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

ANDREW M. CUOMO
Governor

DENISE M. MIRANDA
Executive Director

July 13, 2020

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: [redacted] 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) is required to oversee compliance with the Special Housing Unit (SHU) Exclusion Law and monitor the quality of corrections-based mental health care for inmate/patients (Chapter 1 of the Laws of 2008). To meet this mandate, we conduct quality of mental health care reviews and SHU Exclusion Law compliance reviews to assess if the Office of Mental Health (OMH) programs within the Department of Corrections and Community Supervision (DOCCS) facilities conform to the requirements of the SHU Exclusion Law.

On February 4-5, 2020, the Justice Center conducted a site visit at the Fishkill Correctional Facility's Special Housing Unit 200 (SHU 200) and Long Term Keep Lock (LTKL) to review the quality of mental health care provided to inmate and/or patients in accordance with the SHU Exclusion Law, OMH policies, and DOCCS directives. The attached review details the Justice Center's findings and recommendations.

The Justice Center looks forward to your response to the attached findings and recommendations by August 13, 2020. Please direct any correspondence or concerns related to this review to me at denise.miranda@justicecenter.ny.gov. Thank you for your continued cooperation.

Sincerely,

Denise M. Miranda, Esq.
Executive Director

Cc: Davin Robinson, Deputy Director, Outreach, Prevention & Support
Melissa Finn, Unit Director, Forensics
Angelina LoCascio, Facility Review Specialist, Forensics
Dr. Anne Sullivan, M.D., Commissioner, OMH
Danielle Dill, Acting Executive Director, CNYPC
William Vertoske, Forensic Services Program Administrator 2, OMH
Maureen Morrison, OMH
Meaghan Bernstein, OMH
Bryan Hilton, Associate Commissioner, DOCCS

NOTE: All correspondence related to this matter will be available for public inspection under Article 6 of the Public Officers Law. Material which will be required to be kept confidential or which is protected from disclosure under the Public Officers Law or other laws will be redacted prior to such disclosure.

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

ANDREW M. CUOMO
Governor

DENISE M. MIRANDA
Executive Director

Review of Justice Center Oversight Action
Fishkill Correctional Facility – Special Housing Unit (SHU) Compliance/ Quality of Care
JC#: [redacted]

On February 4-5, 2020, the Justice Center for the Protection of People with Special Needs (the Justice Center) conducted a site visit at the Fishkill Correctional Facility (CF) to review the quality of mental health care provided to inmates, and determine compliance with the SHU Exclusion Law, Office of Mental Health (OMH) policies, and Department of Corrections and Community Supervision (DOCCS) directives.[1] The census of the SHU 200 at the time of the visit was 114 inmates and/or patients. [2] The census of the Long Term Keep Lock (LTKL) at the time of the visit was 58 inmates and/or patients. [3] There were four inmate/patients in the Fishkill CF SHU 200 that met the SHU Exclusion Law criteria for the definition of serious mental illness during our site visit.[4]

In addition to reviewing the OMH clinical case record, DOCCS SHU folders, and the DOCCS guidance records, Justice Center staff members also requested any exceptional circumstances documentation for the current census for a time-period of six months.

Compliance Determination:

To assess compliance, the Forensic Unit toured the SHU 200 and spoke cell-side with 113 inmates and/or patients. [5] The Forensic Unit also toured the LTKL and spoke cell side with 62 inmates and/or patients. We also reviewed the records of 33 inmates and/or patients to determine whether the facility was in compliance with the conditions of the SHU Exclusion Law:

1. *Upon placement of an inmate into segregated confinement at a level one or level two facility, a Suicide Prevention Screening Instrument shall be administered by staff from the Department or the Office of Mental Health who has been trained for that purpose;*

2. *Within one business day of the placement of such an inmate into segregated confinement at a level one or level two facility, the inmate shall be assessed by a mental health clinician;*

