June 22, 2020, the New York City Office of Chief Medical Examiner declared Mr. Villanueva's cause of death to be Acute Bronchial Asthma.

133. Upon review of Mr. Villanueva's death, the SCOC's Medical Review Board found that over the course of his incarceration at Rikers Island, Mr. Villanueva received inadequate monitoring and assessments, lack of adequate documentation of his health care, missed medications, missed appointments, violations of basic security standards and infection control directives to prevent the spread of COVID-19, and the failure of corrections staff to provide first aid and cardiopulmonary resuscitation that led to his death.

134. Upon review of Mr. Villanueva's death, the SCOC's Medical Review Board ordered an investigation of inadequate and thorough assessment by health staff, inadequate monitoring of a COVID-19 positive individual with underlying lung disease, and

inadequate CPR."

135. Mr. Villanueva experienced extreme pain and suffering, emotional distress, and death as a result of Defendants' misconduct, including but not limited to their cruel and unusual treatment of Mr. Villanueva, negligence, and deliberate indifference to his medical needs.

**New York City's Policy and Custom of Failing to Monitor and Care for Medically Disabled and Fragile Prisoners**

136. Defendant the City's failure to house Mr. Villanueva in a medically appropriate setting—such as medical housing—and failure to provide appropriate medical care, monitoring, and assessment to him—particularly in light of his medical disability and fragility—is a product of Defendant the City's longstanding, pervasive custom, policy, and/or practice of failing to safeguard medically disabled and fragile people in its custody, and at Rikers Island in particular, of which Defendant the City, through its officers and employees, was aware, permitted, tolerated, condoned and was deliberately indifferent.

137. These of Defendant the City's customs, policies, and/or practices were evident from both the manner with which it treated Mr. Villanueva over the course of his 111 days at Rikers Island, as described in the preceding paragraphs, and Defendant the City's treatment of other, similarly situated individuals.

138. On December 30, 2017, Joseph Foster died after suffering a fatal brain hemorrhage while he was incarcerated in DOC custody on Rikers Island. Upon information and belief, Mr. Foster had repeatedly requested medical care and the DOC knew that his medical history included high blood pressure and the need for additional monitoring and supervision.

139. On November 23, 2019, LeBarnes McClure died in the custody of the DOC on Rikers Island at the age of 55 years old. Many of the same failures in Mr. McClure's

care that caused his death also contributed to Mr. Villanueva's death less than seven months later. The SCOC Medical Review Board later issued its report finding that CHS medical providers "failed to adequately recognize and manage McClure's acute medical distress when he presented to emergency sick call on 11/22/2019," "failed to recognize McClure's presenting signs and symptoms, in a patient with multiple known risk factors, and "delayed in obtaining emergency transport of McClure to a hospital." Just as with Mr. Villanueva's death, the SCOC Review Board also "identified lapses in McClure's chronic care management," and opined "that had McClure received timely and competent medical care, McClure's death may have been preventable."

140. One month after Mr. McClure's death, the SCOC issued a December 17, 2019 Final Report on the Death of Wayne Henderson, another incarcerated person who had died on Rikers Island in DOC custody on August 27, 2017 due to, upon information and belief, more failures to provide appropriate medical care, monitoring and assessment to a medically fragile prisoner. In that December 17, 2019 Report, the SCOC directed CHS to "commence a comprehensive review and revision of the medication delivery and reconciliation process for inmates within NYC DOC."

141. Studying data of deaths in New York City jails between 2010 and 2016, Dr. Homer Venters, former Chief Medical Officers for the City's Correctional Health Services, previously found that significant numbers of the annual deaths on Rikers Island were "jail-attributable" deaths, meaning, deaths linked to care or conditions at Rikers Island. Upon information and belief, a sizeable portion of these deaths were caused by the failure to provide requisite care for people with chronic and severe medical conditions.

