UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

ANTHONY MORGAN and DAVID NIEVES, as Putative Administrators of the Estate of Their Brother Michael Nieves,

Plaintiffs,

– against –

CITY OF NEW YORK and DOES #1-11,

Defendants.

No. 23 cv 1079

COMPLAINT AND JURY DEMAND

PRELIMINARY STATEMENT

1. This case presents a shocking and unconscionable display of deliberate indifference to the medical needs and welfare of a man incarcerated at Rikers Island. The consequences were fatal. Michael Nieves suffered a premature, tragic, and entirely preventable death, for which the City of New York ("City") is plainly liable.

2. Trial of this action will demonstrate that the conduct of New York City Department of Corrections ("DOC") staff here was exceptionally delinquent: after providing Mr. Nieves—a known suicide risk—*with a razor*, they then left him alone, unsupervised in his cell. When he cut his throat, DOC staff failed to administer any first aid or arrange for the necessary medical treatment that could have saved his life. In essence, DOC staff stood by and watched Mr. Nieves die. There is no excuse or justification for this inhuman treatment.

3. Michael Nieves was arrested in April 2019 and transported to Rikers Island. He was never tried or convicted of the crime he was arrested for. Instead, he remained in custody for more than three years. During that time, he was repeatedly hospitalized for significant mental health problems and was determined to be at clear risk for suicide. His confinement in psychiatric facilities included time at Bellevue Hospital and various state

institutions. On numerous occasions, he was placed on suicide watch.

4. Notwithstanding his extensively documented mental health history and his obvious risk of suicide, on August 25, 2022, Mr. Nieves was given a DOC-issued razor. Mr. Nieves was then permitted to return to his cell without the razor having been retrieved. Left unsupervised in his cell, Mr. Nieves cut his own throat. When DOC staff finally arrived at his cell, they saw him bleeding from the neck but failed to provide the necessary medical care to save his life. In other words, DOC staff stood by and allowed Mr. Nieves to bleed to death.

5. Remarkably, the tragic and unnecessary death of Michael Nieves is not an isolated incident. For years, City and DOC officials have presided over a system of abuse and extreme indifference to the needs of people with mental health problems, many of whom are at clear risk for suicide or serious self-harm. Notwithstanding the crisis level of the problem, nothing effective has been done by DOC or the City to alleviate the obvious failures and deficiencies which led to this and many other deaths. Such failure, over such a protracted period, constitutes a pattern and practice of extreme deliberate indifference.

6. Plaintiffs Anthony Morgan and David Nieves, Mr. Nieves' brothers and the putative administrators of his estate, now bring this civil rights action, seeking compensatory and punitive damages, costs, disbursements, and attorneys' fees pursuant to applicable state and federal civil rights law.

PARTIES

7. Michael Nieves was a citizen of the United States and resided at Rikers Island jail in Bronx County at the time these events occurred.

8. At the time of his August 30, 2022 death, Mr. Nieves was 40 years old.

9. Anthony Morgan and David Nieves are Mr. Nieves's brothers and have

duly applied to the Brooklyn County Surrogate's Court to be appointed the administrators of his estate for purposes of bringing this action.

10. Defendant City of New York ("City") is a municipal corporation that, through the Department of Correction ("DOC"), operates a number of detention jails on Rikers Island including the Anna M. Kross Center ("AMKC"). DOC is responsible for the provision of mental health care and services to prisoners confined in City jails, including AMKC, the jail in which Mr. Nieves was confined in August 2022.

11. 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 mental health care and access to mental health and other programs and 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. These practices, because they are widespread, long-standing, and deeply embedded in the culture of the agency, constitute unwritten DOC policies or customs. DOC is also responsible for the appointment, training, supervision, and conduct of all DOC personnel, including the defendants referenced herein.

12. At all times relevant hereto, defendants Does #1-11 (the "Individual Defendants") were officers of DOC, who participated in and/or had knowledge of and failed to intervene in the denial of prompt medical care to Mr. Nieves on August 26, 2022. At all times relevant hereto, the Individual Defendants were acting under color of state law and within the scope of their capacities as agents, servants, and employees of the City. The Individual Defendants are sued in their individual capacities.

JURISDICTION AND VENUE

13. This action arises under the Fourteenth Amendment to the United States

Constitution and under 42 U.S.C. §§ 1983 and 1988, and New York state common law and constitution.