3. *If an inmate with a serious mental illness is not diverted or removed to a residential mental health treatment unit, such inmate shall be reassessed by a mental health clinician within fourteen days of the initial assessment and at least once every fourteen days thereafter;*

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[1] Correction Law §§137(6)(d) and (e), 401.
[2] [redacted] (DIN [redacted]) was included in the census of the SHU 200, but was in the infirmary during our site visit and not interviewed during the Justice Center's cell side interviews. [redacted] is not on the mental health caseload.
[3] The total of inmates and/or patients in the LTKL was 62, however, only 58 inmates and/or patients could be included in our sample, as four inmates were considered Protective Custody. Justice Center staff were informed that cells one, four, six, and 18 were considered Protective Custody. All four Protective Custody inmates were interviewed cell side by Justice Center staff, did not have any mental health concerns, and were not on the mental health caseload, per the list of active patients provided by OMH.
[4] There were no inmate/patients that met the criteria for the definition of serious mental illness in the Fishkill CF LTKL during our site visit.
[5] The SHU 200 census was 114, but one inmate was in the infirmary and we did not speak with him cell side.

4. *Inmates with serious mental illness who are not diverted or removed from segregated confinement shall not be placed on a restricted diet, unless there has been a written determination that the restricted diet is necessary for reasons of safety and security. If a restricted diet is imposed, it shall be limited to seven days, except in the exceptional circumstances where the joint case management committee determines that limiting the restricted diet to seven days would pose an unacceptable risk to the safety and security of inmates or staff. In such case, the need for a restricted diet shall be reassessed by the joint case management committee every seven days; and,*

5. *All inmates in segregated confinement in a level one or level two facility who are not assessed with a serious mental illness at the initial assessment shall be offered at least one interview with a mental health clinician within fourteen days of their initial mental health assessment, and additional interviews at least every thirty days thereafter, unless the mental health clinician at the most recent interview recommends an earlier interview or assessment.*

During our review period, there were no inmate/patients placed on Exceptional Circumstances at the Fishkill CF. The Justice Center has determined that the Fishkill CF was **NOT** in compliance with the SHU Exclusion Law for the following reasons:

1. [redacted] (DIN [redacted]) was admitted to the Fishkill CF LTKL on January 28, 2020, following his return from the Residential Crisis Treatment Program (RCTP). A DOCCS Suicide Prevention Screening Guidelines #3152 was not completed upon admission. An intake assessment was completed by OMH staff on January 29, 2020.

2. [redacted] (DIN [redacted]) was admitted to the Fishkill CF SHU 200 on January 24, 2020. Mental health staff conducted an intake assessment with [redacted] on January 28, 2020. He met privately with mental health staff and no immediate mental health concerns were noted.

3. [redacted] (DIN [redacted]) was admitted to the Fishkill CF LTKL on December 22, 2019, following his return from the infirmary. DOCCS staff completed a DOCCS Suicide Prevention Screening Guidelines #3152 upon admission to the LTKL. An intake assessment was not completed by OMH staff until December 24, 2019.

4. [redacted] (DIN [redacted]) was admitted to the Fishkill CF SHU 200 on January 13, 2020. DOCCS staff completed a DOCCS Suicide Prevention Screening Guidelines #3152 upon admission to the SHU 200. An intake assessment was not completed by OMH staff until January 15, 2020.

5. [redacted] (DIN [redacted]) was admitted to the Fishkill CF SHU 200 on January 15, 2020. DOCCS staff completed a DOCCS Suicide Prevention Screening Guidelines #3152 upon admission to the SHU 200. An intake assessment was not completed by OMH staff until January 21, 2020.

Quality of Mental Health Care

The Justice Center also reviewed the quality of corrections-based mental health care provided to 20 individuals in the SHU 200 and LTKL. In an effort to complete a thorough evaluation,

Justice Center staff requested private interviews and seven individuals chose to speak with the Justice Center. [6] In addition, we examined clinical documentation, DOCCS SHU folders, Guidance Records, and reviewed the DOCCS Sign-In Log Book and Unit Activity Log Book. Our findings from this review are outlined below.

