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UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

LUZ GUAMAN ON BEHALF OF HERSELF AND AS THE FUTURE ADMINISTATRIX OF THE ESTATE OF SEGUNDO GUALLPA, MARCO GUALLPA, EDWIN GUALLPA, FRANCISCO GUALLPA, AND ALEXISS GUALLPA

Plaintiffs,

— against —

CITY OF NEW YORK, ALDO TEJEDA, TONYA HUSTON, MATT TURNER, AND JOHN DOE CORRECTIONS OFFICERS #1-#25

Defendants.

Index No. 22-cv-9376

COMPLAINT

JURY TRIAL DEMANDED

## PRELIMINARY STATEMENT

1. Segundo Guallpa should still be alive.

2. Like over fifteen other people incarcerated at Rikers Island in 2021, Mr. Guallpa died because the City of New York and its Department of Correction failed him.

3. The high death rate at Rikers Island has continued into 2022.

4. The Department of Correction, its employees, and its leadership have failed, admittedly, to properly staff and prevent self-harm at Rikers Island.

5. In fact, the Commissioner of the New York City Department of Correction has admitted that its failure to adequately staff Rikers Island facilities caused Mr. Guallpa's death.

6. In an article about the epidemic of self-harm at Rikers Island this year, Vincent Schiraldi, the head of the Board of Correction, said "If we don't have enough staff who are working… they are not properly seeing to issues that affect suicide…We've fallen behind on [suicide prevention training] because we are so thinly staffed…All sorts of things start to fall by the wayside when there is not enough staff to make those things happen."[1]

7. Rikers Island is now on the brink of Federal receivership and is facing a broad-based conditions of confinement class action because the Department of Correction has allowed lawlessness and refusal to work to become its de facto policy.

8. Plaintiffs, Mr. Guallpa's widow and her children with Mr. Guallpa, now bring survivorship claims and wrongful death claims on behalf of Mr. Guallpa's to be established estate and on their own behalf against the City of New York and its employees for the death of Segundo Guallpa.

PARTIES

9. Luz Guaman is a resident of Queens, New York, Mr. Guallpa's widow, and the anticipated administratrix of the Estate of Segundo Guallpa.

[1] https://www.thecity.nyc/2021/9/7/22659614/self-harm-suicide-rikers-island-new-york-city-jails-rising

10. Segundo Guallpa was a resident of Queens, New York who died on Rikers Island on August 29th, 2021. His estate is now pending in Queens Surrogate Court.

11. Marco Guallpa is the son of Segundo Guallpa and Luz Guaman and is a resident of Queens, NY.

12. Edwin Guallpa is the son of Segundo Guallpa and Luz Guaman and is a resident of Queens, NY.

13. Francisco Guallpa is the son of Segundo Guallpa and Luz Guaman and lives with Ms. Guaman in Queens.

14. Alexiss Guallpa is the son of Segundo Guallpa and Luz Guaman and lives with Ms. Guaman in Queens.

15. Defendant City of New York is a municipal corporation in the State of New York.

16. Defendant Aldo Tejeda is a New York City Correction Officer assigned to Mr. Guallpa's unit.

17. Defendant Tonya Huston is a New York City Correction Officer assigned to Mr. Guallpa's unit.

18. Defendant Matthew Turner is a supervising New York City Correction Officer assigned to Mr. Guallpa's unit.

19. Defendants John Doe #1-25 are New York City Correction Officers.

JURISDICTION AND VENUE

20. This Court has jurisdiction over this action pursuant to 28 U.S.C. § 1331 and pendant jurisdiction over the state law claims.

21. Venue is proper in this district under 28 U.S.C. § 1391 as the City of New York resides in the Eastern District of New York.

FACTUAL ALLEGATIONS

22. Segundo Guallpa was arrested and sent to Rikers Island on August 19, 2021, after he assaulted Ms. Guaman.

23. Segundo Guallpa was an alcoholic who suffered from depression after suffering a debilitating injury while working.

24. Mr. Guallpa was a kind person and a good husband and father when sober. He took care of the children and cooked for the family.

25. He also provided when possible by doing handywork and managing a property.

26. When he arrived at Rikers Island he was immediately sent to North Infirmary Command ("NIC")/West Facility.

27. Mr. Guallpa was sent to West while the facility confirmed he was TB negative.

28. Mr. Guallpa took antidepressant medication for his depression.

29. While placed in the sick ward, upon information and belief, Mr. Guallpa did not receive his medication.

30. Per Ms. Guaman, Mr. Guallpa suffered significant withdrawal symptoms when he did not receive his antidepressants.

31. Medical records revealed Mr. Guallpa was flagged as detoxing on August 25, 2021, days before he committed suicide.

32. Mr. Guallpa's intake paperwork indicated that he did not drink alcohol, even though his arrest report made clear he had been intoxicated at the time of arrest.