14. The jurisdiction of this Court is predicated upon 28 U.S.C. §§ 1331, 1343(a)(3) and (4), 1367(a) and the doctrine of pendent jurisdiction.

15. The acts complained of occurred in the Southern District of New York, and venue is lodged in this Court pursuant to 28 U.S.C. § 1391(b).

JURY DEMAND

16. Plaintiffs demand trial by jury in this action.

STATEMENT OF FACTS

Background

17. Michael Nieves was born in New York City in 1982.

18. He grew up on the Lower East Side of Manhattan.

19. He loved art. He also loved developing new and creative ideas for inventions and technologies.

20. During his teen years, Mr. Nieves began suffering from bipolar disorder, schizophrenia, and other chronic, serious mental health conditions.

21. These serious mental illnesses continued to plague him for the rest of his life.

22. Mr. Nieves was arrested in Manhattan on or around April 9, 2019.

23. Mr. Nieves remained in custody from April 9, 2019 until his premature and preventable death on August 30, 2022.

24. He was never tried or convicted of the crime for which he was arrested on

April 9, 2019.

25. During the nearly 42 months he spent in custody between his April 9, 2019 arrest and his death on August 30, 2022, Mr. Nieves was sent to a New York State psychiatric hospital twice for evaluation and treatment, and was sent to Bellevue Hospital's Prison Ward approximately five times.

26. By virtue of these repeated hospitalizations and other evidence available to them, the City knew or should have known of Mr. Nieves's precarious psychological condition and his risk of suicide.

27. Upon information and belief, DOC placed Mr. Nieves on suicide watch several times between April 9, 2019 and August 30, 2022.

28. On or around June 8, 2022, Mr. Nieves returned to Rikers Island following his second confinement at a New York State psychiatric hospital.

29. On or around June 10, 2022, Mr. Nieves was assigned to a Program Accelerating Clinical Effectiveness ("PACE") unit on Rikers Island, which houses individuals who are deemed seriously mentally ill by a Correctional Health Services ("CHS") mental health clinician.

30. Upon information and belief, DOC policy requires a psychiatric nurse to be present on the PACE unit at all times.

31. On the morning of August 25, 2022, Mr. Nieves was given an institutional razor from DOC.

32. At approximately 10:30 a.m. on August 25, 2022, DOC staff, Does #1-3, attempted to collect the institutional razor back from Mr. Nieves.

33. DOC staff did not retrieve the institutional razor from Mr. Nieves.

34. Instead, Mr. Nieves was permitted to bring the institutional razor with him back to his cell.

35. Upon information and belief, DOC staff, including Does #1-3, knew, or reasonably should have known, that Mr. Nieves brought an institutional razor back to his cell on the morning of August 25, 2022.

36. At approximately 11:15 a.m. on August 25, 2022, DOC staff, Does #4-5, searched Mr. Nieves's cell for the institutional razor.

37. DOC staff did not find the institutional razor in Mr. Nieves's cell.

38. Upon information and belief, by virtue of Mr. Nieves's assignment to a PACE unit, Does #1-5 knew, or reasonably should have known, that Mr. Nieves was seriously mentally ill and was a suicide risk.

39. A DOC Captain, Doe #6, then instructed a DOC Correction Officer to escort Mr. Nieves to the intake area so he could go through the body scanner.

40. Mr. Nieves refused to exit his cell.

41. DOC Captain Doe #6 then ordered DOC staff to leave Mr. Nieves in his cell, with the institutional razor unaccounted for.

42. A DOC Correction Officer, Doe #7, shut the door to Mr. Nieves's cell, and at approximately 11:28 a.m., all DOC staff left the area and Mr. Nieves was alone without any supervision.

43. Does #6 and #7, and other DOC staff, left Mr. Nieves in his cell alone, without any supervision, for approximately 13 minutes, even though they knew, or reasonably should have known, he had an institutional razor with him, he was seriously mentally ill, and he had been placed on suicide watch several times over the preceding three years.

44. While Mr. Nieves was in his cell alone and unsupervised, he used the institutional razor he had borrowed to slit his throat.

45. His neck began bleeding.

46. At approximately 11:41 a.m., Doe #6 and a DOC Correction Officer, Doe #8, first observed that Mr. Nieves had a laceration on his neck and was bleeding.

