NEW YORK STATE OF OPPORTUNITY.
Justice Center for the Protection of People with Special Needs

KATHY HOCHUL
Governor

DENISE M. MIRANDA
Executive Director

July 7, 2022

Dr. Li-Wen Lee
Associate Commissioner
Division of Forensic Services
NYS Office of Mental Health
44 Holland Avenue
Albany, NY 12229

Anthony J. Annucci
Acting Commissioner
NYS Department of Corrections
And Community Supervision
The Harriman State Campus-Building 2
1220 Washington Avenue
Albany, NY 12226-2050

Re: 1-ACUB8F3 Justice Center Oversight Action

Dear Dr. Lee and Acting Commissioner Annucci:

The Justice Center for the Protection of People with Special Needs (the Justice Center) has completed its review of the mental health services provided to [redacted] (DIN [redacted]), an incarcerated individual who died on [redacted] at the Five Points Correctional Facility (CF). The Justice Center's review found that the documentation of the care provided to [redacted] did not meet the standard of care set forth by the Central New York Psychiatric Center (CNYPC) and the Department of Corrections and Community Supervision (DOCCS). The attached review describes the Justice Center's findings and recommendations.

The Justice Center looks forward to your response to the attached findings and recommendations by August 8, 2022. Please direct any correspondence or concerns related to this review to me at davin.robinson@justicecenter.ny.gov. Thank you for your continued cooperation.

Sincerely,

Davin Robinson
Deputy Director, Office of Outreach, Prevention & Support

Cc: Davin Robinson, Deputy Director, Outreach, Prevention & Support
Nikki O'Meara, Director of Operations, Forensics
Melissa Finn, Director of Quality and Compliance, Forensics
Angelina LoCascio, Acting Supervising Facility Review Specialist, Forensics
Dr. Anne Sullivan, M.D., Commissioner, OMH
Danielle Dill, Executive Director, CNYPC
William Vertoske, Deputy Director Psychiatric Center 2, Corrections-Based Operations
Lisa Murphy, Acting Director of Quality Management, OMH
Maureen Morrison, OMH
Meaghan Bernstein, Advocacy Letter Coordinator
Bryan Hilton, Associate Commissioner, DOCCS

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Justice Center Oversight Action
Mental Health Service Review [redacted] (DIN [redacted])
JC#: 1-ACUB8F3

The Justice Center's review of the standard of care provided by the Central New York Psychiatric Center (CNYPC) and the Department of Corrections and Community Supervision (DOCCS) to the incarcerated individual prior to their suicide follows below.

Background

The incarcerated individual was 61 years old and was serving a state bid with a 17-year sentence for Manslaughter in the 1st Degree and Attempted Murder in the 2nd Degree. They were scheduled to have a parole hearing date in October 2030. Their Conditional Release (CR) date was December 16, 2030 and the Maximum Expiration (ME) date was May 22, 2033.

Prior to incarceration, the incarcerated individual endorsed a history of [redacted] and one [redacted] on [redacted] 2016 "for treatment for self-inflicted poisoning due to the toxic effect of carbon monoxide from setting apartment on fire during the instant offense." While incarcerated in county jail in 2016, the individual attempted suicide by drinking peroxide and cutting his wrist. They endorsed a significant substance abuse history and reported using PCP, Xanax, and Klonopin daily. They also reported moderate cocaine and alcohol use. To assist them in their [redacted], they attended [redacted] in the Bronx, New York.

On October 10, 2019, the incarcerated individual transferred from county jail to the Downstate Correctional Facility (CF), was admitted to mental health services and designated a Mental Health Service Level (MHSL) 1. They were diagnosed with [redacted]. They transferred from the Downstate CF to the Five Points CF on October 21, 2019.

