# Report of Investigation Regarding the Circumstances Surrounding the Death of Inmate Jamel Floyd at the Metropolitan Detention Center (MDC) Brooklyn

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INVESTIGATIONS DIVISION

23-015

JANUARY 2023



REDACTED FOR PUBLIC RELEASE

# REPORT OF INVESTIGATION

| SUBJECT | CASE NUMBER |
|---|---|
| Unknown<br>Metropolitan Detention Center<br>Brooklyn, New York | 2020-010864 |

| OFFICE CONDUCTING INVESTIGATION | DOJ COMPONENT |
|---|---|
| Washington Field Office | Federal Bureau of Prisons |

| DISTRIBUTION | STATUS |
|---|---|
| ☒ Field Office WFO | ☐ OPEN ☐ OPEN PENDING PROSECUTION ☒ CLOSED |
| ☐ AIGINV | PREVIOUS REPORT SUBMITTED: ☐ YES ☒ NO |
| ☒ Component BOP | Date of Previous Report: |
| ☐ USA | |
| ☐ Other | |

## SYNOPSIS

The Department of Justice (DOJ) Office of the Inspector General (OIG) initiated this investigation upon receipt of an incident report from the Federal Bureau of Prisons (BOP) documenting what BOP refers to as an immediate use of force[1] incident on June 3, 2020, involving BOP inmate Jamel Floyd (Reg #90126053). Immediately following the use of force by BOP personnel, Floyd became unresponsive and subsequently died.

The BOP incident report stated that, on the morning of June 3, Floyd was unruly, combative, and aggressive while inside his single occupancy isolation unit cell at the BOP's Metropolitan Detention Center in Brooklyn, New York (MDC Brooklyn). The report further stated that, while speaking with MDC Brooklyn staff from within his cell, Floyd began to violently remove the sink from the wall of the cell which caused flooding of his cell and the surrounding areas. Floyd also was reported to have removed an approximately 6 to 8-inch metal bar from his cell and broken his cell window. The report additionally stated that the MDC Brooklyn Disturbance Control Team (DCT) responded, administered Oleoresin Capsicum (OC) spray, and then opened the cell door, whereupon Floyd charged out of his cell, resulting in BOP personnel using force to place Floyd on the ground and apply hand and leg restraints on him. Immediately thereafter, according to the report, Floyd became unresponsive and MDC Brooklyn staff began life saving measures, which continued until New York City (NYC) Emergency Medical Staff (EMS) arrived at the institution to take over Floyd's medical care. NYC EMS transported Floyd to the hospital where he was subsequently

[1] See BOP Program Statement 5566.06 – Use of Force and Application of Restraints for details regarding immediate versus calculated use of force.

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| DATE | SIGNATURE [redacted] |
| [redacted]<br>PREPARED BY SENIOR SPECIAL AGENT | |
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| Russell W. Cunningham<br>APPROVED BY SPECIAL AGENT IN CHARGE | |

pronounced dead. The BOP incident report did not allege a violation of federal law or misconduct had occurred, only that an inmate (Floyd) had died following a use of force incident with BOP employees.

During the course of the investigation, the OIG learned from the New York Office of the Chief Medical Examiner's (OCME) autopsy report, dated November 18, 2020, the OCME concluded that Floyd's death was accidental, caused by cardiac arrhythmia due to hypertensive cardiovascular disease in the setting of probable proarrhythmic gene mutation, with a contributing factor being recent synthetic cannabinoid use. The autopsy report stated that Floyd had trace amounts of synthetic cannabinoid in his blood at his time of death. The OIG and the Federal Bureau of Investigation (FBI) investigation did not identify any drugs located on Floyd's person at the time of his death or in his cell. The OIG investigation also did not develop further information as to when or where Floyd obtained the synthetic cannabinoid, nor did the OIG identify evidence indicating that BOP staff was involved in bringing the synthetic cannabinoid into the BOP facility.

The OIG, working jointly with the FBI, conducted this investigation to probe whether there was evidence of a criminal violation in connection with Floyd's death. Upon conclusion of the criminal investigation and a declination decision by federal prosecutors, the OIG continued its investigation to determine whether administrative misconduct had occurred.

The OIG investigation concluded that there was insufficient evidence to find that any BOP employees engaged in administrative misconduct in connection with Floyd's death.

The OIG's review of BOP records revealed that, on May 29, 2020, five days before the use of force incident that resulted in Floyd's death, Floyd was involved in another use of force incident with MDC Brooklyn staff. According to BOP records, on that day, Floyd activated a BOP contraband cell phone sensor located in his unit, indicating he may have been in possession of a contraband cell phone. According to BOP records, during a subsequent search, Floyd became combative with staff as he retrieved a cell phone from his shorts and threw it against the wall, resulting in his restraint by BOP personnel.

BOP records further reflect that, on May 30, due to an eye injury suffered during the incident on May 29, Floyd was taken to a local hospital for treatment of the injury. Upon his return that same day to MDC Brooklyn, Floyd was placed in an isolation unit to quarantine as part of special housing procedures at MDC Brooklyn due to Covid-19.