Justice Center Findings:

1. **Four inmate/patients who were designated Mental Health Service Level (MHSL) 1S were housed in the SHU 200 during the Justice Center's visit and all were pending their disciplinary hearing.**

   - [redacted] (DIN [redacted]) was admitted to the SHU 200 on January 29, 2020.
   - [redacted] (DIN [redacted]) was admitted to the SHU 200 on January 17, 2020.
   - [redacted] (DIN [redacted]) was admitted to the SHU 200 on January 24, 2020.
   - [redacted] (DIN [redacted]) was admitted to the SHU 200 on January 19, 2020.

2. **[redacted] (DIN [redacted]) informed mental health staff that he had not received his psychotropic medications for two days while in the Fishkill CF SHU 200.**

   Mental health staff met with [redacted] cell side on October 10, 2019 for a 14-day assessment in the SHU 200. "[redacted] refused to participate in SHU 200 private interview as he claimed he is being released from SHU 200 in 2 days. He did however relate to MHC that he was not getting OMH meds for the past 2 days, NA was subsequently notified. Via email." [7]

3. **There is no documentation demonstrating [redacted] (DIN [redacted]) was assessed by mental health staff following a referral from the Justice Center.**

   During a cell side interview with the Justice Center, [redacted] stated he had not attended any mental health "call outs or medications." [redacted] name, along with an explanation of why he was being referred to be seen, was provided to the OMH Unit Chief on February 5, 2020 and included on the Justice Center's Immediate Action Letter dated February 7, 2020. The Justice Center's letter requested clinical documentation supporting that [redacted] was seen following the Justice Center's site visit.

4. **Two inmate/patients were not seen by psychiatric staff according to policy.** [8]

[6] Justice Center staff offered 10 private interviews for inmate/patients at the Fishkill CF SHU 200 and LTKL. Seven inmate/patients chose to meet with Justice Center staff privately, while three inmate/patients declined.
[7] Special Housing Unit (SHU)/ Long Term Keep Lock (LTKL) Mental Health Interview dated October 10, 2019.
[8] CBO Policy #9.27- Psychiatric Progress Notes, states, "Within one month of transfer into the facility from another facility. Mental Health Level 1 and 2 Patients - a minimum of every 3 months thereafter."

- [redacted] (DIN [redacted]), a MHSL 1, transferred from the Great Meadow CF to the Fishkill CF on November 6, 2019. Per documentation received by the Justice Center, he did not meet with psychiatric staff until December 16, 2019.

- [redacted] (DIN [redacted]), a MHSL 1S, met with psychiatric staff on September 12, 2019. Psychiatric staff should have met with [redacted] in December 2019, but per documentation received by the Justice Center, there is no documentation demonstrating he was assessed by psychiatric staff. He was next assessed by psychiatric staff on January 6, 2020.

5. **[redacted] (DIN [redacted]) requested to meet with psychiatric staff to restart his medications.**

   [redacted], a MHSL 3, was admitted to the Fishkill CF LTKL on January 21, 2020. Mental health staff met with him on January 22, 2020 and he noted symptoms of depression and anxiety and requested to meet with psychiatric staff to restart his medications. Please provide documentation demonstrating [redacted] was assessed by psychiatric staff while in LTKL.

6. **[redacted] (DIN [redacted]) was not assessed by mental health staff within two weeks of transfer according to policy. [9]**

   As documented in [redacted] September 5, 2019 Progress Note, mental health staff documented the following: "Patient returned from court on 8/19/19; however, this facility was not notified of the move. This writer discovered that [redacted] had returned during data review on 9/4/19 and he was scheduled with this writer within twenty-four hours." [10]

7. **While at the Mohawk CF, [redacted] (DIN [redacted]) was not assessed by mental health staff following his transfer. [11]**

   [redacted], a MHSL 2, was admitted to mental health services at the Downstate CF on [redacted] 2019 and was designated a MHSL 2. He transferred from the Downstate CF to the Mohawk CF on September 19, 2019. Per documentation received by the Justice Center, he did not meet with mental health staff until October 16, 2019, when psychiatric staff met with him via Video TeleConferencing.