The incarcerated individual's Treatment Plan was updated on May 26, 2021 to reflect their mental health goals and it was noted they were making satisfactory progress toward their treatment goals and objectives. Their Comprehensive Suicide Risk Assessment (CSRA) was also reviewed on this date and no changes were made. Mental health staff documented "patient continues to demonstrate psychiatric stability, denies and current SI/HI, remains compliant with medication." [1]

During a clinical callout on June 24, 2021, the incarcerated individual reported "feeling down" and shared that they had not been sleeping well, were experiencing racing thoughts, and endorsed increased symptoms of depression. They denied any suicidal ideation at this session. Mental health staff discussed coping skills and encouraged them to express their concerns to their psychiatric provider. Mental health staff noted they would also contact psychiatric staff. The individual met with psychiatric staff via Video Teleconferencing (VTC) on June 28, 2021 and reported feeling "so-so," that they were feeling more depressed lately, had been thinking

[1] Treatment Plan dated May 26, 2021.

about their instant offense and felt guilty as a result of their instant offense. They reported that their thoughts were typically darker during Mother's Day. They denied any issues on their housing unit, noted they were assigned to school, and worked in the mess hall. The individual noted that they still experienced drug cravings, felt "sluggish" during the day, and that their appetite had decreased. They did, however, deny any suicidal ideation. Following this session, their [redacted] were continued, but their [redacted] was discontinued and instead, they were prescribed [redacted] thereafter.

The incarcerated individual met with mental health staff on July 22, 2021. They stated they did not have any significant stressors and were feeling "alright." They had started physical therapy and noted this was a positive, as they had been experiencing pain. They informed mental health staff of their recent medication change and did not report any side effects.

Mental health staff had a private call out with the incarcerated individual on August 17, 2021. They were working in the mess hall and noted they were on the honor block. They remained in contact with their family and expected a visit from them soon. The individual informed mental health staff that they were still experiencing symptoms of depression and wanted to advocate for their [redacted] to be increased. Mental health staff noted they would also follow up with the prescriber, as the individual was demonstrating symptoms of depression. They met with psychiatric and mental health staff on August 24, 2021 via VTC and during this session, they said they were "alright." They reported some family issues, but noted the issues were being taken care of. They were feeling the effects of the [redacted], noting they did not feel as "depressed" anymore. They did, however, note that they experienced moodiness. They denied any cravings for drugs and alcohol, was adhering to treatment, and denied any side effects, except feeling "sluggish." At this session, they were prescribed [redacted].

At their mental health call out on September 17, 2021, the incarcerated individual reported their mood had been "so-so" and they were frustrated due to medical concerns. They stated that they did not believe their medical concerns were being taken seriously by DOCCS medical staff. They continued to report having difficulty sleeping and it was noted they were [redacted] and reported they were "going to be receiving [redacted]." The individual reported remaining in their cell most of the time because they cannot do a lot of the activities they used to do and found this to be frustrating. Mental health staff discussed possible coping mechanisms such as writing, meditating, and breathing exercises. The individual reported continued family contact and reported that they spoke with them weekly. They also denied any thoughts of self-harm.

The incarcerated individual met with psychiatric staff on October 19, 2021 and stated they were "alright." They reported that their moods had been "up and down," as their niece's son was killed and that two more people were killed at the funeral. They stated they were tired of losing people and expressed frustration that they were not there to remedy the situation. They denied any immediate mental health concerns and there were no changes to their medication regimen. Mental health staff also met with the individual that day; they spoke with them regarding the recent tragedy in this family. Mental health staff offered handouts on grief and loss but declined, noting that they had a lot of experience with death. They informed mental health staff that they would be having [redacted] "next week" and was going to have an [redacted] "soon." They stated that their family continued to be a strong support. The individual did not have any immediate mental health concerns and noted they had been medication compliant, stating "I'd be off the hook if I didn't take them, I know that."

At the incarcerated individual's mental health call out on November 19, 2021, they informed mental health staff that their mood had been "so-so, it's up and down," and they reported this as

their baseline. They reported that they had [redacted] and would be having [redacted] as well. They reported that they were still awaiting their [redacted]. The individual noted that their [redacted] contributed to their symptoms of depression and that while working in the mess hall, other incarcerated individuals assisted them when they struggled due to pain. They did not have any mental health concerns and denied any thoughts of self-harm and continued to cite their family as a major support.