33. He was also referred for a mental health screening upon arriving at Rikers.

34. The first attempt for mental health was canceled because of insufficient staffing at Rikers Island.

35. The second attempt, on August 25, was unsuccessful because Mr. Guallpa was irritated and frustrated by his interactions with DOC staff, observations which should have increased the need to perform mental health screening.

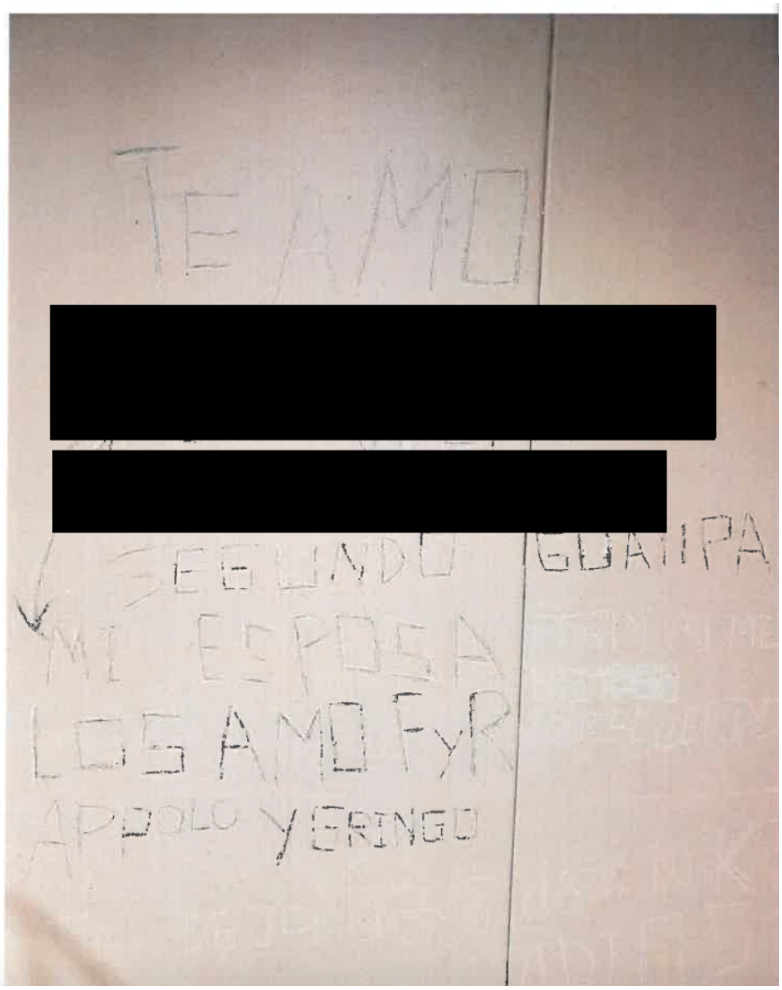
36. On August 29, 2021, video surveillance footage showed Mr. Guallpa pacing inside his cell, running his hands over his head, moving his mouth, as if he were speaking to himself, and waving his arms. He paced inside his cell multiple times.

37. His last contact with correction officers was at 6:00 pm that evening, when DOC staff provided him with a tray of food through the cell door's cuffing port.

38. Later that evening, Mr. Guallpa etched a suicide note into the wall of his jail cell.

39. No guard saw the note which likely took hours to carve, because no guard came by his cell to observe him.

40. The note was nearly 500 characters etched into the wall. A photo of a portion of that note can be seen here:




41. In English, the etched note read, in sum and substance: I'm going to leave you a few words, some of which you will like and some you will not because I'm telling the truth. What you have done to me and what you are doing…I lost my

memory completely. I don't remember anything. I leave you free. Do whatever you want…You accused me without knowing what happened. You are right. Love you, Luz Victoria my wife. Love you Appolo and Gringo [their dogs]."

42. Defendants did not tour the unit consistently and did not tour every thirty minutes as required.

43. No correction officer or captain toured the unit at all between 9:53 p.m. and 11:02 pm, almost certainly the time during which Mr. Guallpa killed himself.

44. Even when officers walked through the unit, they did not look inside the individual cells to verify that the people inside were alive and breathing.

45. Mr. Guallpa turned on the television in his cell at approximately 10:04 p.m.

46. Thereafter, he hung himself using socks to create a ligature that he hung around his bed post.

47. Defendants Huston, Tejeda, and Turner all made logbook entries that indicated Mr. Guallpa was alive in his cell and that they had verified he had exhibited signs of life every 30 minutes.

48. Defendant Huston who admitted to falsifying records in this action indicating she had done her tour of duty, made clear that her failures were the result of systemic understaffing of New York City jails.