8. **While at the Attica CF, it is unclear if [redacted] (DIN [redacted]) was transferred from the SHU to the RCTP while on "RCTP status." If he was transferred out of the SHU, there is no documentary evidence that he received a Suicide Prevention Screening or was assessed by mental health staff within one business day of his readmission to the SHU.**

[9] CBO Policy #9.30- Progress Notes, states, "Within 2 weeks of transfer* in to Level 1 and 2 facilities for active patients with a mental health level of I, II, or III. Monthly thereafter."
[10] Progress Note dated September 5, 2019.
[11] CBO Policy #9.30- Progress Notes, states, "Within 2 weeks of transfer* in to Level 1 and 2 facilities for active patients with a mental health level of I, II, or III. Monthly thereafter."

[redacted] transferred from the SHU to the LTKL on October 11, 2019. [redacted] was admitted to the Attica CF RCTP after hours on [redacted] 2019 after failing DOCCS SPSG #3152 upon admission to the LTKL. Mental health staff met with him in the RCTP on [redacted] 2019. He acknowledged he was admitted due to his failed screening, and following his assessment with mental health staff, he was discharged from the RCTP. An intake assessment was conducted with him upon admission and no immediate mental health concerns were noted. A 14-day assessment was conducted with him on October 28, 2019; he refused a private interview and no immediate mental health concerns were noted.

[redacted] was placed on RCTP status on [redacted] 2019 due to threats of harm to others. Mental health staff met with him on [redacted] 2019. It was noted he was not admitted to the RCTP but placed on RCTP status due to threats of harm to others. He denied the need to be in the RCTP and stated he only became upset because security staff in the SHU denied him a shower. It was noted the interview was terminated early, as [redacted] continued to "reach for his genitals during cell side interview." Following his assessment by mental health staff, he was discharged from RCTP status to the SHU. It is unclear whether [redacted] left the SHU and transferred to the RCTP. He was referred to as "RCTP status."

Justice Center Recommendations:

1. Please provide an update regarding the diversion of inmate/patients who are designated MHSL 1S to a Residential Mental Health Treatment Unit (RMHTU), if applicable. Please provide the dates in which their disciplinary hearings were concluded and the dates they transferred.

2. The Justice Center requests that DOCCS provide an explanation and/or evidence of any corrective actions that were taken pertaining to whether or not [redacted] was provided his psychotropic medications for two days while in the Fishkill CF SHU 200.

3. Please provide documentation demonstrating [redacted] was assessed by mental health staff within the appropriate time frame in accordance with CBO Policy # 1.3 – Mental Health Referrals following the referral from the Justice Center.[12]

4. To maintain quality mental health care for inmate/patients, they should be evaluated and assessed by the treating psychiatrist per policy. All efforts should be made to ensure inmate/patients are scheduled within the documented time frame, for call outs, transfers, or other instances in which psychiatric staff are required to perform assessments.

   Given the findings of our review, OMH should assess how best to ensure that inmate/patients are seen per policy. This may include retraining for OMH staff at the Fishkill CF in CNYPC CBO Policy #9.27, Psychiatric Progress Notes to ensure

[12] All other referrals are addressed within a time frame that is consistent with the nature of the referral and within fourteen days.

inmate/patients are seen in a timely manner. The OMH Unit Chief should also complete quality assurance checks to ensure that inmate/patients are monitored in the required time frames. If there is an error and the inmate/patients were assessed within the given time frame, please provide the Justice Center with that information, if applicable.

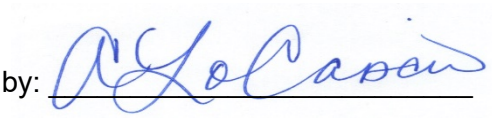
5. Please provide documentation demonstrating [redacted] was assessed by psychiatric staff, if applicable.