142. On April 14, 2020, the Legal Aid Society filed a mass writ of habeas corpus against then-DOC Commissioner Brann in New York County Supreme Court seeking the

release from Rikers Island of 36 elderly or medically vulnerable incarcerated people on the grounds that continuing to hold them in jail constituted deliberate indifference to the risk of serious medical harm. In those pleadings, Petitioners specifically alleged that the City acting through the DOC had not adequately defined or operationalized a plan to separate medically vulnerable people into medically appropriate housing units, and that DOC was not implementing housing recommendations for medically fragile prisoners even when made by CHS staff.[1]

**New York City's Policy and Custom of Failing to Provide Urgent Medical Care During Emergencies**

143. Upon information and belief, the failure of the City, including its employees, the Officer Defendants, and Defendants Jane and John Does 6-11, to promptly summon medical care in response to Mr. Villanueva's medical emergencies on June 20, 2020 and June 21, 2020, and the failure to coordinate a timely response to the medical emergency that caused his death, reflects a longstanding, pervasive custom, policy, and/or practice of DOC officers' deliberate indifference and negligent response to the serious medical needs of incarcerated people on Rikers Island, of which Defendant the City, through its officers and employees, was aware, permitted, tolerated, condoned and was deliberately indifferent. Defendant the City's failure to provide timely emergency medical responses to Mr. Villanueva was part of a pattern and practice of failing to promptly respond to medical emergencies experienced by incarcerated people on Rikers Island.

144. Defendant the City failed to adequately train DOC officers in

[1] *See* Rachel Bedard, *The Disillusionment of a Rikers Island Doctor*, THE NEW YORKER (March 24, 2022), *available at* https://www.newyorker.com/news/essay/the-disillusionment-of-a-rikers-island-doctor (discussing medical care at Rikers Island in 2019, 2020, and other times); Brian Bromwich, *Medical Care at Rikers is Delayed for Thousands, Records Show*, THE NEW YORK TIMES (Feb. 1, 2022), *available at* https://www.nytimes.com/2022/02/01/nyregion/rikers-island-medical-care.html (same); Jan Ransom, *Judge Faults Medical Care for Detainees in Latest Sign of Rikers Crisis*, THE NEW YORK TIMES (May 17, 2022), *available at* https://www.nytimes.com/2022/05/17/nyregion/nyc-correction-department-rikers.html (same).

emergency response protocols although it knew to a certainty that its employees assigned to housing units on Rikers Island would face medical emergencies amongst the incarcerated people for whom they were responsible, and that many of the incarcerated individuals were people with serious medical problems likely to require urgent medical care.

145. Defendant the City's customs, policies, and/or practices were evident from both the manner with which it treated Mr. Villanueva in response to his medical emergencies on June 20, 2020 and June 21, 2020, as described in the preceding paragraphs, and Defendant the City's treatment of other, similarly situated individuals.

146. There were at least four other people who died at Rikers Island in the two years prior to Mr. Villanueva's death under comparable circumstances.

147. In January 2019, the family of Joseph Foster sued Defendant the City of New York after DOC correctional staff at Rikers Island delayed more than an hour in summoning medical assistance or moving Mr. Foster to a medical clinic. The suit alleged that the DOC correction officers responsible for Mr. Foster left him in his cell, screaming in agony, when he needed urgent medical care. Mr. Foster died of a brain hemorrhage on January 4, 2018.

148. On June 7, 2019, Layleen Polanco died following a fatal epileptic seizure and head trauma while incarcerated at Rikers Island after DOC personnel failed to summon medical assistance for more than one hour. The City settled a wrongful death action by Ms. Polanco's family for $5.9 million.

149. On November 27, 2019, 18-year-old Nicholas Feliciano hanged himself with institutional clothing in an intake pen at the George R. Vernon Center on Rikers Island. According to the Board of Correction's review of this incident, he was hanging for 7 minutes and 51 seconds in plain view of DOC Correction Officers, other people in custody, and other employees of Defendant the City before DOC staff cut him down. As a result of prolonged

oxygen deprivation, he suffered significant brain damage and remains in a rehabilitation facility unable to live independently.