49. In her written statement regarding the incident, she wrote:

> To the best of my recollection approximately after 2100hrs, medical staff came into the area and requested to see three individuals in the treatment room, this writer then escorted each inmate, one at a time to see the nurse for medical

> services. The nurse told this writer that she had to go to another sprung to retrieve something pertaining to [unnamed inmate's] medical situation. I do not recall how long she was out of the area, but this writer supervised the inmate in the treatment room. After securing inmate [name redacted] this writer then bought out the last two individuals to be seen. I do not remember how long they were in the treatment room, nor do I remember the time in which the clinics were completed but during that time this writer had to supervise the inmates being seen in the treatment room. Simultaneously during the clinics, multiple inmates were requesting different services such as hot water, change of inmates pin # 's and a couple inmates asking this writer when they will be released from [the Central Disease Unit], this writer got distracted after all these requests and sat down at the officers station to catch up on the institutional logbook. After a short period of time the housing area was quiet at which time this writer turned down the housing area lights by request of the individuals in the housing area. This writer sat at the officer's desk and made a few logbook entries and after a certain amount of time went by my relief Officer Tejeda # 3461 arrived in the area at which time, I signed off post and left the area. When this writer was notified of the situation, I now recognize that my last two logbook entries were made stating that I did a tour of area at which time I did not complete my last couple of tours.

50. At 1:11 am, Defendants Turner and Tejeda, who affirmed that they had living and breathing inmates in the area when they began their tour at 11PM, found Mr. Guallpa in a seated position on the floor with a ligature made from socks wrapped around his neck and the bed frame.

51. He had been likely been dead for hours, as his body was cold to the touch when medical personnel arrived and body temperature readings from Mr. Guallpa's autopsy placed Mr. Guallpa's death hours before he was found.

52. Video surveillance footage also revealed that two officers and a captain entered Mr. Guallpa's cell and appeared to be talking and looking at Mr. Guallpa's body, rather than rendering aid.

53. Mr. Guallpa died from compression on his airway. His neck did not break and had he been observed regularly he might have lived.

54. Many inmates at Rikers Island report not receiving medication right now, due to staff shortages.[2]

55. Politicians who toured Rikers Island spoke with inmates who begged them to help them procure medical attention.

56. The Board of Correction, which is a Department of Correction watchdog for the City, found numerous failings that led to suicides at Rikers Island last year. On September 12, 2022, they used a report noting:

> Whether in a dormitory or assigned cell housing, proper supervision is especially lacking at night, as demonstrated in the deaths of Javier Velasco, Thomas Braunson, Segundo Guallpa, and Esias Johnson. In all four instances, correction officers did not tour consistently overnight and when they did conduct walk-throughs, they did not verify that people in custody under their supervision were alive and breathing.

57. The Board went on to note:

> The cancelation of medical appointments due to a reported lack of DOC escorts is the subject of ongoing litigation. On August 11, 2022, the Department was ordered to pay $100.00 for each missed escort to the infirmary from December 11, 2021 through January 2022 [in Matter of Joseph Agnew et al v. New York City Department of Correction, Sup Ct, Bronx County, Index No. 813431/2021E]. The Court concluded that DOC failed to comply with its duties to provide people in

[2] https://www.npr.org/2021/09/21/1039393818/chaos-at-nycs-rikers-island-sparks-calls-for-reforms

> custody with access to care and provide sufficient security for the movement of persons to and from health services. This issue was also evident in at least four of the reviewed deaths….Segundo Guallpa did not receive an initial mental health assessment before he died by suicide. His scheduled assessments were canceled twice…. One of Segundo Guallpa's initial mental health assessment appointments was canceled by CHS due to "insufficient staffing level in the facility." As a result, Mr. Guallpa did not receive a mental health evaluation before he committed suicide.

58. On most days over that time period, over 15% of DOC employees were out on sick leave, and another 15% were on "restricted duty."

59. This entire time, the Department of Correction and the City of New York were aware of and ignored an illegal "sick out" by correction officers throughout the City.

60. In fact, the Commissioner of the New York City Department of Correction has admitted that its failure to adequately staff Rikers Island facilities caused Mr. Guallpa's death.

61. In an article about the epidemic of self-harm at Rikers Island this year, Vincent Schiraldi, the head of the Board of Correction, said "If we don't have enough staff who are working… they are not properly seeing to issues that affect suicide…We've fallen behind on [suicide prevention training] because we are so thinly staffed…All sorts of things start to fall by the wayside when there is not enough staff to make those things happen."[3]

[3] https://www.thecity.nyc/2021/9/7/22659614/self-harm-suicide-rikers-island-new-york-city-jails-rising

62. Only after the wave of death and self-harm became too politically costly for the City's political leadership did the City begin to acknowledge the crisis that had unfolded on its watch.

63. On September 20, just weeks after Mr. Guallpa's death, and months after the City was aware the problem was causing an epidemic of suicide, the City sued the Correctional Officer Benevolence Association ("COBA") for organizing a strike in violation of its collectively bargaining agreement, in the form of a mass sickout.