6. It is important that DOCCS and OMH staff communicate with one another to ensure OMH staff are aware that an inmate/patient returned to the facility and required an intake assessment. Given the findings of this review and other recent reviews at other correctional facilities, the Justice Center recommends that OMH and DOCCS develop a plan to ensure OMH staff are aware when an inmate/patient has returned, so they are able to conduct their required assessment. The Justice Center requests that this plan be provided for review. The Justice Center also requests the DOCCS Suicide Prevention Screening Guidelines #3152 from [redacted] admission to the SHU 200 on August 19, 2019. The OMH Unit Chief should continue to conduct quality assurance checks to ensure that inmate/patients are monitored in the required time frame, which assisted in determining that [redacted] had not been assessed accordingly.

7. It is imperative that inmate/patients are evaluated and assessed by their Primary Therapist as per OMH policy to ensure quality mental health care is being provided. Private, individual callouts provide inmate/patients the opportunity to discuss concerns they may not want to address while in the presence of others. Regarding transfers, OMH staff play a vital role in ensuring inmate/patients are adjusting well to a new environment, that inmate/patients are aware of how they can contact mental health staff and developing a therapeutic relationship with inmate/patients.

   Given the findings of our review, OMH should assess how best to ensure that inmate/patients are seen per policy. In past reviews, the Justice Center has recommended retraining in CBO Policy #9.30- Progress Notes for OMH staff at the Mohawk CF. It is apparent, however, that continuously retraining staff in this policy is not effective. The Justice Center recommends that the Mohawk CF develop a corrective action plan to ensure mental health staff are meeting with inmate/patients following their transfer per OMH policy. The Justice Center requests that the corrective action plan be provided for review. As stated before, the OMH Unit Chief should also complete quality assurance checks to ensure that inmate/patients are monitored in the required time frame. If there is an error and [redacted] was assessed within the given time frame, please provide the Justice Center with that information, if applicable.

8. Please clarify whether [redacted] did in fact leave the SHU and transfer to the RCTP. If there is an error and [redacted] was assessed by DOCCS and OMH upon his readmission to the SHU within the given time frame, please provide that documentation. If [redacted] was in fact in the SHU under “RCTP Status,” please supply the Justice Center with the appropriate policy/directive pertaining to “RCTP status.”

Review conducted by: 

Angelina LoCascio, Facility Review Specialist

NEW YORK STATE OF OPPORTUNITY. | Office of Mental Health

ANDREW M. CUOMO
Governor

ANN MARIE T. SULLIVAN, M.D.
Commissioner

CHRISTOPHER TAVELLA, Ph.D.
Executive Deputy Commissioner

August 7, 2020

Denise M. Miranda, Esq.
Executive Director
Justice Center for the Protection of People with Special Needs
161 Delaware Avenue
Delmar, New York 12054

Dear Ms. Miranda:

We received your letter dated July 13, 2020 in response to the Justice Center's recent site visit to the Fishkill Correctional Facility Long Term Keeplock (LTKL) to determine the quality of mental health care provided to inmate-patients, and determine compliance with the SHU Exclusion Law, the Office of Mental Health's (OMH) policies, and the Department of Corrections and Community Supervision's (DOCCS) directives.

Below are the Justice Center's findings and recommendations, from the above-referenced review, and OMH's response to each. The related documentation is enclosed. Please note that the documentation includes protected health information and thus should not be redisclosed.

Per your letter, you have determined that the Fishkill Correctional Facility (CF) was not in compliance with the SHU Exclusion Law for the following reasons:

1. "[redacted] (DIN [redacted]) was admitted to the Fishkill CF LTKL on January 28, 2020, following his return from the Residential Crisis Treatment Program (RCTP). A DOCCS Suicide Prevention Screening Guidelines #3152 was not completed upon admission. An intake assessment was completed by OMH staff on January 29, 2020."