Mental health staff met with the incarcerated individual on December 17, 2021 for a private interview. They reported their mood as "depressed" and noted that their daughter was recently hospitalized. The individual reported that their family had been in touch with them, and they would provide them with updates. They did not believe their daughter was at risk of dying but reported being "stressed" by the situation. When asked how they were coping with the stress, the individual stated there was not much they could do because they were in prison. The individual noted they tried to be busy and continue working in the mess hall five days per week. They also noted that being around other people assisted them in coping. They stated they received their second [redacted] had been treated. They stated that they were medication compliant and no immediate mental health concerns were noted.

Progress notes indicate that the incarcerated individual began exhibiting [redacted], 2021. They were admitted to infirmary ISO #2 until all [redacted] had been met. On December 22, 2021 at 9:30 am, the Unit Chief requested that mental health staff assess the individual while they were in the infirmary. They were "observed through the ISO room windows laying in" their "infirmary bed and appeared to be sleeping." [2] Mental health staff knocked on the window, but they did not acknowledge mental health staff. Mental health staff then attempted to conduct a Patient Safety Screener (PSS-3M), but it was not completed due to refusal of a private interview. [3] It was noted that mental health staff would "inform MHU treatment team that patient was not assessed due to being asleep and inquire regarding how to proceed with future assessment due to patient being [redacted]."

While conducting rounds in the infirmary on [redacted] at 9:40 pm, security staff discovered the incarcerated individual hanging in the shower stall with the shower hose around their neck, and they were unresponsive. Security staff called a medical response to the area via radio and the shower hose was removed from their neck. CPR was initiated, and medical staff arrived and applied an AED to their chest; no shock was advised. The ambulance was contacted and arrived at 10:00 pm. CPR was performed on them until 10:05 pm. At 10:05 pm, paramedic staff removed the facility's AED, applied their own and began medical resuscitation. Paramedic staff contacted the outside hospital and informed them that the individual was without pulse or respirations. They were pronounced deceased at 10:21 pm. The preliminary cause of death was suicide by self-strangulation. The room in the infirmary was declared a crime scene at 10:21 pm and the ambulance departed the facility at 10:35 pm. Photos of the cell and body were taken, and the Office of Special Investigation (OSI) cleared the cell at 3:26 pm. It was noted that the individual was last seen alive at 8:45 pm during rounds.

[2] Progress Note dated December 22, 2021.
[3] Patient Safety Screener-3 Modified dated December 22, 2021.

Justice Center Findings

1. **The incarcerated individual was last seen alive at 8:45 pm during rounds in the infirmary.**

   While conducting rounds in the infirmary on [redacted] at 9:40 pm, security staff discovered the individual hanging in the shower stall with the shower hose around their neck, and they were unresponsive. It was noted that they were last seen alive at 8:45 pm during rounds

2. **There was no documentation of efforts by mental health staff to understand more about the incarcerated individual's mental state or form a therapeutic alliance with the individual.**

   Throughout their mental health sessions, the individual indicated they were experiencing symptoms of depression, "feeling down," their mood being "so, so, it's up and down," having difficulty sleeping, a death in the family, and detailing the medical conditions they were experiencing. While the progress notes reviewed by the Justice Center often included details about what the incarcerated individual said, there was no indication of probing, in-depth conversations about their mental state. In addition, a number of the progress notes ended with the same boiler plate statement: "My role was supportive. Chronic risk factors remain the same. At this time the patient is not acutely suicidal, homicidal, delusional or psychotic, nor is he cognitively impaired to the point where he cannot function in his current environment, therefore he is not currently an acute risk to himself or others at this time."[4]

3. **The OMH Unit Chief requested that mental health staff assess the incarcerated individual while conducting rounds in the infirmary on the day of their completed suicide.**

   On December 20, 2021, the individual had been exhibiting [redacted], was [redacted]. They were admitted to infirmary ISO #2 until all [redacted] had been met. On December 22, 2021 at 9:30 am, the Unit Chief requested that mental health staff assess the individual while conducting rounds in the infirmary. When mental health staff arrived at their cell, the individual "was observed through the ISO room windows laying in his infirmary bed and appeared to be sleeping." [5] Mental health staff knocked on the window, but they did not acknowledge mental health staff. Mental health staff attempted to conduct a Patient Safety Screener (PSS-3M), but it was not completed due to their refusal of a private interview. [6] It was noted that mental health staff would "inform MHU treatment team that patient was not assessed due to being asleep and inquire regarding how to proceed with future assessment due to patient being [redacted]."