150. In 2020, Defendant the City settled a wrongful death action filed by Eva Luckey's family, following Ms. Luckey's death while she was a prisoner at Rikers Island. Ms. Luckey died because of negligence on the part of jail staff who failed to provide her with emergency medical system when she complained of difficult breathing and exhibited signs of an asthma attack, failed to provide her with prescription medication needed to control her asthma, and failed to perform CPR on her when she went into respiratory distress.

151. DOC and CHS' pattern, practice, and custom of failing to respond to medical emergencies has been widely documented and reported. According to the BOC, "DOC and CHS do not seem to have an acceptable functioning system for providing emergency care to persons in life-threatening situations."

**FIRST CLAIM FOR RELIEF**

**42 U.S.C. § 1983**
**(Against All Defendants)**

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

153. By reason of the foregoing, and by denying Mr. Villanueva access to adequate medical care, failing to promptly summon medical treatment, failing to provide medical treatment, and/or exhibiting deliberate indifference to Mr. Villanueva's rights by not acting on information which indicated that unconstitutional acts were occurring, the Officer Defendants and Defendants John and Jane Doe 1-11 deprived Mr. Villanueva of 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 Fourth, Eighth, and Fourteenth Amendments to the United States Constitution. The Officer Defendants and Defendants John and

Jane Doe 1-11 acted at all relevant times hereto 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. Villanueva that shocks the conscience. As a direct and proximate result of these violations of Mr. Villanueva's constitutional rights, he suffered the damages hereinbefore alleged.

154. The Officer Defendants and Defendants John and Jane Doe 1-11 acted under pretense and color of state law and in their individual and official capacities and within the scope of their respective employments as DOC officers, agents, employees, and/or contracted personnel. Said acts by Defendants were beyond the scope of their jurisdiction, without authority of law, and in abuse of their powers. Said Defendants acted willfully, knowingly, and with the specific intent to deprive Mr. Villanueva of his constitutional rights secured by 42 U.S.C. § 1983 and by the Fourth, Eighth, and Fourteenth Amendments to the United States Constitution.

155. Defendant the City, through DOC, CHS, and its officers and employees, acting under the pretense and color of law, permitted, tolerated, and were deliberately indifferent to a pattern and practice of medical neglect towards incarcerated people with serious medical needs, and to a pattern and practice of medical neglect, deliberate indifference, and negligence by DOC officers and CHS medical personnel towards the serious medical needs of incarcerated people at the time of Mr. Villanueva's death. Defendant the City denied people in its custody with significant health needs appropriate and timely medical care, monitoring, and assessment.

156. Defendant the City, through DOC, CHS, and its officers and employees, acting under the pretense and color of law, permitted, tolerated, and were deliberately indifferent to a pattern and practice of lackadaisical response to medical emergencies by incarcerated people in their custody.

157. This widespread tolerance of abuse and neglect constituted municipal and corporate policy, practice, and custom, and was a proximate cause of Mr. Villanueva's mistreatment and death.

158. By pursuing, permitting, tolerating, and sanctioning persistent and widespread policies, practices, and customs pursuant to which Mr. Villanueva was denied medical care and died, the City deprived Mr. Villanueva of rights, remedies, privileges, and immunities guaranteed to every citizen of the United States, secured by 42 U.S.C. § 1983 and the Fourth, Eighth, and Fourteenth Amendments to the United States Constitution.

159. As a direct and proximate result of the misconduct and abuses of authority detailed above, Mr. Villanueva and Plaintiff sustained the damages hereinbefore alleged.

**SECOND CLAIM FOR RELIEF**
**Title II of the Americans with Disabilities Act, 42 U.S.C. § 12101, *et seq.***
**(Against Defendant the City of New York)**

160. Plaintiff repeats and realleges the foregoing paragraphs as if the same were fully set forth at length herein. Title II of the Americans with Disabilities Act ("ADA") states, in pertinent part: "[N]o qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity. 42 U.S.C. § 12132." A "public entity" includes state and local governments, their agencies, and their instrumentalities. 42 U.S.C. § 12131(1).