   OMH Response: OMH defers to DOCCS regarding this matter.

2. "[redacted] (DIN [redacted]) was admitted to the Fishkill CF SHU 200 on January 24, 2020. Mental health staff conducted an intake assessment with [redacted] on January 28, 2020. He met privately with mental health staff and no immediate mental health concerns were noted."

   OMH Response: The Justice Center's finding is inaccurate. [redacted] was admitted to the SHU 200 on Friday, 1/24/20 and was assessed on Monday, 1/27/20. The 1/27/20 progress note is enclosed with this response.

3. "[redacted] (DIN [redacted]) was admitted to the Fishkill CF LTKL on December 22, 2019, following his return from the infirmary. DOCCS staff completed a DOCCS Suicide Prevention Screening Guidelines #3152 upon admission to the LTKL. An intake assessment was not completed by OMH staff until December 24, 2019."

OMH Response: The Justice Center's finding is inaccurate. [redacted] returned to LTKL from RCTP status on 12/23/19; therefore, his 12/24/19 intake assessment was completed per policy.

4. "[redacted] (DIN [redacted]) was admitted to the Fishkill CF SHU 200 on January 13, 2020. DOCCS staff completed a DOCCS Suicide Prevention Screening Guidelines #3152 upon admission to the SHU 200. An intake assessment was not completed by OMH staff until January 15, 2020."

   OMH Response: As the clinician who completed this assessment is out on extended leave, policy cannot be reviewed at this time.

5. "[redacted] (DIN [redacted]) was admitted to the Fishkill CF SHU 200 on January 15, 2020. DOCCS staff completed a DOCCS Suicide Prevention Screening Guidelines #3152 upon admission to the SHU 200. An intake assessment was not completed by OMH staff until January 21, 2020."

   OMH Response: As the clinician who completed this assessment is out on extended leave, policy cannot be reviewed at this time.

   As two of the Justice Center's findings were inaccurate, and issues pertaining to OMH were only found for two patients out of a sample of 58 inmate/patients, OMH disagrees with the Justice Center's finding of noncompliance.

Recommendation #1:
"Please provide an update regarding the diversion of inmate/patients who are designated MHSL 1S to a Residential Mental Health Treatment Unit (RMHTU), if applicable. Please provide the dates in which their disciplinary hearings were concluded and the dates they transferred."

OMH Response:
OMH defers to DOCCS regarding this recommendation.

Recommendation #2:
"The Justice Center requests that DOCCS provide an explanation and/or evidence of any corrective actions that were taken pertaining to whether or not [redacted] was provided his psychotropic medications for two days while in the Fishkill CF SHU 200."

OMH Response:
It is unclear why the Justice Center directed this recommendation to DOCCS, as OMH staff are responsible for administering psychotropic medication at Fishkill CF. Upon OMH's review of the Medication Administration Record, it was found that, despite his report, [redacted] received his medications for all of October 2019, as prescribed.

Recommendation #3:
"Please provide documentation demonstrating [redacted] was assessed by mental health staff within the appropriate time frame in accordance with CBO Policy # 1.3 – Mental Health Referrals following the referral from the Justice Center."

OMH Response:
Progress notes demonstrating [redacted] was assessed on 2/4/20 and 2/5/20 are enclosed with this response. OMH would like to note that the handwritten list provided to the Fishkill CF Unit

Chief simply stated [redacted] was being referred for "no callouts or meds." Despite his report to the Justice Center, he had been assessed daily in RCTP from [redacted]/20-[redacted]/20 and was assessed again in SHU on 2/5/20; he was also receiving medication daily during this time. As OMH referrals are made for the purpose of identifying individuals who may need crisis and/or mental health services sooner than their next scheduled callout, it was determined there was no need for him to be reassessed in response to the Justice Center's referral.