47. Prior to Does #6 and #8 observing Mr. Nieves at approximately 11:41 a.m., no DOC staff checked on Mr. Nieves or noticed Mr. Nieves had slit his throat with an institutional razor.

48. Doe #8 asked Mr. Nieves what happened to him.

49. Mr. Nieves did not initially respond.

50. Doe #8 then repeated his question.

51. Mr. Nieves told Does #6 and 8, in sum and substance, that the state forced him to commit suicide.

52. While he was talking with Does #6 and #8, Mr. Nieves was slumped over, with his hands on his knees. He occasionally removed his hands from his knees and placed them over the bleeding razor wound on his neck.

53. Neither Doe #6 nor Doe #8 provided Mr. Nieves with any medical aid.

54. They did not attempt CPR or any other life-saving effort.

55. Upon information and belief, no psychiatric nurse was present on the PACE unit when Mr. Nieves slit his throat, contrary to DOC policy.

56. Eventually, Doe #6 and/or Doe #8 activated a medical emergency.

57. Neither Doe #6 nor Doe #8 nor any other DOC staff told medical staff what

the nature of the medical emergency was.

58. No one told medical staff Mr. Nieves had a razor wound on his neck.

59. No one told medical staff Mr. Nieves was bleeding from his neck.

60. No one told medical staff Mr. Nieves had reported trying to commit suicide.

61. At approximately 11:51 a.m., approximately ten minutes after Does #6 and #8 first observed that Mr. Nieves had slit his throat, CHS medical staff, Does #9-11, arrived at Mr. Nieves's cell.

62. Upon information and belief, Does #9-11 did not know the nature of the emergency when they arrived at Mr. Nieves's cell.

63. Upon information and belief, Does #9-11 did not bring emergency medical supplies to treat Mr. Nieves.

64. Eventually, Mr. Nieves became unresponsive.

65. He was ultimately transported to Elmhurst Hospital.

66. He arrived at Elmhurst Hospital unresponsive and in need of a machine for breathing assistance.

67. On August 26, 2022, Mr. Nieves was declared brain dead.

68. On August 30, 2022, Mr. Nieves was taken off the breathing machine.

69. Mr. Nieves's death certificate states that he died on August 26, 2022 at 1:21 p.m.

70. Mr. Nieves 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. Nieves and deliberate indifference to his medical needs.

The City's Practice and Custom of Indifference to Individuals with Mental Health Conditions

71. DOC correction officers' failure to ensure Mr. Nieves's safety or to intervene when they saw he was in critical condition is not an isolated event, but rather reflects a longstanding and pervasive policy, practice, and custom of DOC officers' deliberate indifference and negligent response to individuals facing a known risk of suicide, which the City, through its officers and employees, was aware of, permitted, tolerated, condoned, and was deliberately indifferent to for years before Mr. Nieves's death.

72. DOC has consistently failed to ensure that officers conduct sufficient rounding and supervision of incarcerated people, including in Rikers Island's mental health units. It also has not addressed repeated failures by officers to render timely first aid to incarcerated individuals found severely injured and/or unresponsive.

73. The City has systematically failed to ensure adequate supervision for people in DOC custody who suffer from mental illness and to provide sufficient training for those responsible for these people's well-being. These systemic failures have led to numerous preventable suicides by individuals in DOC custody in the last several years.

74. In 2021, sixteen people died in DOC custody, six by suicide.

75. On January 22, 2021, Wilson Diaz Guzman, who had reported thoughts of hurting or killing himself during his intake assessment, was found in his cell with a bedsheet wrapped around his neck. In the days preceding his death, Mr. Diaz-Guzman had been seen by mental health staff after reporting that he made superficial scratches to his arm because he feared for his safety and wanted someone to pay attention to him, yet he was not placed on increased supervision or referred for additional mental health care. Mr. Diaz-Guzman committed suicide

while he was left unsupervised for more than 30 minutes despite DOC policies requiring officers to conduct visual observations at 30-minute intervals.

76. On March 2, 2021, Tomas Carlo Camacho was found unresponsive with his head through the cuffing port/food slot of a pen where he was placed while waiting to be taken back to his assigned housing area after a medication reevaluation. He asphyxiated while he was left alone for nearly two hours, even though officers were required to tour every 30 minutes. The correction officers who found him did not immediately administer first aid, even though they were required to do so by DOC policy, but instead waited for CHS staff to arrive. Mr. Camacho died two weeks later.