The OIG investigation additionally determined that, according to BOP records, upon entering MDC Brooklyn in October 2019, Floyd self-reported to BOP officials during his initial medical screening that he suffered from bipolar disorder and schizophrenia. BOP records further reflect that Floyd was prescribed two medications while incarcerated at MDC Brooklyn, 45 mg daily of Mirtazapine (an antidepressant) and 15 mg daily of Olanzapine (an antipsychotic). The OIG investigation also found that, according to BOP records, Floyd did not follow BOP protocols and was noncompliant regarding use of these medications and often refused or did not show up to take his prescribed medications. In March 2020, Floyd refused or did not show up to receive his dose of Mirtazapine 28 times and his dose of Olanzapine 24 times. As such, BOP canceled Floyd's prescriptions, effective April 5, 2020. On April 30, 2020, Floyd returned to the medical unit and requested his medications be reinstated. On May 1, 2020, the BOP medical unit prescribed Mirtazapine and Olanzapine for a 30-day trial period. Floyd's Mirtazapine and Olanzapine prescriptions both expired on May 30, 2020. Floyd's Mirtazapine prescription was renewed on May 31, 2020; however, the BOP did not renew Floyd's Olanzapine prescription until June 2, 2020. Therefore, Floyd did not receive a daily dose of Olanzapine on either May 31 or June 1. Nonetheless, the OCME report found that the level of the antipsychotic medication in Floyd's blood at the time of his death was 21 ng/mL, and the report stated that plasma concentrations required for effective treatment of psychotic episodes range from 20 to 80 ng/mL in adults.

A BOP Senior Officer Specialist and the BOP Chief Psychologist at MDC Brooklyn told the OIG that on the morning of June 3, 2020, during their respective morning rounds, they observed Floyd being in an agitated state, yelling, and banging on his cell door. According to the Senior Officer Specialist, when he asked Floyd if he was okay, Floyd responded by saying that he was okay. The Chief Psychologist told the OIG that when she spoke with Floyd, Floyd apologized for banging on the door and calmly said, "Fixing to be a homicide/murder." The Chief Psychologist recalled asking Floyd, "Who is going to be killed? You seem worked up." Floyd did not respond to the question, and the Chief Psychologist said she took no further action.

According to the Senior Officer Specialist, later that same morning, he again responded to Floyd's cell and heard Floyd yelling, "I have to get out." The Senior Officer Specialist said he then observed Floyd break the glass window of his cell door with a metal rod and place his hand through the broken window. Floyd started to yell, "They are trying to kill me." The Senior Officer Specialist told the OIG that he activated his body alarm and communicated over his radio that there was an emergency and he requested additional staff. The Senior Officer Specialist said he eventually opened the cell door on the command of the Activities Lieutenant and observed Floyd crawl out of the cell on his knees.

A BOP Corrections Systems Officer who responded to the body alarm observed water coming from the cell and Floyd swinging a pipe through the broken glass on the cell window. The Corrections Systems Officer recalled after the deployment of OC spray, Floyd was yelling and agitated when he came out of the cell.

Two DCT members told the OIG that when they responded to the upper tier of unit K-84 on June 3, 2020, Floyd's cell door window had been broken and they observed Floyd in an agitated state, not following officer commands to submit to hand restraints. They approached Floyd's cell, with one holding a ballistic shield, and held their position while a burst of OC spray was administered into the cell. One DCT member recalled it was difficult to see into the cell as it was dark and there was steam coming out of the cell. He observed Floyd comply with orders and lay down after the OC spray was deployed; however, when the cell door was opened, the DCT member observed Floyd "barreling out" of the cell and collide with the shield. The other DCT member recalled that inside the cell, there was blood and glass everywhere and steam and hot water coming from inside Floyd's cell. He observed Floyd yelling and acting "out of control" and not following commands. When the cell door was opened, the DCT member observed Floyd "aggressively rush out" and collide with the shield. Once Floyd was out of his cell, he was immediately placed on the ground so that hand and leg restraints could be placed on him. One of the DCT members was injured during the use of force and stepped away from the scene once Floyd was restrained. The other DCT member observed Floyd was unresponsive when officers tried to sit him up. Life saving measures were immediately initiated and continued until NYC EMS arrived on scene to transport Floyd to the hospital.

The Activities Lieutenant told the OIG that when he responded to the body alarm on unit K-84, he observed that Floyd was not following officer commands and he appeared to be in some sort of mental distress and was yelling, "I will kill you". The Activities Lieutenant ordered Floyd to submit to hand restraints and when Floyd did not comply, the Activities Lieutenant ordered a burst of OC spray be administered into the cell. The Activities Lieutenant recalled that the OC spray was blocked by some sort of material placed in front of the food slot on the inside of the cell. He ordered Floyd again to submit to hand restraints and when Floyd did not comply, he ordered the cell door to be opened. The Activities Lieutenant recalled that when Floyd came out of the cell, he continued to be combative and non-compliant until hand and leg restraints were placed on him. The Activities Lieutenant recalled that when officers sat Floyd upright to remove him from the unit, Floyd did not appear to be in duress; however, when officers placed Floyd in a chair for transport, he observed Floyd's head go back and his face "did not look right." The Activities Lieutenant asked medical personnel onsite to check Floyd's condition.