64. But it was too late for Mr. Guallpa.

65. Mr. Guallpa and others like him suffered from mass violations of New York City Board of Correction minimum standards, New York City Department of Correction directives and regulations, and their constitutional rights.

66. Commissioner Schiraldi is right. The City and its correction employees have caused mass failures to adhere to standards and regulations which have caused numerous deaths at Rikers, including Mr. Guallpa's.

67. Per directive 4514R-C, "Correction officers responsible for the care, custody, and control of the inmates shall remain in their assigned areas and conduct visual observations at 30-minute intervals."

68. That visual observation must include observing "signs of life" in the inmate.

69. The Defendants responsible for the care, custody, and control of Mr. Guallpa did not conduct visual observations of him at 30-minute intervals.

70. DOC's Directive 4521R-A on Suicide Prevention and Intervention also reveals numerous failures by DOC and its staff.

71. As noted by Directive 4521R-A incarcerated individuals have higher than average suicide rates than the general population because of the environment and the isolation.

72. Per Directive 4521R-A, "staff must remain alert for any behavior" that may indicate suicidality. Mr. Guallpa etched a suicide note into his cell wall.

73. Mr. Guallpa was an alcoholic suffering his first prolonged incarceration and had a history of psychiatric care, three of the directive's listed warning signs for suicide.

74. Inmates at Rikers Island also were not receiving the medical intake screenings required by Directive 4521R-A upon arriving at the facility.

75. Mr. Guallpa, given his history of depression and use of antidepressants should have been labeled a potential suicide risk through the intake process, and been referred to mental health.

76. The form attached to 4521R-A, the suicide prevention screening guidelines, if applied to Mr. Guallpa, would have identified him for increased monitoring for suicide, as Mr. Guallpa at the very least was suffering from withdrawal from alcohol, and met numerous criteria on the checklist.

77. New York City's Board of Correction established minimum standards for the operation of New York City's DOC. One such minimum standard is Article 40, §2-02, Mental Health Minimum Standards – Identification and Detection. Per

the minimum standards, "All correction officers and medical services personnel are to receive training and continuing education in programs approved by the Departments of Correction, Health and Mental Health, Mental Retardation and Alcoholism Services regarding the recognition of mental and emotional disorders" that include the following areas:

a. the recognition of signs and symptoms of mental and emotional disorders most frequently found in the inmate population;
b. the recognition of signs of chemical dependence and the symptoms of narcotic and alcohol withdrawal;
c. types of potential mental health emergencies, and how to approach inmates to intervene in these crises;
d. identification and referral of medical problems of mental health inmates;
e. suicide prevention; and
f. the appropriate channels for the immediate referral of an inmate to mental health services for further evaluation, and the procedures governing such referrals.

78. As per Commissioner Schiraldi, DOC failed to train its officers on these topics over the past eighteen months.

79. On September 1, 2021, the Board of Correction issued a statement regarding the rash of suicides at Rikers Island.[4] In it, they wrote:

> Since November 2020, at least five persons have committed suicide while detained on Rikers Island; there were no reported suicides at Rikers in 2018, 2019 and most of 2020 . . . Five suicides in nine months along with an alarming increase in attempted self-harm signals a crisis for persons in custody and for the New York City Department of Correction. The already difficult conditions in the New York City jails have only been made worse by the extreme challenges presented by the COVID-19 pandemic. As of the end of July 2021, 35% of correction officers were out on sick leave or restricted from working with persons in custody, creating unsafe conditions for both staff and detained persons. Furthermore, the

[4] https://www1.nyc.gov/assets/boc/downloads/pdf/News/board-statement-on-recent-suicides-in-the-new-york-city-jails-20210901.pdf

> population of detained persons has again surged. The Board of Correction calls on the City of New York to move with urgency to create a safer environment for persons in custody and staff. Given that several incidents have occurred in intake, the Department must ensure an orderly intake process that quickly provides appropriate housing and medical care for persons in custody, and better identifies and monitors persons in custody who may commit self-harm or harm to others. Until then, we believe the situation will only worsen and result in unacceptably unsafe conditions for persons in custody, for correction officers and for other Departmental staff.

80. In mid-August 2021, "hundreds of correction officers and health practitioners protested jail conditions last week at the foot of the bridge to Rikers Island, chanting "stop the triple shifts" and "safer jails now."[5]

81. George Anderson, a mental health administrator for Correctional Health Services, who has worked on Rikers Island for five years, said "As call lists gets longer, inevitably we'll be missing people who are now at moderate risk for self-injury and suicide," and told reporters that in mid-August someone wrote "help" in blood at one facility.[6]

82. Mr. Guallpa's suicide was allowed to happen in exactly the way that George Anderson noted just days before his death.

83. The systemic problems at Rikers Island, including staffing shortages that made it difficult for healthcare workers to see inmates and for mental health visits to be scheduled, caused Mr. Guallpa's death.