77. On March 19, 2021, Javier Velasco, who had been taken off suicide watch two days earlier in the wake of another suicide attempt, was found unresponsive in his cell early in the morning with institutional linen affixed to an air vent and tied around his neck. Correction officers had not toured Mr. Velasco's housing area at the required intervals during the night, and although they had walked up and down the area periodically, they did not check individual cells to verify that the individuals inside were alive and breathing. The correction officer who found Mr. Velasco did not render immediate aid, but instead walked away from his cell and returned four minutes later with other officers.

78. On August 10, 2021, Brandon Rodriguez was found inside a shower pen in the Central Punitive Segregation Unit (CPSU) with a shirt tied around his neck. On August 8, 2021, he had been taken to the hospital following a fight in the intake area of the Rikers facility where he was being held. During his initial mental health assessment after he returned to Rikers, which took place less than 24 hours prior to his death, he reported that he did not feel safe in the intake area and requested a transfer. He also reported a history of mental illness. Later that day, officers used force against him and placed him in the shower pen in the CPSU. Correction

officers did not check each cell in the CPSU when conducting rounds, and Mr. Rodriguez committed suicide while the correction officer assigned to the area left the CPSU entirely for half an hour.

79. On August 29, 2021, Segundo Guallpa was found dead in his cell with a ligature made from socks wrapped around his neck after correction officers failed to tour his unit at consistent intervals. His initial mental health assessment had been scheduled and canceled twice, so at the time of his death no mental health assessment had been completed. Video surveillance footage showed that when correction officers found Mr. Guallpa unresponsive in his cell, they did not immediately render aid but instead talked to each other and looked at his body while they waited for medical staff to arrive.

80. On October 14, 2021, Anthony Scott, who suffered from mental illness, was discovered with a ligature around his neck in a holding pen across from a correction officer's desk in the Manhattan Court Facility. There was no risk screening form or suicide prevention form in Mr. Scott's records, even though DOC policy required that these forms be filled out before inmates are placed in holding pens. These forms are used to inform staff that certain items, such as belts, drawstrings, neckties, and shoelaces, must be confiscated and safeguarded from individuals identified as being at risk of suicide or self-harm. Although correction officers were required to tour the area and observe all individuals every fifteen minutes, Mr. Scott was left unsupervised for over half an hour, during which time he removed the drawstring from his clothes, jammed the pen's locking mechanism, placed the string around his neck, and lay on the floor out of view. When officers discovered him, they were unable to enter the pen because he had jammed the locking mechanism. Mr. Scott was pronounced dead four days later after he was brought to the hospital in cardiac arrest and placed on a ventilator.

81. Upon information and belief, on November 22, 2021, Ryan Wilson, who

had struggled with mental health problems for years, hanged himself from a light fixture in the Manhattan Detention complex in front of correction officers who ignored his announcement that he would hang himself if he was not allowed out of his cell. One of the correction officers stopped another from cutting Mr. Wilson down, saying he was "playing," and left him hanging from the light fixture for nearly 15 minutes. The correction officer who stopped the other from intervening has been charged with criminally negligent homicide and filing a false report about the episode.

82. In 2022, nineteen people died in DOC's custody, seven of whom appear to have died by suicide, including Mr. Nieves.

83. On May 7, 2022, Dashawn Carter, who was known to suffer from serious mental health disorders and had been transferred from a psychiatric hospital directly to a general population housing unit at Rikers, hung himself from a window in his cell. On the day of Mr. Carter's death, DOC staff did not conduct tours of his unit every 30 minutes in accordance with DOC policy, and when they did tour the housing unit, they did not check individual cells one by one. According to the Board of Correction's review of this incident, it is unlikely that the DOC staff members who were alerted to Mr. Carter's death rendered any first aid, leaving the task of performing CPR to other incarcerated individuals.