Recommendation #4:
"...Given the findings of our review, OMH should assess how best to ensure that inmate/patients are seen per policy. This may include retraining for OMH staff at the Fishkill CF in CNYPC CBO Policy #9.27, Psychiatric Progress Notes to ensure inmate/patients are seen in a timely manner. The OMH Unit Chief should also complete quality assurance checks to ensure that inmate/patients are monitored in the required time frames. If there is an error and the inmate/patients were assessed within the given time frame, please provide the Justice Center with that information, if applicable."

OMH Response:
The Justice Center's findings are inaccurate regarding [redacted]. He transferred from Great Meadow CF to Fishkill CF's LTKL on 12/6/19, rather than 11/6/19. Therefore, the 12/16/19 psychiatric callout occurred sooner than required by policy.

Regarding [redacted], the Fishkill CF Unit Chief reviewed CNYPC CBO Policy #9.27 Psychiatric Progress Notes with the appropriate staff.

Recommendation #5:
"Please provide documentation demonstrating [redacted] was assessed by psychiatric staff, if applicable."

OMH Response:
The 2/6/20 Psychiatric Progress Note is enclosed with this response.

Recommendation #6:
"It is important that DOCCS and OMH staff communicate with one another to ensure OMH staff are aware that an inmate/patient returned to the facility and required an intake assessment. Given the findings of this review and other recent reviews at other correctional facilities, the Justice Center recommends that OMH and DOCCS develop a plan to ensure OMH staff are aware when an inmate/patient has returned, so they are able to conduct their required assessment. The Justice Center requests that this plan be provided for review. The Justice Center also requests the DOCCS Suicide Prevention Screening Guidelines #3152 from [redacted] admission to the SHU 200 on August 19, 2019. The OMH Unit Chief should continue to conduct quality assurance checks to ensure that inmate/patients are monitored in the required time frame, which assisted in determining that [redacted] had not been assessed accordingly."

OMH Response:
OMH would like to note that this was an oversight and is not a common occurrence at Fishkill CF. It is regular practice at Fishkill CF for the Inmate Records Coordinator to email a list of all incoming inmates to the facility. An inmate returning from another facility would be noted in the comment field as "court return." However, in [redacted] case, the appropriate clinician was inadvertently left off the email. Administrative staff will be more observant of the inmate/patients coming into the facility and will include all OMH staff on the incoming list email, if indicated, to ensure this does not happen again.

Recommendation #7:
"...Given the findings of our review, OMH should assess how best to ensure that inmate/patients are seen per policy. In past reviews, the Justice Center has recommended retraining in CBO Policy #9.30- Progress Notes for OMH staff at the Mohawk CF. It is apparent, however, that continuously retraining staff in this policy is not effective. The Justice Center recommends that the Mohawk CF develop a corrective action plan to ensure mental health staff are meeting with inmate/patients following their transfer per OMH policy. The Justice Center requests that the corrective action plan be provided for review. As stated before, the OMH Unit Chief should also complete quality assurance checks to ensure that inmate/patients are monitored in the required time frame. If there is an error and [redacted] was assessed within the given time frame, please provide the Justice Center with that information, if applicable."

OMH Response:
Since 2019, the time of this issue, Mohawk CF OMH staff have designated a staff member to ensure all active transfers are seen per policy and core documentation is completed within the appropriate timeframes. The new Mohawk CF Unit Chief has conducted chart reviews to assess the need for staff retraining and has found that staff are in compliance on this matter and all inmate/patients have been scheduled per policy. The Unit Chief is in the process of developing a training for all OMH staff to review documentation policies and to continue to stress the importance of scheduling inmate/patients timely.

Recommendation #8:
"Please clarify whether [redacted] did in fact leave the SHU and transfer to the RCTP. If there is an error and [redacted] was assessed by DOCCS and OMH upon his readmission to the SHU within the given time frame, please provide that documentation. If [redacted] was in fact in the SHU under 'RCTP Status,' please supply the Justice Center with the appropriate policy/directive pertaining to 'RCTP status.'"