[5] https://www.thecity.nyc/health/2021/8/26/22643199/rikers-staffing-crisis-medical-care
[6] *Id.*

84. Had he been seen by mental health professionals or been observed for his detox, or been monitored at regular intervals by staff, or had staff received proper training, his suicidal tendencies would have been observed and addressed.

85. On August 24, 2021, just days before Mr. Guallpa's death, the Federal monitor assigned to oversee Rikers arising out of a settlement with the City of New York regarding conditions there, wrote to the Federal Judge overseeing the case, Laura Swain. In the letter he wrote, "the Department's response to detainee self-harm incidents continues to be of great concern to the Monitoring Team. The Monitoring Team is aware of at least four presumed in-custody suicides and other troubling self-harm incidents involving detainees since December 2020, with most, if not all cases, raising questions about the adequacy of staff's response to detainees who are at risk of self-harm."[7]

86. The Monitor continued "What is most notable and very alarming about the current state of affairs is that the deterioration of basic security protocols and denial of basic services and protections coincides with a spike in employee absenteeism that began in April 2021. Excessive and unchecked staff absences has led to other officers having to work double and triple shifts, further compromising the safety of the Facilities."

87. The Monitor continued "Staff do not dependably adhere to basic, sound correctional management practices which is the direct cause of many of the problematic use of force incidents that are on the rise. . . . It is important to note that

[7] https://storage.courtlistener.com/recap/gov.uscourts.nysd.383754/gov.uscourts.nysd.383754.378.0.pdf

these problems are pervasive due to supervisory failures in identifying and addressing them when they occur, leading staff to continue their problematic practices unchecked."

88. The monitor noted that one such pervasive issue was staff's "Failure to Act in Self-Harm Events" by being "slow-to-act when confronted with an emergency self-harm situation (e.g., detainee has secured an object around his or her neck)."

89. On September 23, the Monitor released another report, in which he wrote, "Staff continue to fail to timely intervene during incidents in which incarcerated individuals threaten or engage in acts of self-harm. It is troubling that despite the Monitoring Team's repeated voiced and ongoing concerns about Staff failures to timely intervene in acts of self-harm, particularly in intake areas, has only worsened in the past few months."

90. Mr. Guallpa was not discovered until hours after he had taken his life, reflecting the monitor's concern.

91. In the monitor's Eleventh Report from May 2021, he wrote "The Monitoring Team remains concerned that Staff are not responding in the moment with the necessary urgency and/or are not taking threats and self-harm gestures seriously. The Staff response may not always involve an egregious delay, but any delay in preventing or responding to self-harm is potentially significant. Further, Captains, when on scene, rarely direct Staff to enact proper protocols for addressing self-harming behavior."

92. At a September 24, 2021, hearing before Judge Swain, the Federal monitor told Judge Swain that in one instance guards were within "six feet of a hanging inmate, in their direct line of sight, did not detect that."[8] He added "An officer will observe gesturing, the possession of a ligature, preparation of a ligature, and will not intervene. That must be stopped. It must be stopped now."

93. A pervasive fear of violence among detained persons is exacerbated by the DOC's proven failure to adequately respond to injuries that result from violent encounters. In a letter dated September 10, 2021, Dr. Ross MacDonald, the Chief Medical Officer of Correctional Health Services ("CHS"), stated that the "[u]navailability of staff has resulted in delays in transferring patients to clinics for care, to mental health units, or to the hospital, even when 911 has been activated and EMS has arrived to transport them."[9] As a result, tasks like distributing medication and transferring patients to clinics for care have fallen to the wayside.[10]

94. Limitations on accessing mental and medical healthcare begin at intake: when a detained person is brought to Rikers Island, days may pass until they are given a preliminary medical screening, which should occur promptly upon their arrival. During that time, individuals are frequently deprived of medications that they require for the treatment of ongoing conditions.

[8] https://twitter.com/macfathom/status/1441406162558197760
[9] Ross MacDonald, M.D. Letter to Keith Powers (Sept. 10, 2021), https://www.ny1.com/content/dam/News/static/nyc/pdfs/RM-city-council-letter-9-10-21.pdf.
[10] *See id*.

95. In 2022 alone, over 15 people have died in custody on Rikers Island. In 2021, that number was sixteen.[11] Dr. MacDonald attributed the deaths to a collapse in basic jail operations, including the delays in medical care, which he said were caused by the unavailability of correction officers.[12]

96. Jeanette Merrill, a spokesperson for CHS, has also expressed that "[t]he department's staffing shortages are affecting health operations, including the availability of escorts to bring patients to the clinic and of DOC personnel to staff the clinics."[13]

97. A Board of Corrections report into the DOC's responsibility for the death of persons in their custody found similar deficiencies in access to emergency medical care: "*DOC and CHS do not seem to have an acceptably functioning system for providing emergency care to persons in life-threatening situations*."[14] (emphasis added).