Justice Center Recommendations

[4] Progress Notes dated June 24, 2021, July 22, 2021, August 17, 2021, September 17, 2021, October 19, 2021, November 19, 2021, and December 17, 2021.
[5] Progress Note dated December 22, 2021.
[6] Patient Safety Screener-3 Modified dated December 22, 2021.

1. Please provide the Justice Center with documentation demonstrating rounds in the infirmary were completed and the protocol for how often they are supposed to be completed specifically if an incarcerated individual has been diagnosed with [redacted].

2. OMH staff at the Five Points CF should be re-trained on CBO Policy #9.30- Progress Notes to ensure they are clear on their responsibilities and are asking questions to better understand what the individual is struggling with and documenting the answers to those questions. The Justice Center also discourages the "cut and paste" practice when completing progress notes.

3. While the Justice Center understands that it is an incarcerated individual's right to refuse to meet with mental health staff, it is concerning more efforts were not made to engage an individual exhibiting symptoms of depression. Prior to being placed in the infirmary after being diagnosed with [redacted], they had repeatedly expressed to mental health staff that concerns about their family that were causing them stress and often spoke about their significant medical issues. Following their refusal to see mental health staff at 9:30 a.m., there is no documentation another attempt to assess them was completed prior to their suicide [redacted]. While the Progress Note does not offer indication as to why, it was noted that the Unit Chief requested they be assessed during rounds in the infirmary, which would indicate they were someone who might require mental health assistance.

   Please provide the Justice Center with documentation demonstrating if another assessment was attempted with the incarcerated indivual on [redacted]. If there is no such document, please explain if any steps were taken to follow up with him while in the infirmary on that date prior to their death.

Review conducted by: _____

Angelina LoCascio
Supervising Quality Care Facility
Review Specialist, Forensic Unit

NEW YORK STATE OF OPPORTUNITY. Office of Mental Health

KATHY HOCHUL
Governor

ANN MARIE T. SULLIVAN, M.D.
Commissioner

MOIRA TASHJIAN, MPA
Executive Deputy Commissioner

September 2, 2022

Davin Robinson
Deputy Director of Outreach, Prevention and Support
Justice Center for the Protection of People with Special Needs
161 Delaware Avenue
Delmar, New York 12054

Dear Ms. Robinson:

We received your letter dated July 8, 2022, in response to the Justice Center's (JC) review of the mental health services provided to [redacted] (DIN [redacted]) an inmate/patient who died on [redacted], at Five Points Correctional Facility (CF).

Below are the Justice Center's findings and recommendations from the above-referenced review, and OMH's response to each.

Recommendation #1:
"Please provide the Justice Center with documentation demonstrating rounds in the infirmary were completed and the protocol for how often they are supposed to be completed specifically if an incarcerated individual has been diagnosed with [redacted]."

OMH Response:
OMH defers to the Department of Corrections and Community Supervision (DOCCS) regarding this recommendation.

Recommendation #2:
"OMH staff at the Five Points CF should be re-trained on CBO Policy #9.30- Progress Notes to ensure they are clear on their responsibilities and are asking questions to better understand what the individual is struggling with and documenting the answers to those questions. The Justice Center also discourages the 'cut and paste' practice when completing progress notes."

OMH Response:
It is important to acknowledge that the actual clinical care provided to [redacted] was determined to be adequate, and this is specifically a matter of documentation practices. Both clinicians responsible for these progress notes no longer work for CNYPC, and therefore, policy reviews could not be completed. The matter was referred to the facility Unit Chief and Acting Director of Social Work so they can continue to be cognizant of this when completing future quality assurance reviews.