The BOP Paramedic onsite during the use of force and subsequent medical emergency told the OIG that when he responded to Floyd's cell, he observed water, blood, and steam coming from Floyd's cell and that Floyd's cell door

window was broken and Floyd was yelling incoherently and making swinging motions with his hand and arm through the window. The Paramedic stated he tried to talk to Floyd and tell him that he (the Paramedic) was there to help him; however, Floyd never looked at or spoke to the Paramedic directly. The Paramedic recalled Floyd was actively combative, punching the DCT shield through the window, yelling, and ignoring commands. The Paramedic stated a correctional officer eventually administered OC spray through the food slot of Floyd's cell door and when the DCT finally opened the cell door, Floyd was still combative and yelling and showed no signs of being affected by the OC spray. The Paramedic explained that, as the officers were putting Floyd on the ground, he (the Paramedic) was yelling to the officers, "Put him on his right side. Put him on his right side." Once restrained and placed in a wheelchair, the Paramedic went toward Floyd to begin a medical assessment and saw Floyd's head "flop back." The Paramedic ordered officers to get an AED and to move Floyd downstairs. Once downstairs, the Paramedic and other officers began chest compressions and other life saving measures. Floyd was transported by NYC EMS to a local hospital where he was pronounced dead.

In the course of the investigation, the OIG also reviewed video, shift logbooks, shift assignments, memoranda, inmate history reports, inmate medical history, use of force reports, and the OCME autopsy report related to Floyd and the June 3, 2020 incident. The OIG also viewed Floyd's cell and observed the sink pulled from the wall, a metal pipe on the ground, the mattress on the ground with the stuffing strewn about, and clothing on the floor.

The OIG's review of the institution's video footage did not enable us to determine what occurred prior to and after the time the OC spray was used, and whether Floyd charged out of the cell or crawled out on his knees because the BOP staff that had responded to the cell block were surrounding the cell, thereby limiting what could be seen on the video. We also noted that the poor quality of the BOP's video camera footage impacted its value. We further noted that none of the BOP staff that responded to Floyd's cell took a portable camera with them, which BOP policy requires "as soon as feasible." BOP policy does not specify who is responsible for obtaining a portable camera during an immediate use of force response. The OIG found that the limited available video evidence did not allow us to observe the use of OC spray, Floyd exiting his cell, or the force used to subdue Floyd.

The OIG was unable to conclude that the use of OC spray on Floyd violated BOP policy which provides that a warden or designee can approve the use of OC spray, and a shift lieutenant may authorize the use of OC spray in situations that require an immediate response in the absence of higher-level approval. BOP policy cautions that OC spray may be harmful to an inmate with certain underlying conditions, including psychosis, and directs BOP personnel to consult medical staff before such use and to avoid such use on an inmate with one of the listed conditions, "unless other means of control have been attempted or deemed likely to be ineffective." Although not specifically consulted about the use of OC spray on Floyd, medical staff was present when the Activities Lieutenant ordered the use of OC spray and raised no concerns about its use on Floyd. Under all of the circumstances, the OIG was unable to conclude that BOP policy was violated by the use of OC spray on Floyd, who suffered from a form of psychosis, where other means of control appeared to be ineffective or deemed to be ineffective.

On January 27, 2021, the United States Attorney's Office for the Eastern District of New York (USAO-EDNY) declined prosecution of this matter.

On November 16, 2021, the DOJ Civil Rights Division declined prosecution of this matter.

The OIG has completed its investigation and is providing this information to the BOP for its review.

Unless otherwise noted, the OIG applies the preponderance of evidence standard in determining whether DOJ personnel have committed misconduct. The Merit Systems Protection Board applies this same standard when reviewing a federal agency's decision to take adverse action against an employee based on such misconduct. See 5 U.S.C. § 7701(c)(1)(B); 5 C.F.R. § 1201.56(b)(1)(ii).

# DETAILS OF INVESTIGATION

## Predication

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During the course of the investigation, the OIG learned from the New York Office of the Chief Medical Examiner's (OCME) autopsy report, dated November 18, 2020, the OCME concluded that Floyd's death was accidental, caused by cardiac arrhythmia due to hypertensive cardiovascular disease in the setting of probable proarrhythmic gene mutation, with a contributing factor being recent synthetic cannabinoid use. The autopsy report stated that Floyd had trace amounts of synthetic cannabinoid in his blood at his time of death. The OIG and FBI investigation did not identify any drugs located on Floyd's person at the time of his death or in his cell. The OIG investigation also did not develop further information as to when or where Floyd obtained the synthetic cannabinoid, nor did the OIG identify evidence indicating that BOP staff was involved in bringing the synthetic cannabinoid into the BOP facility.

The OIG, working jointly with the Federal Bureau of Investigation (FBI), conducted this investigation to probe whether there was evidence of a criminal violation in connection with Floyd's death. Upon conclusion of the criminal investigation and a declination decision by federal prosecutors, the OIG continued its investigation to determine whether administrative misconduct had occurred.

## Investigative Process

The OIG's investigative efforts consisted of the following:

Interviews of the following BOP personnel:

[2] See BOP Program Statement 5566.06 – Use of Force and Application of Restraints for details regarding immediate versus calculated use of force.

