Justice Center for the Protection of People with Special Needs

KATHY HOCHUL
Governor

MARIA LISI-MURRAY, ESQ.
Acting Executive Director

Final Review of Justice Center Oversight Action
Mental Health Service Review [REDACTED] (DIN # [REDACTED])
JC#: 77010153644

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 the incarcerated individual prior to their suicide follows below.[1]

Background

At the time of their death, the incarcerated individual was a 44-year-old Black male serving their fourth NYS bid for up to 25 years for first degree manslaughter. The individual had a parole interview in June 2034 for release conditions, a conditional release date of August 25, 2034, and a maximum expiration date of March 23, 2038.

According to the Pre-Sentence Report, they were homeless and using drugs daily prior to their incarceration and under parole supervision at the time of their instant offense. They were adjudicated as a youthful offender in 1995 and sentenced to state prison in 1997 after their probation was revoked. According to their Core History, they had several episodes of mental health outpatient treatment from CNYPC while incarcerated, and three prior suicide attempts in 1997, 2000 and 2014 by overdose. They reported a prior inpatient psychiatric hospitalization in Bellevue in 2010, with trials of Seroquel and Trazadone due to depression. They were diagnosed with "mood disorder NOS and bi-polar NOS" noted in transfer paperwork from Riker's County Jail and reportedly was noncompliant with treatment and medication.[2] Prior diagnoses included anti-social personality disorder, cyclothymic disorder, cannabis dependence, and unspecified mental disorder. The individual had one prior RCTP admission in March 2021 due to threats of self-harm.[3]

The individual was being housed in General Population at Green Haven Correctional Facility (CF) as a Mental Health Service Level (MHSL) 3 for the six months prior to their suicide. On July 6, 2022, they met privately with a mental health clinician for a scheduled callout and presented as psychiatrically stable. They said they felt fine and denied any mental health related concerns or symptoms. At the time, they were prescribed Remeron and Prozac "for sleep" but said they did not take it all the time. An attempt was made by the clinician to educate them on remaining compliant with medications to achieve a positive benefit. They were not programming, not going to the yard, not exercising, and reported staying in their cell to listen to music and play games on the tablet. The individual said they had sporadic contact with supports in the community. In the progress note it was noted they had no history of self-injurious or suicidal behaviors but had made threats in the past, and the clinician noted there was

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[1] [REDACTED] (DIN # [REDACTED]) is hereinafter referred to as incarcerated individual.
[2] Per Core History, completed on March 17, 2021, page 4.
[3] Termination Transfer Progress Note (Form 420 MED CNYPC) dated January 6, 2023.

no current imminent risk evident with a return to care in eight weeks. A Treatment Plan was initiated during the callout which identified their primary diagnosis as adjustment disorder with depressed mood.

On August 10, 2022, the individual participated in a fight outside the commissary area. After being examined and cleared by medical both individuals were returned to their cells pending disciplinary action. The individual met privately with their new primary therapist, on August 31, 2022. They reflected on a desire to improve relationships with their family and friends in the community, specifically their young daughter. The therapist encouraged them to stay medication compliant. They denied suicidal or homicidal ideation, thoughts or plans and was attentive and cooperative. Their mental status exam was normal, and a follow-up was planned for 4-8 weeks. A Patient Safety Screener -3 modified (PSS-3M) was completed with no triggers noted, and no completion of a Comprehensive Suicide Risk Assessment (CSRA) was required.

The individual had medication orders written on September 9, 2022, to continue their Prozac and Remeron through December 10, 2022.[4]

On October 28, 2022, the individual was a no-show for their psychiatric callout with the prescriber and primary therapist and was to be rescheduled.[5] The individual presented for their scheduled psychiatric callout on November 8, 2022. They were still in general population housing and reported that Prozac makes them drowsy and requested Wellbutrin to help with anxiety. When psychiatric staff explained to them that Wellbutrin could worsen anxiety, they became upset. They were to be tapered off Prozac until November 15, 2022, when the Prozac could be discontinued. Their Remeron dosage was increased (for mood) and medication education was provided. The individual denied suicidal or homicidal ideation.