161. Disability discrimination under Title II includes the refusal to make reasonable modifications to policies, practices, and procedures where necessary to ensure that persons with disabilities do not experience discrimination. 28 C.F.R. § 35.130(b)(7).

162. At all relevant times, Defendant the City and the DOC jails it owns and

operates were a "public entity" within the meaning of Title II of the ADA.

163. At all relevant times, Mr. Villanueva was a qualified individual with a disability within the meaning of Title II of the ADA. *See* 42 U.S.C. § 12102. He had severe asthma, COPD, liver disease, and other serious, chronic health conditions that substantially limited his major life activities, and he was incarcerated on Rikers Island and thus qualified to participate in the programs, services, and facilities of DOC activities, including but not limited to, access to appropriate medical housing, appropriate medical care, and necessary, life-saving medical treatment.

164. Defendant the City denied Mr. Villanueva reasonable modifications necessary to avoid discrimination against him due to his disability by failing to provide him with the essential health services necessary to prevent his medical health from precipitous decline, culminating with his death.

165. Defendant the City discriminated against Mr. Villanueva because of his disability. It denied him requisite medical services, including but not limited to denying him medical housing, access to appropriate medical care, and prompt response to his medical emergencies, as detailed in the preceding paragraphs.

166. Defendant was deliberately indifferent to Mr. Villanueva's rights secured by the ADA.

167. Defendant the City's failure to provide Mr. Villanueva with reasonable accommodations caused him unnecessary pain and suffering, increased the severity of his medical conditions, and was a proximate cause of his death.

**THIRD CLAIM FOR RELIEF**
**Wrongful Death**
**(Against All Defendants)**

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

169. By reason of the foregoing, the statutory distributees of Mr. Villanueva's estate sustained pecuniary and non-economic loss resulting from the loss of love, comfort, society, attention, services, and support of Mr. Villanueva. Defendants are liable for the wrongful death of Mr. Villanueva.

170. As a consequence, Plaintiff has suffered damages in an amount to be determined at trial.

**FIFTH CLAIM FOR RELIEF**
**Negligence**
**(Against All Defendants)**

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

172. Defendants owed a duty of care to Mr. Villanueva as an inmate at Rikers Island.

173. Defendant the City breached the duty of care that it owed to Mr. Villanueva by failing to place him in medically-appropriate housing despite his serious, chronic medical conditions, known medically vulnerable status, and worsening health, and failed to provide him with adequate or timely medical care, and failed to respond to his medical emergencies with timely assistance.

174. The Officer Defendants and Defendants John and Jane Doe 1-11 breached their duty of care to Mr. Villanueva by failing to respond to his medical emergency.

175. All Defendants breached the duty of care that they owed to Mr. Villanueva by denying him access to prompt and adequate medical care.

176. Defendants' breach of their duty of care was a proximate cause of Mr. Villanueva's severe pain and suffering and death.

177. Defendant the City, as employer of the Officer Defendants, is responsible for their negligence under the doctrine of respondeat superior.

178. As a direct and proximate result of the misconduct and abuse of authority detailed above, Plaintiff sustained the damages hereinbefore alleged.

**PRAYERS FOR RELIEF**

WHEREFORE, Plaintiff respectfully requests judgment against Defendants as follows:

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

2. Awarding punitive damages against the Officer Defendants and Defendants John and Jane Doe 1-11 in an amount to be determined at trial;

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

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

Dated: February 27, 2023
New York, New York

EMERY CELLI
BRINCKERHOFF ABADY
WARD & MAAZEL LLP

/s/
Katherine Rosenfeld
Daniel M. Eisenberg
600 Fifth Avenue, 10th Floor
New York, New York 10020
(212) 763-5000

*Attorneys for Plaintiff Eva Villanueva*