- [redacted], Senior Officer Specialist;
- [redacted], Corrections Systems Officer;
- [redacted], Chief Psychologist;
- DCT Member [redacted], Counselor;
- DCT Member [redacted], Correctional Officer;
- [redacted], Activities Lieutenant;
- [redacted], Paramedic;
- [redacted], Health Services Administrator;
- [redacted], Clinical Director;
- [redacted], Physician; and
- [redacted], Psychiatrist (contractor).

Review of the following:

- BOP incident packet dated May 29, 2020;
- Video camera footage dated May 29, 2020;
- BOP Digital Forensics Unit Report dated April 7, 2021;
- BOP incident packet dated June 3, 2020;
- Video camera footage dated June 3, 2020;
- BOP Inmate Medical History Report;
- BOP Psychology Services Report; and
- New York Office of the Chief Medical Examiner report dated October 30, 2020.

## Background

BOP Program Statement 5566.06 – Use of Force and Application of Restraints §552.20, Section 1, Purpose and Scope, states the BOP authorizes staff to use force only as a last alternative after reasonable efforts to resolve a situation have failed. When authorized, staff should only use the amount of force necessary to gain control of the inmate, to protect and ensure the safety of inmates, staff, and others, to prevent serious property damage, and to ensure institution security and good order. Staff are authorized to apply physical restraints as necessary to gain control of an inmate who appears to be dangerous because the inmate: a) assaults another individual; b) destroys government property; c) attempts suicide; d) inflicts injury upon self; or e) becomes violent or displays signs of imminent violence.

BOP Program Statement 5500.15 – Correctional Services Manual, Chapter One – Use of Force, Section 103 – Use of Aerosol Chemical and Oleoresin Capsicum Dispenser, states the "warden or designee can approve the use of chemical agents and OC. The shift lieutenant may authorize use of chemical agents and OC in situations that require an immediate response, where there is not enough time for higher-level approval. If an inmate has respiratory or cardiovascular disease, chronic dermatitis, or psychosis, chemical agents or OC may be harmful. Consult medical staff before use; avoid use on an inmate with any of these conditions unless other means of control have been attempted or deemed likely to be ineffective."

BOP Program Statement 5500.15 – Correctional Services Manual, Chapter One – Use of Force, Section 101 – Use of Force Team Technique, Item 4 – Immediate Use of Force, states when a threat to the safety of the inmate, staff or others, or property, requires an immediate response, staff are obligated to obtain a video camera and begin recording the event as soon as feasible. As soon as control of the situation has been obtained, staff must record information on injuries; circumstances that required the need for immediate use of force; and identifications of inmates, staff, and others involved.

Floyd first entered the New York State (NYS) Correctional System in the early 2000s. As part of his initial screening conducted by the NYS Correctional System, Floyd stated he suffered from anxiety and depression and claimed to have attempted suicide in 2001. Floyd was transferred to MDC Brooklyn on federal charges in October 2019. Upon reporting to BOP, Floyd underwent an initial medical screening in which he self-reported that he suffered from bipolar disorder and schizophrenia. As part of the initial medical screening, Floyd's medication was reconciled against his incoming paperwork from his prior facility and BOP health services continued his prescription for antipsychotic medication. A psychological assessment of Floyd was not conducted at that time; however, BOP psychology personnel evaluated him at a later date and designated him as a Care Level 1 for mental health.

On May 29, 2020, Floyd was involved in a use of force incident with MDC Brooklyn staff. The OIG reviewed video camera footage from the incident and the BOP incident report packet, both dated May 29, 2020. On that day, Floyd activated a BOP contraband cell phone sensor located in his unit, indicating he may have been in possession of a contraband cell phone. During a subsequent search of Floyd in the staff restroom, Floyd became combative with staff as he retrieved a cell phone from his shorts and threw it against the wall, resulting in his restraint by BOP personnel. Subsequent to the use of force, Floyd was escorted to the MDC Brooklyn medical unit to be assessed. Floyd was determined to have a small, shallow laceration on the upper right eye which was treated with Bacitracin, a steri-strip, and an eye patch by MDC Brooklyn medical staff.

The OIG also reviewed the BOP Digital Forensics Unit Report, dated April 7, 2021, regarding the BOP forensic examination of the cell phone in Floyd's possession on May 29, 2020. The forensic examination did not identify the source of the cell phone, or any evidence regarding the source of the synthetic cannabinoid found in Floyd's blood at the time of his death.

On May 30, 2020, Floyd was sent to the emergency room at a local hospital to check on his eye after Floyd reported worsening of symptoms, specifically Floyd stated his eye was blurry and he needed it "cleaned out". Floyd returned to MDC Brooklyn from the hospital on this same date and received follow-up care and prescription medication for his eye on June 1, 2020. Floyd also received follow-up care on June 2, 2020, and reported improving symptoms and no further complaints about the injury.

Due to special housing procedures at MDC Brooklyn created due to Covid-19, when Floyd returned from the hospital on May 30, 2020, he was required to quarantine in an isolation unit, where his contact with MDC Brooklyn staff and other inmates was very limited.