98. The report identified significant delays in responsive emergency care for persons experiencing fatal medical emergencies.[15] In two cases, only one officer was stationed in the control unit bubble, despite DOC policy requiring two officers.[16]

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[11] *See* Michael Wilson and Chelsea Marcius, *16 Men Died in New York City Jails Last Year. Who Were They?*, N.Y. Times (Pub. Jan. 28, 2022, Updated Jan. 31, 2022), https://www.nytimes.com/2022/01/28/nyregion/rikers-island-prisoner-deaths.html.
[12] *See* Gloria Pazmino, *Rikers Island Detainees Expose Lack of Medical Care While in Custody*, NY1 (Sep. 21, 2021), https://www.ny1.com/nyc/all-boroughs/public-safety/2021/09/22/rikers-island-detainees-expose-lack-of-medical-care-while-in-custody.
[13] *Supra* n.34.
[14] City of New York Board of Corrections, "February & March 2022 Deaths in DOC Custody Report and Recommendations," (May 9, 2022), https://www1.nyc.gov/assets/boc/downloads/pdf/Reports /BOC-Reports/deaths-report-and-chs-response-202202-202203.pdf.
[15] *See id*.
[16] *See id.* at 6.

And in at least three cases resulting in death, detained persons were the first to provide aid and notify DOC staff of the medical emergencies.[17]

99. According to former Commissioner Schiraldi, inadequate staff is the sole reason for missed medical appointments.[18] New York City Comptroller Brad Lander also told the City Council that when he toured DOC facilities in September 2021, medical providers told him they were not seeing 90 percent of the people on their call list each day.[19]

100. The DOC does not even deny they lack the man-power necessary to provide constitutionally-adequate medical care. In a filing in *Agnew, et al. v. New York City Department of Correction*, Index No. 813431/2021E, the *DOC admitted that:*

> Respondent [the DOC] does not dispute the applicability of the mandates, and has freely acknowledged deficiencies in its ability to escort individuals in custody to clinic appointments, primarily due to lack of staff in the jails. … There is no real dispute between the parties as to the following facts: DOC is required to provide access to medical care for individuals in its custody, and the inability to consistently do so is due to serious staff shortages related to the pandemic.

101. The City's deliberate indifference to these issues has interfered with timely and adequate medical care for years. In November 2018, 21 percent of incarcerated people who needed specialty medical services were not produced to on-Island specialty clinics.[20] That number increased to 30–33 percent in November 2019

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[17] *See id.*
[18] *See id.* at 98:10–12.
[19] *See* Transcript of New York City Council Hearing of September 15 at 86:20–21, https://legistar.council.nyc.gov/LegislationDetail.aspx?ID=5117031&GUID=C0114C55-A2DB-430F-84B3-3A451359F9AF&Options=&Search=.
[20] *See* Correctional Health Services, "CHS Access Report: November 2018," (January 29, 2019), https://www1.nyc.gov/assets/boc/downloads/pdf/Reports/CHS_Access_Report_Nov_2018_v2.pdf.

and 2020[2122], and leapt to a shocking 53 percent in November 2021.[23] Medical care is even denied by staff as a form of punishment, or because gang members, who have taken control in the jails,[24] obstruct access for persons seeking care.[25]

102. On May 13, 2022, Bronx Supreme Court Judge Taylor found the DOC in contempt of a December 2021 court order directing the DOC to provide access to sick call and not prohibit or delay access to health services.[26] But that December, 1,061 medical appointments were missed because of a lack of officer escorts.

103. These significant delays functionally amount to a complete denial of emergency medical care.

104. Productions to mental health appointments are similarly dismal. Between November 2018 and November 2021, 19 to 35 percent of mental health appointments were missed because staff failed to produce detained persons to their mental health services.[27] George Anderson, a mental health administrator for CHS, said that "with such long wait times for medical care—sometimes weeks, where it was once

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[2121] *See* Correctional Health Services, "CHS Access Report: November 2019," (February 25, 2020), https://www1.nyc.gov/assets/boc/downloads/pdf/Reports/BOC-Reports/chs-access-report-q4cy19.pdf.

[22] *See* Correctional Health Services, "CHS Access Report: November 2020," (August 31, 2021), https://www1.nyc.gov/assets/boc/downloads/pdf/Reports/chs-access-report-cy20q4.pdf.

[23] *See* Correctional Health Services, "CHS Access Report: November 2021," (February 7, 2022), https://www1.nyc.gov/assets/boc/downloads/pdf/Reports/Correctional-Health-Authority-Reports/CHS-Access-Report-CY21Q4.pdf.

[24] Ransom, Jan, *A Look Inside Rikers: 'Fight Night' and Gang Rule, Captured on Video*, N.Y. Times (January 12, 2022), https://www.nytimes.com/2022/01/12/nyregion/rikers-jail-videos.html.

[25] Ransom, Jan, *Judge Faults Medical Care for Detainees in Latest Sign of Rikers Crisis*, The New York Times (May 17, 2022), https://www.nytimes.com/2022/05/17/nyregion/nyc-correction-department-rikers.html.