On November 14, 2022, an Unusual Incident Report was generated at the Green Haven CF after the individual assaulted another incarcerated individual in the medical clinic. During the a.m. medication pass, the individual was observed on camera approaching the other individual from behind, hitting them in the face with a closed fist punch and causing them to lose consciousness, fall to the floor and be sent to an outside hospital for further evaluation. The individual refused to be examined by medical and was placed in a SHU cell pending disciplinary action for the incident. A suicide screening (#3152) was administered with no triggers noted.[6] The individual received a Tier III Misbehavior Report for assault on inmate, violent conduct, creating a disturbance, and being out of place.[7] The following day, November 15, 2022, they had an intake mental health interview completed cell side, due to refusal of private interview (no reason for refusal was documented). Their evaluation was unremarkable, the individual reported both outpatient treatment and inpatient psychiatric hospitalization history, identified past

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[4] Physician's Orders (Form 89 MED) dated September 9, 2022.
[5] This missed callout was referenced in the OMH Special Investigation Report and the facility responded with "All staff were provided with policy relevant to missed callouts".
[6] NYS DOCCS Suicide prevention Screening Guidelines for Incarcerated Individuals (Form 3152) dated November 14, 2022.
[7] NYS DOCCS Green Haven Correctional Facility Incarcerated Individual Misbehavior Report (Form 2171B) dated November 14, 2022.

sources of stress and denied thoughts of self-harm. A PSS-3M was not completed due to refusal of private interview, and it was noted that a CSRA was not indicated at that time. On November 21, 2022, the individual was screened for suicide risk in the SHU via 3152 for readmission after being discharged from the infirmary with no triggers noted.[8] They were seen cell-side by mental health staff the following day for an intake mental health interview on November 22, 2022. The interview noted that they had "returned from the infirmary yesterday "I was not feeling well, but I am better. The unit officers speculated he was going through drug withdrawal, but this was not confirmed". Their evaluation was normal, they denied thoughts of self-harm and reported to be coping well in SHU. A PSS-3M was not completed due to the refusal of a private interview and a CSRA wasn't indicated. The individual asked when their ticket would be finished as they had been in SHU for several days without a tier hearing having started. According to the Special Investigation Final Report, they had a disciplinary tier hearing on November 22, 2022, and "received credit for 8 days of pre-hearing confinement as well as 30 days of the SHU sanction, which he was serving at the time of his attempted hanging that resulted in their death." [9]

At approximately 7:30 a.m. on [redacted], the individual accepted their morning meal in their SHU cell from security. During static tablet distribution at 8:00 a.m. the individual was observed in their cell facing the rear wall with their back against the gate. They had a garrote (fashioned from braided strips of ripped state bed sheets) tied around their neck on one end with the other end tied to the cell bars. The garrote measured 79 inches in length. The individual used their body weight to apply downward pressure to the garrote and was never suspended. A medical response was called, security staff reached through the cell bars and untied the garrote from the individual's neck. Security unsecured the cell and made entry to initiate lifesaving measures to the unresponsive individual. A sternum rub did not elicit a response. At 8:01 a.m. the AED was applied, and no shock was advised, and security began chest compressions. At 8:02 and at 8:04 a.m. security administered doses of intranasal Narcan with no effect and CPR was continued. At 8:05 a.m. medical staff arrived at the scene, had the individual placed on a backboard, and at 8:06 a.m. the area sergeant radioed base to summon EMS and 9-1-1 was called. A third dose of intranasal Narcan was administered by security at 8:08 a.m. without desired effect and a fourth dose was administered intramuscularly (IM) to their right hip by a Registered Nurse (RN) with no response at 8:12 a.m. The individual was placed on a stretcher and transported to facility medical with CPR in progress. The RN administered a 5th dose of Narcan intranasally at 8:14 a.m. without desired effect. At 8:16 a.m. medical relieved security of chest compressions and they began breathing and medical ceased chest compressions and gave a 6th dose of IM Narcan in their left hip without the desired effect. A 7th dose of intranasal Narcan was administered at 8:18 a.m. At 8:19 a.m. EMS arrived at the facility and left the facility at 8:41 a.m. transporting the individual to Mid-Hudson Hospital for further treatment. An addendum was added on [redacted], that on December 27, 2022, the individual was taken off life support at the Mid-Hudson Regional Hospital