OMH Response:
[redacted] was brought to the mental health unit on 10/15/19 by security due to reporting he was homicidal. Mental health staff assessed him on 10/16/19 and determined he did not require admission to the RCTP and was therefore returned to SHU. As he was never admitted to the RCTP, there was no need for OMH staff to complete a new SHU intake assessment upon his return.

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., Acting Executive Director, CNYPC
William Vertoske, Associate Director, Corrections Based Operations, CNYPC
File

NEW YORK STATE | Corrections and Community Supervision

ANDREW M. CUOMO
Governor

ANTHONY J. ANNUCCI
Acting Commissioner

July 27, 2020

Denise M. Miranda, Esq.
Executive Director
NYS Justice Center for the Protection
of People with Special Needs
161 Delaware Avenue
Delmar, NY 12054

Re: [redacted] Justice Center Oversight Action

Dear Ms. Miranda:

This is in response to the New York State Justice Center's report of the site visit conducted at Fishkill Correctional Facility on February 4-5, 2020 ensuring the quality of corrections-based mental health care for incarcerated individuals and compliance with the SHU Exclusion Law compliance.

Recommendations:

1. Please provide an update regarding the diversion of inmate/patients who are designated MHSL 1S to a Residential Mental Health Treatment Unit (RMHTU), if applicable. Please provide the dates in which their disciplinary hearings were conducted and the dates they were transferred.

Response:

[redacted], pending to Coxsackie RMHU. His hearing was completed on May 15th. His diversion to RMHTU has been delayed due to COVID-19 issue at Fishkill CF.

[redacted], his hearing was dismissed, and he returned to G.P. on February 7th.

[redacted] Hearing completed on January 30th and sanctioned with 30 days of confinement. He returned to G.P. after completion of his sanctions.

[redacted], Hearing completed on January 22nd and sanctioned with 30 days of confinement. February 11th returned to G.P. and on February 20th transferred Sing CORP. He was released on June 15th.

2. The Justice Center requests DOCCS provide an explanation and/or evidence of any corrective action that were taken pertaining to whether or not incarcerated individual [redacted] was provided his psychotropic medications for two days while in the Fishkill SHU 200.

Response:

The dispensing of psychotropic medications at Fishkill CF is the responsibility of Office of Mental Health (OMH). If OMH notified us of any issues they need assistance with DOCCS will work cooperatively with OMH to resolved.

6. It is important that DOCCS and OMH staff communicate with one another to ensure OMH staff are aware that an inmate/patient returned to the facility and required an intake assessment. Given the findings of this review and other recent reviews at other correctional facilities, the Justice Center recommends that OMH and DOCCS develop a plan to ensure OMH staff are aware when an inmate/patient has returned, so they are able to conduct their request assessment. The Justice Center requests that this plan be provided for review. The Justice Center also requests the DOCCS Suicide Prevention Screening Guideline #3152 form for [redacted] admission to the SHU200 on August 19, 2019. The OMH Unit Chief should continue to conduct quality assurance check to ensure that inmate/patients are monitored in the required time frame, which assisted in determining that Sokolov had not been assessed accordingly.

Response:

Upon further investigation, incarcerated individual [redacted] did return from court, but he was placed in General population instead of SHU, so no Suicide Screening Guideline Form #3152 was required. However, you raise a good point of improving the communication between DOCCS and OMH at Fishkill CF for incarcerated individuals returning to the facility, as well as system wide. OMH and DOCCS have been in the process of establishing suicide screening form for all incarcerated individuals returning to the facility from outside hospital, court, parole hearings, etc. This will assist in communication between DOCCS and OMH on incarcerated individuals returning to a facility. Once the suicide screening form is finalized will send you a copy.

Thank you for the opportunity to comment on your report. I look forward to continuing working productively with the Justice Center to improve the services for our population.

Sincerely,

B. Hilton

Bryan Hilton
Associate Commissioner

cc: Emily Williams, Acting Superintendent – Fishkill Correctional Facility
Angelina LoCascio, Facility Review Specialist