84. On June 10, 2022, Antonio Bradley tied his sweater around his neck and hanged himself in a holding cell in Bronx criminal court, where he had been transferred for a court appearance. On multiple occasions, including approximately one week before he hanged himself, Mr. Bradley had reported suicidal ideation to DOC medical staff. He had also disclosed several mental health problems to DOC medical staff, including bipolar disorder and depression, and he had attempted suicide at least one other time while in DOC custody. On June 10, 2022, Mr. Bradley hung for several minutes before a DOC supervisor noticed him. By the time

correction officers removed the sweater from Mr. Bradley's neck, he was unconscious. He died about a week later.

85. On August 15, 2022, Ricardo Cruciani was found sitting in a shower area of a DOC jail with a sheet around his neck. He died shortly thereafter. Although a New York Supreme Court judge had ordered that Mr. Cruciani be placed in protective custody and on suicide watch, DOC records show that the DOC did not place him either on suicide watch or in protective custody.

86. These and other suicides in the months and years leading up to Mr. Nieves's death in August 2022 alerted the City to the dire ramifications of its disregard for the wellbeing of incarcerated people with mental illnesses. But in August 2022, the City still was not taking even the most elemental precautions to protect incarcerated people from harm.

87. And the City has not taken any action to remedy its disregard for incarcerated people with mental illnesses and/or a known risk of suicide in the wake of Mr. Nieves's death. To this day, DOC's extreme indifference continues to have appalling consequences, as evidenced by the fact that three more individuals have committed suicide in DOC custody since Mr. Nieves's death.

88. On September 14, 2022, Kevin Bryan was found hanging from a pipe inside a locked staff bathroom and pronounced dead shortly thereafter. He locked himself in the bathroom after being forced out of a housing area by other detainees through a gate that had been opened by a correction officer.

89. On September 20, 2022, Gregory Acevedo, an inmate with a history of mental health problems, climbed a security fence on the roof of the Vernon C. Bain Center, a detention barge operated by DOC, and jumped into the East River. Although officers threw him life rafts, he refused to accept them. When the Police Department's harbor unit pulled him from

the water, he was unresponsive. Mr. Acevedo died later that day.

90. On October 22, 2022, Erick Tavira, another inmate suffering from mental illness, was found unresponsive with a sheet around his neck in a mental health observation unit on Rikers Island. Correction officers were supposed to check on Mr. Tavira every 15 minutes, but he hanged himself when he was left alone for an hour.

91. The City has also settled a number of lawsuits brought by families of individuals who committed suicide in DOC custody.

92. For example, the City agreed to settle a case brought by the family of Aris Hiraldo, who hanged himself in his cell in 2011 using the drawstring of his sweatpants ten days after a social worker took him off suicide watch, even though he continued to show signs that he was a threat to himself.

93. DOC's failure to prevent suicide attempts leading to death and severe injury has also led to criminal charges against correction officers in recent years.

94. In addition to the criminal charges brought against the correction officer who stopped another officer from intervening when Ryan Wilson hung himself in 2021, four correction officers face criminal charges for doing nothing for nearly eight minutes as Nicholas Feliciano tried to hang himself with institutional clothing in an intake pen at the George R. Vernon Center on Rikers Island in November 2019. Mr. Feliciano survived but suffered severe brain damage due to prolonged oxygen deprivation and to this day remains in a rehabilitation facility unable to live independently.

95. The independent monitor appointed by a federal court as part of the settlement in *Nunez v. City of New York* to oversee the City's reforms to Rikers Island issued a report on October 28, 2022 identifying the following "readily apparent" "practice failures" as

having "likely contributed" to deaths in DOC custody in 2022: "poor security practices (including inadequate touring by staff, ineffective searching, failures in securing of doors, and failures in ensuring the removal of sight obstructions, such as cell window coverings), staff mismanagement (including posts that are unmanned), operational deficiencies, failed suicide prevention measures, and potential staff inaction." The report stated that its "findings and concerns about poor security and operational practices among DOC staff have been described in the Monitoring Team's reports for years." *Second Status Report on DOC's Action Plan by the Nunez Independent Monitor*, October 28, 2022, *available at* https://www.nyc.gov/assets/doc/downloads/pdf/2022-10-28_Second_Status_Report_Action_Plan.pdf, at 21.