[26] *See Agnew et al v. New York City Dep't of Corr.*, Index No. 813431/2021E (Sup. Ct. Bronx Co. 2021), Doc. No. 126.

[27] *See* nn.46–49, *supra*.

days—there is now greater incentive for detained persons to self-harm in order to be seen."[28]

105. Self-harm in the city's jails is, in fact, extremely elevated. In March of 2021, "148 people harmed themselves, including 12 seriously."[29] Despite this, the small group of staffers available is not properly trained in suicide prevention.[30]

106. Because of the severe absenteeism, officers are not around to prevent incarcerated individuals from self-harming, oftentimes finding someone well after they are severely injured or have died.[31] Other times, the few officers who are available are in the midst of triple shifts, raising questions about their ability and capacity to properly surveil at-risk populations or intervene in mental health crises.[32]

107. Since December 2020, at least six other people detained in the DOC's custody have committed suicide, including Brandon Rodriguez; Wilson Diaz Guzman; Tomas Carlo-Camacho; Javier Velasco; Anthony Scott, and Dashawn Carter.

108. At the same time, the City's unmanageable staffing practices and continued indifference have severely limited access to necessary services known to improve overall wellbeing, including counseling, education, recreation, programming, and religious services.

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[28] *Id.*
[29] *See* Jan Ransom, *Disorder and Chaos in N.Y.C. Jails as Pandemic Recedes*, N.Y. Times (Pub. June 19, 2021, Updated Oct. 18, 2021), https://www.nytimes.com/2021 /06/19/nyregion/rikers-island-chaos-suicides.html
[30] *Id.*
[31] *Id.* (providing various instances in which inmates were found hanging in their cells, including one inmate who had been left hanging for 15 minutes).
[32] *See* Jonah E. Bromwich and Jan Ransom, *An 'Absolute Emergency' at Rikers Island as Violence Increases*, N.Y. Times (Oct. 11, 2021), https://www.nytimes.com/2021 /08/24/nyregion/rikers-island-emergency-chaos.html.

109. In sum, "[e]very person they send to jail is at great risk of harm or death."[33]

**FIRST CAUSE OF ACTION**

42 U.S.C. § 1983, Fourteenth Amendment to the United States Constitution
Against Defendants Tejeda, Huston, Turner, and John and Jane Does 1-25

110. Plaintiff realleges the foregoing paragraphs as if fully set forth herein.

111. The Individual Defendants were at all relevant times New York City employees responsible for Segundo Guallpa's custody and care.

112. Defendants failed to perform routine duties including observing signs of life in cells on their floor.

113. Had they performed routine duties, they would have observed Mr. Guallpa etching a suicide note into the wall of his cell and putting together a noose.

114. The Defendants knew or should have known and were deliberately indifferent to, and/or recklessly disregarded the fact that that Mr. Guallpa faced a substantial risk of serious harm left unmonitored for hours at a time.

115. The acts and omissions of the Individual Defendants, which provided Mr. Guallpa with the opportunity and tools to hang himself, were deliberately indifferent to a knowable and substantial risk of serious injury to him.

[33] *See id.*

SECOND CAUSE OF ACTION
42 U.S.C. § 1983, Fourteenth Amendment to the United States Constitution
**Against Defendant City of New York**

116. Plaintiff realleges the foregoing paragraphs as if fully set forth herein.

117. Defendant City was put on notice of the risk of inaction by the numerous suicides and acts of self-harm in 2021 as documented extensively by the Federal monitor, media, and the Board of Correction.

118. Self-harm incidents reached 95 per 1,000 inmates in the second quarter of 2021 per data from the City of New York, almost double the rate from 2016-2020.

119. The Commissioner of the Department of Correction admitted that the Department of Correction was failing to care for inmates leading to self-harm and unable to do trainings to prevent self-harm.

120. The City's failure to staff, train, and supervise staff adequately led to the spike in self-harm at Rikers Island in 2021 and continuing through the present, leading to Segundo Guallpa's death.

121. Correction officers and DOC employees repeatedly ignore the medical needs of inmates with mental health issues as noted by the Federal monitor on August 24, 2021, before Mr. Guallpa's death.

122. Systemic failures in providing medication to inmates exacerbated self-harm and suicide at Rikers Island and led to Mr. Guallpa's death.

123. New York City's correction officers have not been disciplined for the mass sick out and AWOL policy and the City tolerated the mass sick out until after Mr. Guallpa's death. They did so with deliberate indifference to the needs of people incarcerated at Rikers Island.

124. The City, by its failure to discipline, supervise, and train its employees while on notice of the risks faced by inmates with medical needs in punitive segregation, was deliberately indifferent to the constitutional rights of inmates.

