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

KATHY HOCHUL
Governor

DENISE M. MIRANDA
Executive Director

February 23, 2024

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

Jamie Donahue
Associate Commissioner
NYS Department of Corrections
And Community Supervision
The Harriman State Campus-Building 2
1220 Washington Avenue
Albany, NY 12226-2050

Dear Dr. Lee and Associate Commissioner Donahue:

Thank you for your responses to the Justice Center for the Protection of People with Special Needs (the Justice Center) review of the mental health services provided to [redacted] (DIN# [redacted]), an incarcerated individual who died on [redacted], at the Greene Correctional Facility (CF).

Based on the responses received from the Department of Corrections and Community Supervision (DOCCS) and Office of Mental Health (OMH), the Justice Center now considers this report to be final. [1]

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

[1] OMH response on February 12, 2024 and DOCCS response on February 5, 2024

Cc: Denise M. Miranda, Esq., Executive Director, Justice Center
Robert Miller, Acting Executive Deputy Director, Justice Center
Melissa Finn, Director, Forensics
Katie Farley, Supervising Facility Review Specialist, Forensics
Dr. Anne Sullivan, M.D., Commissioner, OMH
Danielle Dill, Executive Director, CNYPC, OMH
William Vertoske, Deputy Director, Corrections-Based Operations, OMH
Lisa Murphy, Acting Director of Quality Management, OMH
Maureen Morrison, Director of Suicide Prevention, OMH
Meaghan Bernstein, Advocacy Letter Coordinator, OMH
Daniel Martuscello, Acting Commissioner, DOCCS

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

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

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

At the time of their death, the incarcerated individual was a 19-year-old serving their first NYS state bid with a 1-to-3-year sentence for Burglary in the 2nd, and two counts of Grand Larceny in the 4th. They had a Conditional Release date of March 31, 2024, and a Maximum Expiration date of March 31, 2025. Although this was their first incarceration, the individual had four previous arrests and one juvenile delinquent adjudication.

Prior to their incarceration, the individual received inpatient and outpatient mental health services in the community on multiple occasions for attention deficit hyperactive disorder (ADHD), mood disorder, and oppositional defiant disorder. Past inpatient records indicate treatment for mood disorders with aggressive behaviors and mental health concerns. There was evidence of treatment in 2015 for suicidal ideation.

According to the individual's November 10, 2022 Screening/Admission note, upon entering the Elmira Correctional Facility reception center, they were diagnosed with antisocial personality disorder (ASPD). The individual was designated a Mental Health Service Level (MHSL) 3 and admitted to services with an active medication order to include Remeron and Trazadone. Their treatment would include individual therapy and medication with continued risk assessment every 30 days or as needed. The risk factors identified included their young age, early in their first bid, new/pending transfer, residing in reception, limited supports, antisocial personality disorder traits, history of aggression, guarded affect, poor historian and reported poor sleep. They reported poor sleep adding that they can go 7-10 days without sleep "without adverse effects." They denied any current or history of suicidal ideation and a Patient Safety Screener-3M (Modified) completed on November 10, 2022, did not show any concerns.

In a Termination Transfer Progress Note dated November 25, 2022, the individual was scheduled for a routine active transfer to the Greene CF via an overnight at the Ulster CF. They were considered guarded, but congruent with mood and fair insight. The progress note indicated that there were no recent changes in risk or protective factors.

