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

KATHY HOCHUL
Governor

MARIA LISI-MURRAY, ESQ.
Acting Executive Director

August 28, 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 Clinton 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, Outreach, Prevention and Support

[1] OMH response on May 6, 2024 and DOCCS response on April 29 2024

Cc: Maria Lisi-Murray, Esq., Acting Executive Director, Justice Center
Robert Miller, Executive Deputy Director, Justice Center
Melissa Finn, Director, Forensics
Kathryn Farley, 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, 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.

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 41 years old and serving their first NYS bid for Predatory Sexual Assault against a Child, Incest in the 1st degree, Attempted Murder in the 2nd degree, and Sexual Abuse in the 1st degree. They had a 46 year to life sentence with a parole interview date of August 2055, no conditional release, and a maximum expiration of life. According to their clinical record, the individual did not receive mental health treatment prior to their incarceration. They did self-report a history of suicidality describing four previous suicidal attempts and gestures, one incident occurred in county jail when they used a comb to cut their wrist. The other three occurred prior to incarceration, including an incident in 2008 when they took approximately 50 Celexa pills after their girlfriend broke up with them.[1] The individual was unable to remember the details, methods, or corresponding dates for the other two of incidents.

The individual was admitted to the mental health caseload on July 3, 2010, during reception as a Mental Health Service Level (MHSL) 2 due to depression and anxiety. They were changed from a MHSL 2 to a 3 on September 19, 2013, due to their stability. Their most recent diagnosis record was dated June 15, 2015, and noted the individual was diagnosed with Persistent Depressive disorder, alcohol, cannabis and cocaine use disorder. According to their Core History, the individual spent their early incarcerated years working on their appeal and in recent years was working on apprenticeships and became a tool clerk in custodial maintenance in 2019.

On October 3, 2022, the incarcerated individual was seen for their regularly scheduled mental health callout while in the Clinton CF Assessment and Program Preparation Unit (APPU). They informed staff that they refused to take their psychiatric medications over the past two days as they wanted to stay awake to watch television. They did report increased anxiety. Mental health staff noted in their progress notes, they believed the anxiety was a result of not taking their medication and the individual reported being

[1] OMH Core History

worried about their family while they were traveling. At the time, the individual worked in the tailor office but recently asked to be moved back to their previous job in custodial services. They were informed they needed to remain in the tailor shop for another 60 days to assist with a big project. The individual noted that they continued to work with their legal team who they believed would help them get released.

The individual was next seen by mental health staff on December 2, 2022, for their regularly scheduled call out. They reported medication compliance but voiced that they continue to be unhappy with their current job placement, and it was impacting their stress levels. They discussed taking up drawing again as it helped with their stress levels. Although they reported that they had phone contact with their mother and aunt, they were concerned because their mother hadn't answered the phone recently. They stated they would try again that weekend.

On January 9, 2023, the individual reported during their scheduled mental health monthly call out that they were happy they had been moved back to their previous job in custodial services. They denied any acute mental health symptoms and were compliant with their psychiatric medications. According to the progress note, the individual reported increased anxiety due to a scheduled outside hospital trip to get an MRI on their wrist. The individual acknowledged that the anxiety was due to the fact that they would be around a lot of people in the community, and they had not had any outside trips during their incarceration. They also noted that the Innocence Project had written to let them know they would not be taking on their legal case. The individual stated they planned to get a lawyer from "the outside" to assist with their case instead regardless of the expense.

During their February 10, 2023, regularly scheduled callout with mental health staff, the individual reported that they made themselves go on their outside hospital trip and it went better than they thought it would. When they returned to the facility, they were drenched in sweat due to anxiety. They continued to be medication complaint and denied any acute mental health symptoms including suicidal/homicidal ideation, plan, and intent. The individual reported maintaining contact with their family members and had recently reconnected with two old friends.

The individual attended a psychiatric callout on March 2, 2023, and reported being stressed about an upcoming assessment regarding their placement in the APPU. They felt safe in the APPU and did not want to move. They told psychiatric staff they had not been sleeping well the last couple weeks due to the stress. Their prescribed doses of Remeron and Vistaril were continued, and they were scheduled to follow up in three months. The individual discussed concerns about their neighbor in their regular scheduled callout on March 23, 2023, as their neighbor's mother had recently passed and that they offered support, trying to talk to them. They reported anxiety about an

upcoming meeting with the housing committee and their fear they will get transferred out of the APPU. The individual and clinician worked through the plan of what they would say to the committee. They denied any mental health symptoms as well as any suicidal/homicidal ideation, plan, or intent. According to the DOCCS Chronological Record, on March 24, 2023, the "Subject was seen by the assessment committee on this date and the committee has recommended a referral."

