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

KATHY HOCHUL
Governor

DENISE M. MIRANDA
Executive Director

February 29, 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], an incarcerated individual who died on [redacted] at the Clinton Correctional Facility.[1] We now consider this report to be final.

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 of Outreach, Prevention and Support

[1] OMH Response dated January 31, 2024 and DOCCS response dated February 5, 2024

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

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Final Mental Health Service Review [redacted]
JC#: [redacted]

The Justice Center's review of the care provided by the Central New York Psychiatric Center (CNYPC) and the Department of Corrections and Community Supervision (DOCCS) to [redacted] six months prior to his suicide follows below.

Background

[redacted] was a 30-year-old incarcerated individual who was serving a state bid at the Clinton CF with a 15-year sentence for Aggravated Sexual Abuse in the 2nd Degree and Assault in the 1st Degree. They were scheduled for a parole hearing date in July 2033. Their Conditional Release (CR) date was September 18, 2033 and their Maximum Expiration (ME) date was November 10, 2035.

Prior to incarceration, it was noted that the individual reported one suicide attempt in 2018 and a review of their records indicated they attempted to overdose on barbiturates in 2020 and received treatment at a hospital. It was also noted they "reported multiple suicide attempts without precipitants." [1] The individual received inpatient and outpatient services for their psychiatric concerns and substance abuse issues in the community. They endorsed a history of using benzodiazepines, opiates, stimulants such as Adderall and Cocaine, Cannabis, Alcohol, and lysergic acid diethylamide (LSD).

The individual was admitted to mental health services at the Elmira Reception Center in March 2022 and designated a Mental Health Service Level (MHSL) 2 with a diagnosis of borderline personality disorder. [2] Their Treatment Plan was developed to reflect their mental health goals, specifically their history of depression and self-harming behaviors. The plan also indicated their seizure disorder would be addressed by medical staff and their substance related issues would be addressed by DOCCS. [3] At the end of March 2022, the individual transferred from the Elmira CF to the Clinton CF. Psychiatric staff who assessed them in general population at the Clinton CF also diagnosed them with Alcohol Use Disorder Severe. [4] Although borderline personality disorder was their primary diagnosis, an April 11, 2022 Initial Psychiatric Progress Note documented that anti-social personality disorder should remain a secondary diagnosis. Prior to the Justice Center's review period psychiatric staff were working closely with the individual to address their psychiatric symptoms with medication changes. [5]

The individual met with psychiatric staff on March 14, 2023 where they reported they utilize their tablet however they recently had concerns with mood changes. They discussed that "2 of father's sisters had passed away back-to-back" and that for about a month they had felt 'depressed' 'empty' 'not talking much'". The individual discussed that their mother is supportive and that he gets visits from her and their sisters. As a result of their mood changes, their

[1] Core History dated July 13, 2023.
[2] Diagnosis Record dated March 22, 2022.
[3] Treatment Plan dated March 16, 2022.
[4] Initial Psychiatric Progress Note dated April 11, 2022.
[5] Physician's Orders and Psychiatric Progress Notes from 2022 to 2023.

Effexor XR increased and their Remeron dosage remained the same. During a call out with mental health staff the following day, March 15, 2023; they reported that they completed their General Education Diploma (GED) and wanted to enroll in college courses. They stated they were in close contact with their family members and a friend, remained positive and did not have any immediate mental health concerns. They stated they hoped their recent medication adjustment would help maintain their mood. It was noted they would be seen bi-monthly or by the request of the individual or DOCCS staff.

The incarcerated individual met with mental health staff on May 17, 2023 and stated they were supposed to start college courses but that the courses might be offered in the fall instead. They continued to work in the tailor shop and stated that they read books and listened to music to keep them occupied. They also continued to have visits with their family. No mental health concerns were mentioned during this session. The individual attended a call out with psychiatric staff on June 13, 2023 and it was documented they were compliant with their medications and had no symptoms of mood or anxiety concerns. They did report frustration with poor sleep. Their Remeron and Effexor XR remained the same, and Vistaril was added to their medication regimen.

On July 12, 2023, the individual received a Tier II ticket at the Clinton CF for Creating a Disturbance and Refusing a Direct Order after they were talking in the commissary bull pen even thought they had been spoken to regarding this issue repeatedly and there is a sign in the bull pen that specifically states, “no talking.” They met with mental health staff on July 13, 2023; they informed mental health staff that they received their GED and graduated with some of the highest test scores in their class. They reported receiving a Tier II ticket and stated they were trying to “brush it off” as they did not receive any sanctions. The individual noted that Vistaril was added to their medication regimen to assist them with difficulty sleeping. They continued to report remaining engaged in preferred activities, receiving visits and communicating with their family and working in the tailor shop. They stated that they had been working on a short story on their tablet about real events. No mental health concerns were noted in this session, and it was noted they continued to remain stable. Included in the disciplinary hearing packet was an email they sent to their mother on July 15, 2023 regarding the ticket; they denied the incident occurred, were very upset stating this was the only ticket they had ever received and focused on losing their commissary privileges and their job as the official shop foreman. Their disciplinary hearing began on July 20, 2023 and concluded on the same date. They were found guilty of both charges and received a loss of commissary and recreation for a period of 30 days.