## June 3rd Use of Force

On June 3, 2020, Floyd was involved in a second incident that resulted in the use of force by BOP staff to restrain him. Floyd required medical attention when he became unresponsive after that use of force. At the time of the incident, Floyd was still housed in the isolation unit, Unit K-84, that he was placed in on May 30 due to Covid-19 protocols.

During a voluntary interview, Senior Officer Specialist [redacted] told the OIG that as he was conducting his initial morning rounds on Unit K-84, he heard a "banging" noise coming from a cell on the second-floor tier. [redacted] responded to the second floor and observed Floyd looking through the glass window of the door. He recalled Floyd appeared to be agitated and when asked if he was okay, Floyd said that he was okay. [redacted] stated that Floyd continued to shake and bang on his cell door throughout the morning; however, he stopped doing so each time an officer or staff member asked him if he was okay. Later in the morning as he was sitting at the officer's station, [redacted] heard a different sound coming from the top tier of the unit. As he was approaching Floyd's cell, he heard Floyd yelling, "I have to get out." [redacted] then observed Floyd break the glass window of his cell door with a metal rod and place his hand through the broken window. Floyd started to yell, "They are trying to

kill me." [redacted] activated his body alarm and communicated over his radio that there was an emergency and he requested additional staff. When given the command to do so by the supervisor on site, [redacted] said he unlocked the cell door and observed Floyd crawling out on his knees. [redacted] told the OIG that his view was blocked by other personnel while restraints were placed on Floyd; however, he observed Floyd being placed on a chair to be taken out of the unit and a staff member performing chest compressions on Floyd.

During a voluntary interview, Corrections Systems Officer [redacted] told the OIG that he responded to Unit K-84 after a body alarm was activated on that unit. [redacted] recalled that when he arrived at the unit, there was water coming from a cell on the upper tier and he observed an inmate, later identified as Floyd, swinging a pipe out the window of his cell door and yelling that someone was trying to kill him. [redacted] stated that he maintained a position on the upper tier while the DCT positioned themselves to extract Floyd from his cell. [redacted] recalled that OC spray was administered into the cell and then, shortly after, the cell door was opened, and Floyd came out yelling and agitated. [redacted] stated he assisted the DCT with applying hand restraints on Floyd, then he exited the area.

During a voluntary interview, Counselor [redacted] told the OIG that he responded to Unit K-84 as a member of the DCT. [redacted] and another DCT member arrived at the same time and immediately went to the top tier, where the disturbance was occurring. [redacted] said another DCT member was holding a shield and they approached the cell door, side by side. [redacted] recalled it was very hard to see inside the cell, it was dark, and there was steam coming from the cell. [redacted] stated Floyd was yelling and acting very agitated and irate and was not following commands from officers. [redacted] recalled that after he initiated a two-second burst of OC spray into the cell, Floyd complied with officer commands and laid down on the floor. However, as soon as the cell door opened, Floyd came "barreling out" of the cell and collided with the shield and the DCT. [redacted] stated Floyd was put on the ground very quickly and his arms and legs were restrained. When they picked Floyd up to place him in the restraint chair, Floyd "went limp" and was unresponsive. At that point, life saving measures were started and continued until EMS arrived and transported Floyd to the local hospital.

During a voluntary interview, Correctional Officer [redacted] told the OIG that he responded to Unit K-84 as a member of the DCT. [redacted] stated he was the third DCT member "in the stack" on the cell door; however, after a burst of OC spray was sprayed inside the cell, [redacted] replaced the DCT member who was originally holding the shield at the "front of the stack" because that team member did not have his gas mask. [redacted] recalled that inside the cell, there was blood and glass everywhere, and there was steam and hot water coming from the cell. [redacted] stated that Floyd was yelling and acting "out of control" and was not following commands from officers. [redacted] stated as soon as the cell door opened, Floyd "aggressively rushed out" of the cell and collided with the ballistic shield that he was holding. [redacted] stated as soon as Floyd hit the shield he stopped and collapsed on the ground. [redacted] stated he passed off the shield to someone else and immediately controlled Floyd's head using the least amount of force necessary while others restrained his arms and legs. Once Floyd was restrained, [redacted] was replaced by another DCT member due to injuries, including pain in his arms and cuts to his knees, that [redacted] sustained during the incident.

During a voluntary interview, Activities Lieutenant [redacted] told the OIG that when he arrived at Unit K-84, he heard an inmate screaming from the top tier of the unit. The inmate, identified as Floyd, was non-compliant to commands and appeared to be in some sort of mental distress. [redacted] stated that Floyd was yelling, "I will kill you." [redacted] ordered Floyd to place his hands through the "food slot" (horizontal opening) in the cell door to submit to hand restraints; however, Floyd did not comply. [redacted] then ordered a member of the DCT to administer a two second burst of OC spray through the food slot; however, [redacted] said that when the OC spray was deployed, it was blocked by some sort of material placed in front of the food slot by Floyd. [redacted] ordered Floyd again to submit to hand restraints, but Floyd continued to be non-compliant. [redacted] ordered the cell door opened, and Floyd came out and encountered the DCT member holding a shield. Floyd remained combative and was non-compliant to submit

to hand restraints. [redacted] recalled that DCT members were able to place hand and leg restraints on Floyd and prepare him to be transported out of the unit. When DCT members sat Floyd up from being on the ground, there were no signs of medical duress being exhibited by Floyd; however, [redacted] told the OIG that when Floyd was moved to the restraint chair, he recalled that Floyd's head went back and "his face did not look right." [redacted] stated he called out to BOP medical personnel, who were on scene, to check Floyd's condition. Thereafter, medical personnel began life saving measures due to Floyd being unresponsive. Sometime thereafter, NYC EMS personnel arrived on scene and transported Floyd to the hospital where he was subsequently pronounced dead.