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[8] NYS DOCCS Suicide Prevention Screening Guidelines for Incarcerated Individuals (Form 3152) dated November 21, 2022.
[9] See the Confidential Special Investigation Final Report, page 10.

at the request of their next of kin and pronounced dead by the attending physician on [redacted], at 10:00 p.m.[10]

Justice Center Findings:

1. **Despite having a prior diagnosis of bi-polar depression, the individual was diagnosed with adjustment disorder with depressed mood, and they were designated a MHSL 3.[11]**

   According to the individual's pre-sentence report, they carried a prior diagnosis of bi-polar depression and was prescribed an anti-psychotic in the past.[12] The individual presented as a person with extremely volatile emotions and dramatic mood changes but diagnosed with adjustment disorder with depressed mood and prescribed anti-depressants. They had a longstanding history of impulsive self-directed violence, including suicide attempts and psychiatric admissions for depression and anxiety. According to the records provided, there was no documented analysis of their prior diagnoses and whether bipolar disorder would best describe their symptomology.

Request and Recommendation:

The Justice Center requests the Clinical Director explain what other treatment modalities were considered or utilized and why a diagnosis of bi-polar disorder wasn't explored for this individual based on their presentation, history, and violent nature of their crime. This individual had an extensive history of receiving both inpatient and outpatient mental health services with diagnoses that included d bi-polar disorder in the community and while incarcerated. Had the individual been diagnosed with a bipolar disorder and prescribed an antipsychotic, specifically in the time leading up to their death when their paranoia and depression emulsified into anger and physical aggression, it may have assisted in stabilizing their mood and reducing their anxiety.

2. **The individual, a MHSL 3, had been placed in segregated confinement two days prior to their death.**

   Segregated confinement poses serious risks to a person's mental health and people with ongoing mental health needs should be provided with access to therapeutic programming instead of placement in solitary confinement for any time period.

Recommendation:

The Justice Center continues to recommend that anyone who has been determined to need mental health services should not be placed in segregated

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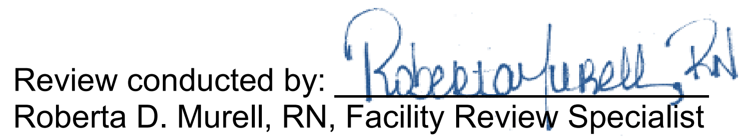
[10] NYS DOCCS Unusual Incident Report generated at Green Haven CF dated [redacted], page 4.
[11] CNYPC Treatment Needs/Service Level Designation (Form 167 Med CNYPC) dated March 12, 2021.
[12] Per the Core History, page 4.

confinement. Instead, they should be immediately diverted to a therapeutic setting with ongoing access to mental health care.

Review conducted by: 
Roberta D. Murell, RN, Facility Review Specialist

Office of Mental Health
Central New York Psychiatric Center

KATHY HOCHUL
Governor

ANN MARIE T. SULLIVAN, M.D.
Commissioner

February 5, 2025

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 January 2, 2025 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 Green Haven 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:
"The Justice Center requests the Clinical Director explain what other treatment modalities were considered or utilized and why a diagnosis of bi-polar disorder wasn't explored for this individual based on their presentation, history, and violent nature of their crime. This individual had an extensive history of receiving both inpatient and outpatient mental health services with diagnoses that included d [sic] bipolar disorder in the community and while incarcerated. If the individual was diagnosed with a bipolar disorder and prescribed an antipsychotic medication, specifically in the time leading up to their death when their paranoia and depression emulsified into anger and physical aggression, it may have assisted in stabilizing their mood and reducing their anxiety."