96. The Board of Correction's reports on deaths in DOC custody in 2021 and 2022 echo these conclusions, finding that many deaths can be traced back to insufficient rounding and supervision, insufficient staffing, lack of immediate emergency first aid by officers, failure to flag concerning behavior or use of contraband, and failed suicide prevention, among other things. *See* New York City Board of Correction, *Report and Recommendations on 2021 Suicides and Drug-Related Deaths in New York City Department of Correction Custody*, *available at* https://www1.nyc.gov/assets/boc/downloads/pdf/Reports/BOC-Reports/2021-suicides-and-drug-related-deaths-report-and-chs-response.pdf; New York City Board of Correction, *Second Report and Recommendations on 2022 Deaths in New York City Department of Correction Custody*, Nov. 16, 2022, available at https://www.nyc.gov/assets/boc/downloads/pdf/Reports/BOC-Reports/FINAL-Second-Report-and-Recommendations-on-2022-Deaths-in-DOC-Custody-and-CHS-response.pdf.

97. The City's chronic deliberate indifference to incarcerated individuals with mental health conditions and its failure to take action to address known risks to the health and safety of those in their care caused Mr. Nieves's and many others' deaths.

Plaintiffs' Notice of Claim

98. Plaintiffs have complied with the requirements of New York General Municipal Law Section 50-i. Plaintiffs served a notice of claim on the municipal defendant City of New York on November 10, 2022, within the time required by the New York General Municipal Law Section 50-e. More than 30 days have passed since the service of the Notice of Claim.

FIRST CLAIM FOR RELIEF
42 U.S.C. § 1983
(Against the Individual Defendants)

99. Plaintiffs repeat and reallege the foregoing paragraphs as if the same were fully set forth at length herein.

100. By reason of the foregoing, and by failing to provide Mr. Nieves with adequate supervision, denying Mr. Nieves access to adequate medical and mental health care, failing to provide medical treatment, and/or exhibiting deliberate indifference to Mr. Nieves's medical needs, the Individual Defendants deprived Mr. Nieves 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 Fourteenth Amendment to the United States Constitution. The Individual Defendants 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. Nieves that shocks the conscience. As a direct and proximate result of these violations of Mr. Nieves's constitutional rights, he suffered the damages hereinbefore alleged.

101. The Individual Defendants 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. The Individual Defendants acted willfully, knowingly, and with the specific intent to deprive Mr. Nieves of his constitutional rights secured by 42 U.S.C. § 1983 and by the Fourteenth Amendment to the United States Constitution.

SECOND CLAIM FOR RELIEF
42 U.S.C. § 1983
(Against the City)

102. Plaintiffs repeat and reallege the foregoing paragraphs as if the same were fully set forth at length herein.

103. Defendant City, through DOC and its officers and employees, acting under the pretense and color of law, permitted, tolerated, and was deliberately indifferent to a pattern and practice of medical neglect towards individuals in DOC custody who suffer from mental illness and/or face a known risk of suicide, and to a pattern and practice of medical neglect, deliberate indifference, and negligence by DOC officers towards individuals in DOC custody who suffer from mental illness and/or face a known risk of suicide.

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

105. As a direct and proximate result of the misconduct and abuses of authority detailed above, plaintiffs sustained the damages hereinbefore alleged.

THIRD CLAIM FOR RELIEF
Wrongful Death
(Against All Defendants)

106. Plaintiffs repeat and reallege the foregoing paragraphs as if the same were

fully set forth at length herein.

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

108. As a consequence, Plaintiffs have suffered damages in an amount to be determined at trial.

FIFTH CLAIM FOR RELIEF
Negligence
(Against All Defendants)

109. Plaintiffs repeat and reallege the foregoing paragraphs as if the same were fully set forth at length herein.

110. At all times relevant to this complaint, Defendants owed a duty of care to Mr. Nieves because he was in DOC custody on Rikers Island.

111. Defendants breached their duty of care to Mr. Nieves by failing to provide him with adequate supervision and denying him access to prompt and adequate medical and mental health care.

112. Defendants' breach of their duty of care was the proximate cause of Mr. Nieves's severe pain and suffering and death.

113. Defendant City, as employer of the Individual Defendants, is responsible for their negligence under the doctrine of *respondeat superior*.

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

PRAYERS FOR RELIEF

WHEREFORE, Plaintiffs respectfully request judgment against Defendants as follows:

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

2. awarding punitive damages against the Individual Defendants in an amount to be determined at trial;

3. awarding Plaintiffs 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 8, 2023
New York, New York

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