During a voluntary interview, Paramedic [redacted] told the OIG that he arrived at Unit K-84 to speak to another inmate when a medical emergency came over the radio, so [redacted] responded to the location of the emergency which was Floyd's upper tier cell. [redacted] recalled Floyd's cell door window was broken and Floyd was yelling incoherently and making swinging motions with his hand and arm through the window. [redacted] also recalled there was water, blood, and steam coming from underneath the cell door. [redacted] stated he tried to talk to Floyd and tell him that he [redacted] was there to help Floyd; however, Floyd never looked at or spoke to [redacted] directly. [redacted] stated that Floyd continued to yell, as if he were in an "excited delirium of some sort."

[redacted] recalled when the DCT arrived, they covered the broken cell door window with a shield and the lieutenant gave continual verbal commands to Floyd, telling Floyd to calm down and submit to hand restraints. [redacted] stated Floyd continued to be combative, punching the shield, yelling, and ignoring commands. Eventually, the lieutenant ordered a correctional officer to administered OC spray through the food slot of Floyd's cell door. [redacted] believed that Floyd must have tried to block the food slot door with his mattress inside the cell because after the OC spray was administered it "splashed back" into the hallway outside the cell. [redacted] stated personnel were coughing, sneezing, choking, and backing away, if possible. [redacted] stated when the DCT finally opened the cell door, Floyd was still combative and yelling and he observed Floyd grab the shield and do a "bulldozing motion" towards the officers. [redacted] said that Floyd showed no signs of being affected by the OC spray. [redacted] recalled officers put Floyd on the ground to gain control and as they applied restraints to Floyd, Floyd was still combative. [redacted] stated as the officers were putting Floyd on the ground, [redacted] was yelling to the officers, "Put him on his right side. Put him on his right side." [redacted] said he yelled that to prevent Floyd from being positionally asphyxiated. Once restrained and placed in a wheelchair, [redacted] went toward Floyd to begin a medical assessment and he saw Floyd's head "flop back." [redacted] did an initial assessment and discovered Floyd was not breathing. He ordered officers to get an AED and to move Floyd downstairs. Once downstairs, [redacted] and other officers began chest compressions and other life saving measures.

During a voluntary interview, MDC Brooklyn Chief Psychologist [redacted] told the OIG that staff members of the Psychology Department conduct daily rounds in the isolation units to include walking by the cell and having a brief conversation with each inmate. When [redacted] arrived for morning rounds on June 3, 2020, she went directly to Floyd's cell because he was yelling and banging on his cell door. As [redacted] approached Floyd's cell, Floyd apologized for banging on the door and calmly said, "Fixing to be a homicide/murder." [redacted] recalled asking Floyd, "Who is going to be killed? You seem worked up." Floyd did not respond to the question. [redacted] believed that Floyd's behavior was not uncommon for inmates in isolation, so she did not request Floyd be removed from his cell and be placed in a more private area to conduct an official clinical encounter. Later that same morning, [redacted] received a call that Floyd was banging on his cell door again. Before she could respond to the unit to talk to Floyd, a body alarm was activated in Unit K-84 and when [redacted] arrived, she observed Floyd unresponsive, being transported downstairs in a chair. [redacted] heard someone request an AED for Floyd. As [redacted] was returning to her office, another medical emergency alarm sounded, and she responded to the Receiving and Discharge area and observed staff members performing CPR on Floyd. [redacted] offered to assist and thereafter assisted staff with CPR on Floyd.

The OIG reviewed all of the available video camera footage and the BOP incident report package, both dated June 3, 2020.[3] The OIG observed that the video was of poor quality and did not capture the inside of Floyd's cell. The OIG was able to observe on the video the BOP officers and DCT members responding to Floyd's cell, Floyd being removed in a wheelchair, and chest compressions being performed on Floyd by BOP personnel. However, because of the number of BOP personnel who responded to Floyd's cell, the view of Floyd on the video was obscured and Floyd first appeared on the video after he was placed in the wheelchair. Accordingly, the OIG was unable to observe on the video the use of OC spray, Floyd exiting his cell, or the force used to subdue Floyd. The OIG also noted that, during an immediate use of force such as occurred here, BOP Program Statement 5500.15 provides that staff are "obligated" to obtain a video camera and begin recording the event "as soon as feasible." BOP policy does not specify who is responsible for obtaining the video camera during this type of response and, in this instance, staff did not secure a camera until the incident and medical debriefs occurred.