OMH Response:
References to [redacted] diagnosis of Bipolar Disorder were based on his self-report. Available treatment records did not definitively confirm a Bipolar Disorder diagnosis. While Rikers County Jail reportedly diagnosed [redacted] with Bipolar Not Otherwise Specified (NOS), this is a broad diagnosis that is often changed after additional clinical assessment.

[redacted] had been incarcerated with DOCCS four times since 1997 and had several admissions to the mental health caseload during that time. He had not required a Mental Health Service Level (MHSL) higher than a 2 at any point, and there was no evidence of major affective illness over the years. This remained the case despite his inconsistency with accepting psychiatric medication. [redacted] primary concerns throughout his incarceration pertained to his environment and overall safety. He also had a history of significant substance use, and, as noted in the Justice Center's report, [redacted] appeared to be "going through drug withdrawal" [redacted] prior to his death. As such, there is evidence that environmental issues and possible

substance use were impacting his mental health. The Adjustment Disorder diagnosis and prescription of antidepressants were most appropriate in his case.

Recommendation #2:
"The Justice Center continues to recommend that that anyone who has been determined to need mental health services should not be placed in segregated confinement. Instead, they should be immediately diverted to a therapeutic setting with ongoing access to mental health care."

OMH Response:
OMH continues to work with DOCCS to ensure all incarcerated individuals on the mental health caseload are appropriately housed not only in accordance with their diagnoses and MHSL, but also in accordance with their assessed treatment needs. For those individuals who remain in SHU for 15 days or less, OMH offers mental health callouts per policy and also more frequently if needed. All individuals, regardless of caseload status, are also assessed cellside during regular rounds.

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

Department of Corrections and Community Supervision

KATHY HOCHUL
Governor

DANIEL F. MARTUSCELLO III
Commissioner

January 21, 2025

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

Draft Review of Justice Center Oversight Action
Mental Health Service Review ████████████ (DIN #███████)
JC#: 77010153644

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 ████████████ (DIN# ███████), an incarcerated individual who died on ████████████, at the Green Haven Correctional Facility.

1. Request:

The Justice Center requests the Clinical Director explain what other treatment modalities were considered or utilized and why a diagnosis of bi-polar disorder wasn't explored for this individual based on their presentation, history, and violent nature of their crime. This individual had an extensive history of receiving both inpatient and outpatient Mental Health Services with diagnoses that included d bi-polar disorder in the community and while incarcerated. If the individual was diagnosed with a bipolar disorder and prescribed an antipsychotic medication, specifically in the time leading up to their death when their paranoia and depression emulsified into anger and physical aggression, it may have assisted in stabilizing their mood and reducing their anxiety.

Response:

DOCCS will defer to OMH on this request.

2. Recommendation:

The Justice Center continues to recommend that that anyone who has been determined to need mental health services should not be placed in segregated confinement. Instead, they should be immediately diverted to a therapeutic setting with ongoing access to mental health care.

Response:

Incarcerated individuals who do not fall under the criteria of Special Populations can be placed in SHU for up to 15 days as per the HALT Legislation and recently vetoed Senate Bill S4621 that was introduced to expand the definition of persons with disability.

However, 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 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.

Commissioner Martuscello launched a Suicide Prevention Task Force composed of individuals from various disciplines including the Office of Special Investigations, Crisis Intervention Unit, Program Services, Ministerial Services, Medical Services, DOCCS Mental Health, Facility Superintendents, as well as outside agencies such as 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

cc: Mark Miller, Superintendent–Green Haven Correctional Facility