The individual met with the Green CF DOCCS staff for an initial interview on November 30, 2022. They denied any safety or "OMH concerns" and a treatment plan was

initiated.[1] On December 2, 2022, the individual was involved in an altercation with another incarcerated individual where they exchanged closed fist punches. During the subsequent investigation, the individual stated they did not want to live at Greene CF and fought due to being part of a group known as the "latin kings".[2] A "cutting type of weapon consisting of a sharpened piece of ceramic tile with a paper handle wrapped in clear tape" was found on the individual after the altercation. After the incident, the individual was escorted to medical, and it was discovered they had a 2 ½ inch scrape on their right neck and a 3 ½ inch red area on their right cheek. At 3:00 p.m. a DOCCS Mental Health Referral was made by infirmary staff due to the individual "crying often for no apparent reason" and "appearing sad." According to the document, those two *non-verbal/unusual behaviors* would warrant an immediate phone referral, however, regular referral was checked and "call to [redacted] @ 3PM 12/2/22 - regular referral recommended" was documented on the form. A regular referral would be forwarded to OMH, triaged, and the individual would be seen within fourteen days.[3] Later that same day, December 2, 2022 at 6:36 p.m., the individual was transferred to the Residential Rehabilitation Unit (RRU) and a suicide prevention screening guidelines form was completed upon their transfer. They did not answer affirmatively to any of the trigger questions; therefore, no mental health referral was required.

On [redacted], at 3:38 p.m. while handing out evening meals a corrections officer was unable to see the individual inside their cell due to a sheet being hung in the front of the bunk. The officer banged on the cell, received no response which prompted them to enter the cell. The individual was observed with a sheet around their neck and a medical emergency was called. The officer cut the sheet and placed the individual on the floor where they were unresponsive but still breathing. A nurse initiated a sternum rub with no response. At 3:42 p.m. the AED was applied with no shock advised. The individual was moved onto a stretcher to the upper holding pen. At 3:48 p.m. CPR was initiated and Narcan was administered to the left nostril at 3:49 p.m. The Coxsackie ambulance arrived at 4:02 p.m. and at 4:32 p.m. a paramedic contacted the Albany Medical Center and was advised to halt all life saving measures and death was pronounced at 4:34 p.m. According to the Unusual Incident Report, the individual was last observed by security staff during rounds at 1:35 p.m.

A termination transfer progress note completed on December 5, 2022 noting the individual's death. Under the *Clinical Formulation of Risk* section, it is documented that "Upon transfer into the RRU a 3278 was conducted. [redacted] allegedly answered 'yes' to the question asking if he lost a loved one in the past six months. He said one of his brothers died. OMH has not received the referral at the time of his death." The Justice Center was provided an illegible copy of the *DOCCS Mental Health Screening for Reception/Classification, Transfers, SHU or Separate KL Unit or Adolescent Offender Admissions* (Form 3278). It is unknown if it was completed upon their reception to the Elmira CF or the Greene CF RRU following their December 2, 2022 fight.

[1] DOCCS Chronological for Greene CF

[2] DOCCS Inmate Misbehavior Report dated December 2, 2022

[3] CNYPC CBO Policy #1.3 Mental Health Referrals

JUSTICE CENTER FINDINGS:

1. **The incarcerated individual's DOCCS Mental Health Referral, dated December 2, 2022, was designated as a regular referral instead of an immediate referral.**

   A DOCCS mental health referral completed by medical staff at 3:00 p.m. noted the individual "cries often for no reason" and "appears sad". Based on the DOCCS mental health referral form these symptoms warranted an immediate phone referral, however, following a phone call to "[redacted]", the referral was designated as a regular referral which means the individual would be triaged by OMH and be seen by mental health within 14 days.

   At the time of the referral, the incarcerated individual was 19 years old, reported gang affiliation, and had been in DOCCS custody for less than a month. They had no known contact with mental health staff at Greene CF since their arrival between November 25, 2022 and November 28, 2022, and they had multiple risk factors upon entering DOCCS custody.[4] These included being young and being early in their first incarceration, pending transfer, limited supports, antisocial personality disorder traits, history of aggression, and poor sleep. According to their treatment history prior to their incarceration they had received inpatient and outpatient treatment for mood disorders and suicidal ideation. Additionally, the individual had been involved in a physical altercation earlier in the day and was scheduled to be admitted into the RRU until their disciplinary hearing. Despite those factors and their current circumstances, the referral was designated as a regular referral, where the individual may not be seen by mental health staff for up to fourteen days per policy.[5]

REQUEST:

Given the multiple risk factors present and the individual's presentation, please clarify whether it was OMH or DOCCS that was called on December 2, 2022 as a result of the referral from DOCCS. In addition, please provide the Justice Center with an explanation and the justification as to why this referral was marked as a regular referral and the individual was not seen immediately by OMH.