Per the incarcerated individual’s Physician’s Orders, their medications were reviewed for continuity of care on September 11, 2023 and no changes were made to their medication regimen. When they met with mental health staff on September 12, 2023, they stated that although they had been medication compliant, they had missed a few doses of their morning medications because they were “too tired to even get up,” but denied any negative side effects from missing their medications. The individual reported they were sick and denied any immediate distress. Sick call and emergency sick call was discussed.”. They also reported they had “not missed work until recently due to not feeling well physically.” The individual went on to state that due to the Tier II ticket they received, they could no longer be the tailor shop instructor. They remained hopeful that they would begin college courses in the fall and wanted to further their education. They reported receiving visits and remaining in contact with their family, indicating they were concerned with their sister’s “reckless and impulsive behavior” but noted that “she has to do the work” to get better. The individual continued to remain engaged in their preferred activities and enjoyed assisting peers in the tailor shop. They did not cite any mental health concerns during this session and continued to remain both engaged and future oriented.

On [redacted] another incarcerated individual noticed the individual was in distress inside their cell. The incarcerated individual alerted security staff and when security staff arrived at the individual's cell, they were observed in distress but "alert and responsive to verbal commands." Additional security staff responded and opened the cell door. The individual was removed from their cell by security staff and placed on a backboard on the company, remaining alert and responsive. While on the way to the facility hospital, security staff notified the Watch Commander and EMS. Once in the facility hospital elevator, the individual became unresponsive and medical staff could not detect a pulse. Security staff initiated CPR chest compressions, medical staff applied an AED, but no shock was advised. A total of ten doses of Narcan were administered with no effect. The ambulance arrived at the facility hospital at approximately 3:00 p.m. and [redacted] was pronounced deceased. Facility medical staff medically examined [redacted] and noted a 1 and ½ inch long laceration to his left forearm. It was noted that [redacted] was last seen alive at 2:20 p.m. When examining his cell for evidence, investigators recovered "fingernail clippers, state razor with no blade, two suicide notes, and a razor blade measuring 1 and ½ inch long by 3/8" wide" in his small cell locker.

Justice Center Findings

1. **The incarcerated individual's JPAY letter to their mother includes concerning statements about their current state of mind after receiving the ticket.**

   The individual's JPAY letter to their mother was sent on July 15, 2023 and indicated that they had already gone in front of the tier board and received their sanctions from the Tier II ticket. The disciplinary hearing packet documents that the individual's hearing began and concluded on July 20, 2023.

   Furthermore, the individual was clearly disturbed by the ticket and losing their commissary, discussing at the end of letter, "that it's going to be over soon" and "it's all over, but I guess there's some relief in knowing there'll be no more bullshit." It also notes, "if I miraculously make it to 7/29 I'll bring the ticket to show you."

   Requests:

   Please provide an explain of why this JPAY letter was included in the tier hearing packet and whether it was forwarded to OMH. If it was forwarded to OMH, please provide information about the follow up from OMH.

2. **Per documentation received by the Justice Center, [redacted] Treatment Plan was not reviewed or updated according to policy.**

   The Justice Center did not receive any documentation demonstrating that the incarcerated individual's Treatment Plan review was conducted within the designated time frames. [6] The only document provided was the individual's March 16, 2022 Treatment Plan.

[6] OMH CBO Policy #9.23 states, "Six (6) months from the date of the Treatment Plan completion, every six (6) months thereafter, AND as indicated if a significant change in the incarcerated patient's mental health functioning, behavior, or significant event (i.e., suicide attempt) warrant a new review and/or update of the current Treatment Plan."

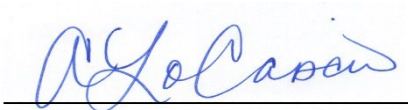
Request and Recommendations:

Treatment Plan reviews should be completed every six months to evaluate and document the incarcerated individual's progress towards their goals and objectives identified in the Treatment Plan. Given the findings of this review, clinical staff at the Clinton CF should be re-trained on OMH CBO Policy #9.23 – Treatment Plan Review and documentation of this training should be provided to the Justice Center.

3. **It is the Justice Center's understanding that the OMH Special Investigation of the incarcerated individual's mental health treatment is "currently ongoing."** [7]

Request:

Please forward the OMH investigation into the individual's mental health treatment to the Justice Center upon completion.