The OIG separately viewed Floyd's cell and observed that the sink had been pulled from the wall, the mattress was on the ground with the stuffing torn out, and there was clothing on the floor. The OIG found Floyd's cell in disarray, with clothing, mattress stuffing, and toilet paper strewn about. Photos of Floyd's cell are below.

[3] BOP video cameras are video only and do not record audio.

The OIG also reviewed Floyd's Medical Administration Record (MAR) from November 2019 through June 2020. The OIG noted the MAR reflected Floyd had a prescription for two medications, 45 mg daily of Mirtazapine (an antidepressant) and 15 mg daily of Olanzapine (an antipsychotic).

The BOP records reflect that, prior to May 1, 2020, Floyd was frequently noncompliant regarding use of these medications and often refused or did not show up to take his medication. For example, in March 2020, Floyd refused or did not show up to receive his dose of Mirtazapine 28 times and his dose of Olanzapine 24 times. As such, BOP canceled Floyd's prescriptions, effective April 5, 2020. On April 30, 2020, Floyd returned to the medical unit and requested his medications be reinstated.

On May 1, 2020, the BOP medical unit prescribed Mirtazapine and Olanzapine for a 30-day trial period. Floyd's Mirtazapine and Olanzapine prescriptions both expired on May 30, 2020. Floyd's Mirtazapine prescription was renewed on May 31, 2020; however, the BOP did not renew Floyd's Olanzapine prescription until June 2, 2020. Therefore, Floyd did not receive a daily dose of Olanzapine on either May 31 or June 1.

During a voluntary interview, BOP Health Services Administrator [redacted] told the OIG that she was familiar with Floyd and advised she was the Institution Duty Officer (IDO) when he died on June 3, 2020. [redacted] reviewed Floyd's MAR for May 2020 and June 2020 and confirmed that Floyd's prescription for Olanzapine expired on May 30, 2020 and was not reordered until June 2, 2020. [redacted] did not know why there was a two-day gap in the prescription; however, she stated that, in her view, missing two days of this medication would not have been the cause of Floyd's psychotic behavior on June 3, 2020.

During a voluntary interview, MDC Brooklyn Clinical Director [redacted] told the OIG that he provides care to an estimated 1,600-1,700 MDC Brooklyn inmates, as well as oversees and supervises the nurses, nurse practitioners, physician assistants, paramedics, and dentists who are part of the medical unit. [redacted] explained that nurses or nurse practitioners generally cover intakes for all incoming inmates. As part of intake, nurses discuss current medications with the inmates and reconcile their information with incoming records to prescribe an initial dosage of medication until inmates can see a physician, if necessary. [redacted] was familiar with Floyd because of the eye injury Floyd sustained on May 29, 2020. [redacted] examined Floyd in the days following the injury to determine if he needed outside care. On the day before Floyd's death, [redacted] examined Floyd's eye again and recalled that Floyd was "in pretty good spirits" and that Floyd told him his eye was feeling better. Floyd did not make any statements, comments, or complaints about his mental health to [redacted] when [redacted] saw him the several days prior to his death.

During a voluntary interview, MDC Brooklyn physician [redacted] told the OIG that MDC Brooklyn is a very busy facility, with a lot of movement of inmates. [redacted] stated that 60-70% of inmates are not cooperative and do not comply with their medication protocols. [redacted] stated that inmates "want what they want", meaning they want their medications, but they do not want to follow the protocols for those medications. [redacted] stated it is the responsibility of the inmate to request a refill or request to be seen by medical staff if their prescription is running out and they need a refill. [redacted] stated that a nurse, nurse practitioner, or physician can order a refill. The physician's name on the order does not necessarily reflect that the physician evaluated the inmate or ordered the medication. [redacted] reviewed Floyd's Medication Administration Record for May 2020 and June 2020 and confirmed that Floyd's prescription for Mirtazapine and Olanzapine expired on May 30, 2020. [redacted] did not know why Floyd's Mirtazapine prescription was reordered on May 29, 2020, but his Olanzapine prescription was not reordered until June 2, 2020. [redacted] stated that in his medical opinion missing two or three doses of Olanzapine would not cause a psychotic episode. [redacted] did not recall an instance in his tenure with the BOP in which he was consulted prior to the use of OC spray.

During a voluntary interview, MDC Brooklyn Psychiatrist [redacted] told the OIG that he is a part time contract psychiatrist with the BOP and works approximately two 4-hour shifts per week at MDC Brooklyn. [redacted] explained that he sees approximately four inmates per shift. These inmates have been preselected for an appointment, based upon the particular problems they are having at that time. [redacted] was not familiar with Floyd and advised that he did not recall ever seeing Floyd for a session or prescribing any medications for Floyd.

An autopsy report dated November 18, 2020, prepared by OCME concluded that Floyd's death was accidental, caused by cardiac arrhythmia due to hypertensive cardiovascular disease in the setting of probable proarrhythmic gene mutation, with a contributing factor being recent synthetic cannabinoid use.