On [redacted], at approximately 10:50 p.m. security staff discovered the individual slumped over in their cell with their back against the cell bars. A medical emergency was called, and staff noted they had a shoestring tied around their neck and the cell bars. At 10:53 p.m., the response team and medical arrived to the cell. The staff removed the shoestring and opened the door. The individual was placed on a stretcher and the AED was applied by the Nurse. There was no shock advised so staff applied a bag valve mask and started CPR. At 11:02 p.m., the first dose of Narcan was applied to the right nostril and the ambulance was called. A total of 10 doses of Narcan were given with the desired effect not achieved. The individual was moved to the infirmary and CPR was done continuously by security staff. The ambulance arrived at the facility at 11:22 p.m. and the individual was pronounced deceased at 11:36 p.m.

According to the OMH Special Investigation Final Report, dated January 2, 2024, it was learned after the individual's death that they were feeling anxious about possible negative consequences related to communication on their tablet with a former DOCCS employee.

Justice Center Findings:

1. **The OMH clinical record inconsistently documents the individual's history of suicidal gestures and attempts.**

   The individual's most recent Comprehensive Suicide Risk Assessment (CSRA), dated September 3, 2020, did not have a history of suicidal behavior checked as a risk factor despite it also indicating that there was one *verified suicide attempt*. In the assessment of previous suicide attempts, it was noted "no hx. of suicide attempts" and there is no documentation of any of the previous suicidal gestures or attempts. Per the individual's Core History, which was updated on March 27, 2020, the individual reported "four previous suicide gestures" including an incident where they cut their wrist with a comb upon their admission to county jail.

   According to the individual's Treatment Plan, dated January 9, 2023, "there is no record of suicide attempts in the patient's history or self-report." Lastly, the Termination-Transfer Progress Note competed upon the individual's death states "Reported to have cut wrist two days after his arrest and was placed on suicide watch for 3 days. He had a small superficial scar on his wrist. September 13,

2008, he reported an attempt to overdose by ingesting approximately 50 Celexa pills, due to girlfriend leaving him. He also cut wrists in 2005."

Recommendation:

The individual's clinical records lack depth and appear as though clinical staff were simply transcribing the individual's report; not digging into the underlying issues or concerns. This is evident in the inconsistent documentation of the individual's suicidal history. The Justice Center requests that the CNYPC Clinical Director review the record to determine if the individual's suicidal history has been documented correctly in the clinical record. In addition, the Justice Center requests that Clinton CF staff are retrained on the importance of consistently documenting previous suicidal gestures, attempts or ideations for the individual's entire bid.

2. **There is no clinical progress note referencing the outcome of the individual's Transfer Assessment Committee (TAC) meeting on March 24, 2023.**

   Per the DOCCS Chronological Record, the individual had an assessment meeting on March 24, 2023, and a referral was recommended. Despite the individual telling mental health staff that this meeting was causing them anxiety, there does not appear to be any follow up from mental health staff in the week after the meeting and prior to their death.

   According to the OMH Special Investigation, an OMH clinician was present during the individual's TAC meeting, however no progress note was written. As a result of the investigation, the Clinton CF OMH Unit Chief was requested to have a supervisory discussion with pertinent staff regarding the importance of accurate and thorough documentation.

3. **It was well documented that the individual was experiencing a great deal of stress about being transferred.**

   The individual was very concerned about being transferred out of AAPU and died by suicide shortly after the decision was made to transfer them.

   Recommendation:

   In its draft report, the Justice Center requested that DOCCS provide the meeting minutes for TAC and the transfer policies regarding transferring individual's out of special programs like the APPU. DOCCS replied that there were no meeting minutes. The Justice Center recommends that all individuals that are discussed during all future TAC Meeting be memorialized in writing.

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

May 6, 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 March 22, 2024 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 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.