Recommendation #3:
"…Following their refusal to see mental health staff at 9:30 a.m., there is no documentation another attempt to assess them was completed prior to their suicide [redacted]. While the

Progress Note does not offer indication as to why, it was noted that the Unit Chief requested they be assessed during rounds in the infirmary, which would indicate they were someone who might require mental health assistance.

Please provide the Justice Center with documentation demonstrating if another assessment was attempted with the incarcerated indivual [sic] on [redacted]. If there is no such document, please explain if any steps were taken to follow up with him while in the infirmary on that date prior to their death."

OMH Response:
As part of the CBO Risk Management Special Investigation, it was learned that the Unit Chief requested [redacted] be seen earlier on [redacted] because a DOCCS extra service nurse working the previous evening shift [D.M.] indicated he requested to see mental health (a specific reason was not provided). In response, mental health staff attempted to meet with him at 9:30am, as noted by the Justice Center. As [redacted] did not provide a reason for wanting to see mental health, and there was no indication at the time that there was an imminent concern, per policy OMH staff had 14 days to respond to the referral. Therefore, there was no indication that the mental health clinician needed to attempt to see [redacted] again that same day.

It was learned during the Risk Management investigation that the facility Deacon verbally notified an OMH nurse [B.J.] around 5pm on [redacted] that Mr. Maldonado was "really angry," and the Deacon had concerns about him. As a formal written referral was not received from the Deacon, it is unknown if any additional information would have been provided about [redacted] presentation and concerns. In her interview with Risk Management, B.J. advised that she met with [redacted] cellside in response to the Deacon's concerns, but he stated he was fine and did not want to talk.

Two hours later, around 7pm, [redacted] was throwing his medication during medication pass. The nurse administering medications [D.M., now working in an OMH capacity] shared this with B.J. who attempted to speak with [redacted], but again he would not speak with her. B.J. reported during her Risk Management interview that, due to his behavior and presentation, she told a DOCCS officer that [redacted] needed to be placed on a 1:1 watch. It does not appear that this watch was initiated by DOCCS, or that formal paperwork was started by B.J. Additionally, B.J. did not write progress notes for her interactions with [redacted] on 12/22/21. As such, CBO Risk Management made recommendations for policy reviews and supervision as indicated to address these noted issues. The Special Investigation has not been closed at this time; a copy will be sent to the Justice Center once it is.

We thank you for bringing your concerns to our attention.

Sincerely,

Li-Wen Lee, M.D.
Associate Commissioner
Division of Forensic Services

cc: Danielle Dill, Psy.D., Executive Director, CNYPC
William Vertoske, Deputy Director, Corrections Based Operations, CNYPC
File

NEW YORK STATE | Corrections and Community Supervision

ANDREW M. CUOMO
Governor

ANTHONY J. ANNUCCI
Acting Commissioner

July 20, 2022

Davin Robinson
Deputy Director, Office of Outreach, Prevention & Support
NYS Justice Center for the Protection
of People with Special Needs
161 Delaware Avenue
Delmar, NY 12054

Re: 1-ACUB8F3 Justice Center Oversight Action

Deputy Director Robinson:

The Justice Center for the Protection of People with Special Needs, the Justice Center has completed its review of the mental health services provided to [redacted], an incarcerated individual who died on [redacted], at the Five Points Correctional Facility.

Recommendation: Please provide the Justice Center with documentation demonstrating rounds in the infirmary were completed and the protocol for how often they are supposed to be completed specifically if an incarcerated individual has been diagnosed with [redacted].

Response: The requested documentation will be included with this response. The documentation includes section of the logbook on [redacted], and memorandum from former Deputy Commissioner for Correctional Facilities on Procedures for Individuals in Isolation/Quarantined Housing Units. This incident was investigated by Office of Special Investigation (OSI), determining rounds were properly being performed by staff.

Thank you for your oversight services because this helps improve our department. I look forward to continuing working productively with the Justice Center to improve the services for our population.

Sincerely,

Bryan Hilton
Associate Commissioner

cc: Amy Lamanna, Superintendent – Five Points Correctional Facility
Angelina LoCascio, Facility Review Specialist, Justice Center