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[4] There are two Termination Transfer Notes, one dated November 25, 2022, noting a transfer from the Elmira CF to the Greene CF via an overnight to the Ulster CF and another dated November 28, 2022, noting a transfer from the Greene CF to the Greene CF RRU.

[5] CNYPC CBO Policy #1.3- Mental Health Referrals- "A referral suggesting that the referred inmate is at imminent risk for self-harm or injury to others requires that the inmate be assessed immediately and/or placed on a Suicide Watch" and "All other referrals are addressed within a time frame that is consistent with the nature of the referral and within fourteen days."

2. **OMH indicated on the individual's December 5, 2022 Termination Transfer progress note that a "3278 was conducted" and it appeared to have warranted a referral to mental health.**

   According to the progress note, although no acute warning signs were reported or witnessed, the individual "allegedly answered 'yes' to the question asking if he lost a loved one in the past six months. He said one of his brothers died. OMH has not received this referral at this time." The Justice Center was provided an illegible copy of the *DOCCS Mental Health Screening for Reception/Classification, Transfers, SHU or Separate KL Unit or Adolescent Offender Admissions* (Form 3278). It is unknown when it was completed but it can only be assumed it was either upon their transfer to the Greene CF or the Greene CF RRU following their December 2, 2022 fight. Despite not knowing when it was filed, there are no documentary evidence that the individual was seen by OMH in the days leading up to their death.

   Based on the Incarcerated Individual Suicide Preventive directive provided with the DOCCS response on February 5, 2024, Form 3278 is completed by health service staff when entering DOCCS custody at reception, transfer into a facility, and admission to a Special Housing Unit (SHU), Step-Down Program (SDP), RRU, Residential Mental Health Unit (RMHU), Therapeutic Behavioral Unit (TBU), and Behavioral Health Unit (BHU). This form should be completed as soon as possible within 24 hours or the day of the incarcerated individual's arrival.

3. **The individual was last observed in their cell by security staff two hours prior to their death.**

   In the [redacted] Unusual Incident report, it is noted that the last time the individual was observed was at 1:35 p.m. in their cell. At 3:38 p.m. an officer was unable to observe the individual inside their cell due to a sheet being hung in the front of the bunk. The officer entered the cell and found the individual was observed with a sheet around their neck and a medical emergency was called. Based on the RRU directive," Rounds will be made at least every 30 minutes, but on an irregular basis. Each incarcerated individual and cell will be observed to ensure that anyone in need of medical attention receives prompt care".[6]

REQUEST:

Please provide the Justice Center with the RRU logbook and round sheets for [redacted] and an explanation for why the rounds did not occur every 30 minutes per directive.

[6] RRU Directive: Section XI Inspections-A

Review Conducted by:

Kathryn Farley, Supervising Facility Review Specialist

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

February 12, 2024

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 December 29, 2023 in response to the Justice Center's (JC) review of the mental health services provided to [redacted] (DIN# [redacted]), an incarcerated patient who died on [redacted] at Greene Correctional Facility (CF).

Below are the Justice Center's findings and requests from the above-referenced review, and the Office of Mental Health's (OMH) response to each.

Request #1:
"Given the multiple risk factors present and the individual's presentation, please clarify whether it was OMH or DOCCS that was called on December 2, 2022 as a result of the referral from DOCCS. In addition, please provide the Justice Center with an explanation and the justification as to why this referral was marked as a regular referral and the individual was not seen immediately by OMH."