Recommendation #1:
"The individual's clinical records lack depth and appear as though clinical staff were simply transcribing the individual's report; not digging into the underlying issues or concerns. This is evident in the inconsistent documentation of the individual's suicidal history. The Justice Center requests that the CNYPC [Central New York Psychiatric Center] Clinical Director review the record to determine if the individual's suicidal history has been documented correctly in the clinical record. In addition, the Justice Center requests that Clinton CF staff are retrained on the importance of consistently documenting previous suicidal gestures, attempts or ideations for the individual's entire bid."

OMH Response:

OMH disagrees with the Justice Center's conclusion that historical inconsistencies in the record suggest [redacted] clinical care "lack[s] depth" and that clinical staff were "not digging into the underlying issues or concerns." Per the clinical progress notes, the treatment team regularly assessed [redacted] and worked with him to identify and clinically address sources of anxiety. Examples of staff inquiry of [redacted] anxiety are noted throughout treatment. Over time, various identified stressors contributing to anxiety included job changes, anxiety related to "being around a lot of people" and having to travel to an outside hospital for Magnetic Resonance Imaging (MRI). In March 2023, [redacted] reported feeling "stressed out" due to "an upcoming meeting with the housing committee and their fear they will get transferred out of the Assessment for Program Preparedness Unit (APPU)." As noted in the Justice Center's report, "The individual and clinician worked through the plan of what they would say to the committee." These examples are clear examples of exploration by OMH staff to assess the etiology of [redacted] symptoms.

In addition, the CNYPC Suicide Prevention Department continues to provide CBO staff in general, including Clinton Staff, clinical support, education and training around the assessment and documentation of suicide risk assessment and history.

Request #2:
"The Justice Center requests that DOCCS provide the meeting minutes for TAC and the transfer policies regarding transferring individual's out of special programs like the APPU."

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

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

April 29, 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

Justice Center Oversight Action
Draft Mental Health Service Review [redacted] (DIN: [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 services provided to [redacted] (DIN #[redacted]) an incarcerated individual who died on [redacted], at the Clinton Correctional Facility.

1. Recommendation:
The individual's clinical records lack depth and appear as though clinical staff were simply transcribing the individual's report; not digging into the underlying issues or concerns. This is evident in the inconsistent documentation of the individual's suicidal history. The Justice Center requests that the CNYPC Clinical Director review the record to determine if the individual's suicidal history has been documented correctly in the clinical record. In addition, the Justice Center requests that Clinton Correctional Facility staff are retrained on the importance of consistently documenting previous suicidal gestures, attempts or ideations for the individual's entire bid.

Response:
The New York State Department of Corrections and Community Supervision (DOCCS) will defer to The Office of Mental Health (OMH) on this recommendation.

2. Recommendation:
There is no clinical progress note referencing the outcome of the individual's Transfer Assessment Committee (TAC) meeting on March 24, 2023.

Response:
DOCCS will defer to OMH on this recommendation.

3. Request:
The Justice Center requests that DOCCS provide the meeting minutes for TAC and the transfer policies regarding transferring individual's out of special programs like the APPU.

Response:
There were no Transfer Assessment Committee (TAC) meeting minutes related to incarcerated individual [redacted] discharge from the Assessment and Program Preparation Unit (APPU). The APPU's Assessment Committee Transfer Procedure from the Clinton Correctional Facility's Operations Manual as well as the Referral/ Discharge Decision of the Assessment Committee and Unscheduled Transfer Review for incarcerated individual [redacted] are attached.

Every suicide is a tragic event that we do not take lightly. These misfortunate events are thoroughly reviewed at several levels by our department, which includes investigations by the 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.

Acting Commissioner Martuscello recently launched a Suicide Prevention Task Force composed of individuals from various disciplines including DOCCS Office of Special Investigations, Crisis Intervention Unit, Program Services, Ministerial Services, Medical Services, Mental Health, facility Superintendents, as well as outside agencies that includes the Office of Mental Health Suicide Prevention Department and Chemung County Jail Suicide Prevention staff. The goal of the task force is to review existing policies, procedures and practices, as well as develop new strategies designed to assist in reducing suicidal behaviors.

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.

We have added a pre-recorded message to our phone system for family and friends of incarcerated individuals prompting them to reach out to the facility if they have any concerns related to suicide or self-harm during the call.

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

Attachment(s)

cc: Marie Josee King, Superintendent–Clinton Correctional Facility
Kathryn Farley, Supervising Facility Review Specialist