125. The City exhibited deliberate indifference because it failed to act when the need for more or better supervision, training, and discipline to protect against constitutional violations was obvious. The City tacitly authorized the pattern of misconduct witnessed here. Nothing was done to investigate or forestall such incidents until after Mr. Guallpa's death.

126. The City admitted as much in their lawsuit in against the Correction Officer Benevolent Association, alleging that "In short, the dramatic increase in mass absenteeism by correction officers is clearly coordinated and an outright abdication of correction officers' basic responsibilities to protect the health and safety of the individuals housed in their facilities."[34]

127. But the City had tolerated that behavior for months, knowing completely the effects of that policy. The City's deliberate indifference to the constitutional rights of inmates and the risks of self-harm by the inmates caused Mr. Guallpa's death.

[34] https://iapps.courts.state.ny.us/nyscef/ViewDocument?docIndex=HyUdqM8VpQeNrCtcNykRyQ==

128. A pattern and practice of ignoring inmate self-harm exists at Rikers Island, as described by the Federal Monitor in *Nunez v. City of New York et al.*

129. The pattern and practice includes ignoring inmates who are hanging, like Mr. Guallpa.

130. The City of New York knew or should have known that inmates at Rikers Island were at increased risk of self-harm in 2021 and was deliberately indifferent to that risk.

131. The City's willful blindness to the risks of inmates to engage in self-harm led to Mr. Guallpa's death.

132. But for the City's myriad acts and ommissions indicating a failure to prevent self-harm in its facilities, Mr. Guallpa's self-harming behavior would have been discovered.

**THIRD CLAIM FOR RELIEF**
SURVIVORSHIP
*Against all Defendants and the City of New York by respondeat superior*

133. Plaintiff realleges the foregoing paragraphs as if fully set forth herein.

134. New York City correction officers have a duty of care to those housed in New York City jails.

135. The Individual Defendants failed to exercise reasonable care in observing and monitoring his cell and in responding to Segundo Guallpa's hanging.

136. Defendants failed to observe Mr. Guallpa every 30 minutes and check for signs of life, in violation of departmental regulations, which align with the

ordinary standard of care.

137. They failed to recognize obvious signs of distress.

138. Had they adhered to departmental regulations, Defendants would have prevented Mr. Guallpa from killing himself or, in the alternative, would have found Mr. Guallpa in a timely manner and been able to remove the ligature's from his neck and resuscitated him.

139. Because of their failures to adhere to a reasonable standard of care, the Defendants foreseeably caused Mr. Guallpa's death.

140. Moreover, the City's failures cited above were negligent in their duty of care to inmates in their custody.

141. Because of the negligence Mr. Guallpa suffered predeath pain and suffering.

**FOURTH CLAIM FOR RELIEF**
WRONGFUL DEATH
*Against all Defendants and the City of New York by respondeat superior*

142. Plaintiff realleges the foregoing paragraphs as if fully set forth herein.

143. New York City correction officers have a duty of care to those housed in New York City jails.

144. The Individual Defendants failed to exercise reasonable care in observing and monitoring his cell and in responding to Segundo Guallpa's hanging.

145. Defendants failed to observe Mr. Guallpa every 30 minutes and check for signs of life, in violation of departmental regulations, which align with the

ordinary standard of care.

146. They failed to recognize obvious signs of distress.

147. Had they adhered to departmental regulations, Defendants would have prevented Mr. Guallpa from killing himself or, in the alternative, would have found Mr. Guallpa in a timely manner and been able to remove the ligature's from his neck and resuscitated him.

148. Because of their failures to adhere to a reasonable standard of care, the Defendants foreseeably caused Mr. Guallpa's death.

149. Moreover, the City's failures cited above were negligent in their duty of care to inmates in their custody.

150. Prior to the aforementioned incident, Mr. Guallpa was in sound health, was providing support for the benefit of his spouse Luz Guaman, children and family, and was rendering other services to his spouse Luz Guaman, children and family.

151. By reason of the above the distributees of Segundo Guallpa have been deprived of his love, nurturing guidance, and support in all respects and have incurred funeral expenses and other expenses for the deceased, all to Plaintiff's damage.

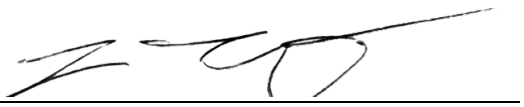
152. Because of the City's failures, Plaintiffs suffered pecuniary injuries.

WHEREFORE, Plaintiff demands judgment against the above-captioned Defendants as follows:

a. For compensatory damages, jointly and severally, in an amount to be determined at trial, but not less than $25 million;
b. For punitive damages, jointly and severally, in an amount to be determined at trial;
c. For reasonable attorneys' fees, costs, and disbursements, under 42 U.S.C. § 1988 and other applicable laws;
d. For pre- and post-judgment interest as allowed by law; and
e. For such other relief as this Court deems just and proper.

Dated: New York, New York
November 1, 2022

WERTHEIMER LLC

By: 

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