OMH Response:
The DOCCS nurse who completed the 12/2/22 referral called an OMH staff person who advised that the referral could be treated as "regular." As such, the paper copy was processed as a regular referral and not received by OMH until 12/6/22. This could not be reviewed with the clinician involved, as they no longer work for CNYPC. This situation was discussed at CNYPC administrative review meetings and the joint OMH and DOCCS Suicide Prevention Work Group (SPWG). Both agencies acknowledged the need to retrain their respective staff on the importance of referrals and triaging accordingly.

Request #2:
"The Justice Center requests the DOCCS Directive pertaining to Form 3278, which should include who is authorized to complete the form, in what time frame it should be completed, and the steps taken to refer the individuals for mental health assistance."

OMH Response:
The Form 3278 in question is dated 12/2/22, 6:45pm. It was received by OMH staff on 12/6/22, after [redacted] died, along with hard copies of other referrals dated 12/2/22, and therefore could not be addressed by mental health. The matter of these referrals not being date stamped by OMH

was addressed by the Corrections-Based Operations Risk Management Department's Special Investigation.

Request #3:
"Please provide the Justice Center with the RRU logbook and round sheets for [redacted], and an explanation for why the rounds did not occur every 30 minutes per directive."

OMH Response:
OMH defers to DOCCS regarding this matter.

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

KATHY HOCHUL
Governor

DANIEL F. MARTUSCELLO III
Acting Commissioner

February 5, 2024

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

Greene Correctional Facility
Justice Center Oversight Action
Draft Mental Health Service Review [redacted]
JC#: [redacted]

Dear Deputy Director Robinson:

This is in response to the New York State Justice Center's review of the quality of corrections-based mental health care for [redacted], an incarcerated individual who died on [redacted], at the Greene Correctional Facility's RRU.

Request:
Given the multiple risk factors present and the individual's presentation, please clarify whether it was OMH or DOCCS that was called on December 2, 2022, as a result of the referral from DOCCS. In addition, please provide the Justice Center with an explanation and the justification as to why this referral was marked as a regular referral and the individual was not seen immediately by OMH.

Response:
On December 2, 2022, at approximately 3:00 p.m., a DOCCS nursing staff made an immediate phone referral to an OMH clinician. Based on the information shared, the OMH clinician recommended a regular referral instead. Form 3150 is attached.

After reviewing this unfortunate incident, some corrective actions were taken by DOCCS and included additional training for the staff at Greene Correctional Facility. Our mental health department has developed and presented a training on Mental Health Referrals on September 22, 2023, at Greene Correctional Facility.

DOCCS will defer to OMH for the explanation as to why incarcerated individual [redacted] was not seen immediately.

REQUEST:
The Justice Center requests the DOCCS Directive pertaining to Form 3278, which should include who is authorized to complete the form, in what time frame it should be completed, and the steps taken to refer the individuals for mental health assistance.

Response:
Directive #4101, 'Incarcerated Individual Suicide Prevention," which pertains to form 3278 is attached.

Request:
Please provide the Justice Center with the RRU logbook and round sheets for [redacted], and an explanation for why the rounds did not occur every 30 minutes per directive.

Response:
Copies of the RRU logbook for [redacted], are attached. This incident is still under review by the Office of Special Investigation (OSI) and upon completion, DOCCS will take any necessary corrective actions.

Every death by suicide is a tragic event and we do not take this lightly. These misfortunate events are thoroughly reviewed at several levels by our department, which includes investigations by Office of Special Investigations, Health Services, DOCCS Bureau of Mental Health and the Office of Mental Health.

In collaboration with OMH, we continue to review trends and potential prevention efforts at various work groups attended by administrative staff from both agencies.

We continue to use the JPAY secure messaging system to educate and inform the family and friends of incarcerated individuals of the warning signs for suicide risk, and how to reach out for help.

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

Sincerely,

James Donahue
Associate Commissioner

Attachments

cc: Denisha Goodman – Superintendent Greene Correctional Facility
Kathryn Farley, Supervising Facility Review Specialist, NYS Justice Center