Review conducted by: 
Angelina LoCascio, Supervising Facility Review Specialist

[7] OMH Record Request email dated November 30, 2023.

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

January 31, 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], an incarcerated patient who died on [redacted] at Clinton 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:
"Please provide an explain of why this JPAY letter was included in the tier hearing packet and whether it was forwarded to OMH. If it was forwarded to OMH, please provide information about the follow up from OMH.

The Justice Center also requests confirmation of the date of the hearing since the JPAY letter says the hearing occurred on July 15."

OMH Response:
OMH staff at Clinton CF were not made aware of this JPAY letter, nor was this information shared with OMH in the joint Suicide Prevention Work Group reviews. OMH defers to DOCCS regarding the remainder of this request.

Recommendation #2:
"The Justice Center recommends that DOCCS Central Office complete a review of the circumstances and evidence collected referencing the incarcerated individual's death to ascertain whether the laceration should have been treated sooner and why the individual needed ten doses of Narcan."

OMH Response not indicated as this recommendation is directed to DOCCS.

Request and Recommendation #3:
"Treatment Plan reviews should be completed every six months to evaluate and document the incarcerated individual's progress towards their goals and objectives identified in the Treatment Plan. Given the findings of this review, clinical staff at the Clinton CF should be re-trained on OMH CBO Policy #9.23 – Treatment Plan Review and documentation of this training should be provided

to the Justice Center. Should this document exist, please forward it to the Justice Center for review."

OMH Response:
This matter was also discovered during the Corrections-Based Operations (CBO) Risk Management investigation and will be addressed via the Special Investigation which is currently in progress.

Request #4:
"Please forward the OMH investigation into the individual's mental health treatment to the Justice Center upon completion."

OMH Response:
The CBO Risk Management Special Investigation will be provided to the Justice Center once it is closed at the Incident Review Committee.

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

Clinton Correctional Facility
Draft Mental Health Service Review [redacted], [redacted]
JC#: [redacted] – Clinton Correctional Facility

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], [redacted], an incarcerated individual who died on [redacted], at the Clinton Correctional Facility.

Requests:
Please provide an explanation of why this JPAY letter was included in the tier hearing packet and whether it was forwarded to OMH. If it was forwarded to OMH, please provide information about the follow up from OMH.

The Justice Center also requests confirmation of the date of the hearing since the JPAY letter says the hearing occurred on July 15.

Response:
Every death by suicide is a tragic event and we do not take this lightly. These unfortunate 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. Corrective actions are recommended if necessary. This incident was reviewed by the Mortality Review committee at Central Office and the hearing officer in this case reported he did not utilize the letters during the hearing and did not forward them to OMH. The recommended plan of corrective action includes educating and training the hearing officer on the mental health referral process (Form 3150) in accordance with Directive #4101 "Incarcerated Individual Suicide Prevention". The disciplinary hearing was completed on July 20, 2023.

Recommendation:
The Justice Center recommends that DOCCS Central Office complete a review of the circumstances and evidence collected referencing the incarcerated individual's death to ascertain whether the laceration should have been treated sooner and why the individual needed ten doses of Narcan.

Response:
The mortality review concluded that when the Registered Nurse (RN) arrived at the scene of the incident, the security staff had placed incarcerated individual [redacted] on a backboard outside his cell and was responsive to the RN's voice. It is documented that his pulse was 110 and respirations were 22. The RN noted a laceration on incarcerated individual's [redacted] left forearm with no active bleeding. She reported that the laceration appeared non-significant and did not need immediate attention. On route to the medical building, incarcerated individual [redacted] became unresponsive. Security staff began CPR, the RN applied the AED, and a second RN applied oxygen and administered Narcan. CPR and Narcan (administered every 3 minutes) were continued until the ambulance arrived in compliance with Directive #4059, "Response to Health Care Emergencies".

Request and Recommendations:
Treatment Plan reviews should be completed every six months to evaluate and document the incarcerated individual's progress towards their goals and objectives identified in the Treatment Plan. Given the findings of this review, clinical staff at the Clinton CF should be re-trained on OMH CBO Policy #9.23 – Treatment Plan Review and documentation of this training should be provided to the Justice Center. Should this document exist, please forward it to the Justice Center for review.

Response:
DOCCS will defer to OMH for this request.

Request:
Please forward the OMH investigation into the individual's mental health treatment to the Justice Center upon completion.

Response:
DOCCS will defer to OMH for this request. We continue to review every death by suicide thoroughly. In collaboration with OMH, we continue to review trends and potential prevention efforts at various work groups attended by administrative staff from both agencies.

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

cc: Mariejosee King, Superintendent Clinton Correctional Facility
Angelina Locasio, Supervising Facility Review Specialist, NYS Justice Center