The OIG learned from the OCME autopsy report that the level of Olanzapine, a drug used to treat psychotic disorders, in Floyd's blood was 21 ng/mL. According to the report, plasma concentrations required for effective treatment of psychotic episodes range from 20 to 80 ng/mL in adults. Schizophrenic patients stabilized with Olanzapine at an average daily dose of 14 ng/mL had steady-state Olanzapine plasma concentrations averaging 37 +/- 26 ng/mL.

On January 27, 2021, the United States Attorney's Office for the Eastern District of New York (USAO-EDNY) declined prosecution of this matter.

On November 16, 2021, the DOJ Civil Rights Division declined prosecution of this matter.

**OIG's Conclusion**

The OIG investigation concluded that there was insufficient evidence to find that any BOP employees engaged in administrative misconduct in connection with Floyd's death.

Based on the OIG's review of documentary evidence, interviews with BOP staff that responded to the incident, and examination of Floyd's cell subsequent to the incident, the OIG found that Floyd was extremely agitated on June 3 when staff responded to the banging and yelling from inside his cell, that he had removed the sink from the cell wall, that water was entering the cell as a result, that Floyd used a metal bar to break his cell door window, and that he did not comply with BOP staff instructions in their efforts to remove him from the cell. The BOP Activities Lieutenant said that he ordered the use of OC spray after the failed efforts to have Floyd comply with orders so that Floyd could be removed from the cell. The OIG received varying accounts from BOP staff of what occurred after the use of the OC: two staff stated that Floyd had blocked it; several staff said that, after the OC spray was used, Floyd came charging out of the cell when the cell door was opened; while one staff member told us that he observed Floyd crawl out of the cell. The OIG's review of the institution's video footage did not enable us to determine what occurred prior to and after the time the OC spray was used, and whether Floyd charged out of the cell or crawled out on his knees because the BOP staff that had responded to the cell block were surrounding the cell, thereby limiting what could be seen on the video. We also noted that the poor quality of the BOP's video camera footage impacted its value.[4] We further noted that, while none of the BOP staff that responded to Floyd's cell took a portable camera with them, BOP policy only requires that they do so "as soon as feasible" and does not specify who is responsible for obtaining a portable camera during an immediate use of force response. The OIG found that the limited available video evidence did not allow us to observe the use of OC spray, Floyd exiting his cell, or the force used to subdue Floyd.

The OIG further determined that, because his prescription expired and was not renewed by BOP staff, Floyd was not given his antipsychotic medication on May 31 and June 1, and that it was resumed on June 2, the day before his death. While we could not rule out the possibility that the failure to take his medication on May 31 and June 1 could have had an effect on Floyd, we did not find sufficient evidence to conclude that it did. First, BOP records reflect that Floyd previously had voluntarily refused to take his antipsychotic medication on multiple occasions, including 24 times during the month of March and for nearly all of April. Yet, he had no psychotic episodes during those time periods. Second, the OCME report found that the level of the antipsychotic medication in Floyd's blood at the time of his death was 21 ng/mL, and the report stated that plasma concentrations required for effective treatment of psychotic episodes range from 20 to 80 ng/mL in adults. Thus, while we found insufficient evidence to find that the failure to timely renew Floyd's antipsychotic medication played a role in the June 3 events, we nonetheless were disturbed to find that no one at MDC Brooklyn could explain how this failure occurred.

Lastly, the OIG was unable to conclude that the use of OC spray on Floyd violated BOP policy. BOP Program Statement 5500.15 provides that a warden or designee can approve the use of OC spray, and a shift lieutenant may authorize the use of OC spray in situations that require an immediate response when there is not enough time to obtain higher-level approval. However, that BOP policy also cautions that OC spray may be harmful to an inmate with certain underlying conditions, including psychosis, and directs BOP personnel to consult medical staff before such use and to avoid such use on an inmate with one of the listed conditions, "unless other means of control have been attempted or deemed likely to be ineffective." We concluded that Lieutenant [redacted] appeared to have the authority under BOP policy to authorize the use of OC spray, given that the situation required an immediate

[4] The OIG has repeatedly expressed its concern about both the quality of the BOP's video footage and the lack of camera coverage at its facilities. Most recently, the OIG issued a Management Advisory Memorandum regarding the issue. U.S. DOJ OIG, *Notification of Needed Upgrades to the Federal Bureau of Prisons' Security Camera System*, Management Advisory Memorandum 22-001 (October 2021), https://oig.justice.gov/reports/management-advisory-memorandum-notification-needed-upgrades-federal-bureau-prisons-security.

response due to Floyd's extremely agitated behavior inside of his cell, his removal of the sink from the cell wall, and his use of a metal bar to break his cell door window. Additionally, although not specifically consulted about the use of OC spray on Floyd, medical staff (i.e., the Paramedic) was present when Lieutenant [redacted] ordered the use of OC spray and raised no concerns to [redacted] about its use on Floyd. Under all of these circumstances, the OIG was unable to conclude that BOP policy was violated by the use of OC spray on Floyd, who suffered from a form of psychosis, where other means of control appeared to be ineffective or deemed to be ineffective. Nonetheless, we found the BOP's policy on the use of OC spray on individuals with certain known medical conditions to be less than clear, and we therefore will be separately issuing a Management Advisory Memorandum to the BOP on this issue.

The OIG has completed its investigation and is providing this information to the BOP for its review.