Review of Justice Center Oversight Action
Mental Health Service Review [redacted] (DIN #: [redacted])
JC #: 77010180532

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] (DIN #: [redacted]) prior to their suicide follows below.

Background:

At the time of their death, the incarcerated individual was 36 years old and serving their first NYS bid with an 8-year sentence for Rape in the 1st Degree. They were scheduled for a parole interview in June 2031, with a conditional release (CR) date of August 19, 2031. Their maximum expiration (ME) date was October 11, 2032. The individual had previous convictions for Attempted Burglary in the 2nd Degree which was plead down from Burglary in the 2nd Degree. Following this conviction, they were ordered to complete drug court, which they completed successfully, and were then able to withdraw their plea to the felony charge and were sentenced to 3-years of probation for misdemeanor Criminal Mischief in the 4th degree. In 2019, they were charged and convicted with Forcible Touching, which appears to have been plead down to Attempted Endangering the Welfare of a Child, however official records of the charges they pled to vary.

The individual's time in state incarceration was brief, having been received into state custody on July 16, 2025, at the Elmira Correctional Facility (CF) Reception Center. Per their Presentence Investigation Report, the individual disclosed being concerned about how they would be treated in state prison due to their criminal conviction. It is further documented that the individual told law enforcement officers at the time of their 2019 arrest, that they first experienced a sexual encounter at the age of 14 with a 38-year-old woman, and that they had "paid for prostitutes in the past and had gone to massage parlors to help with the urges". Historically, the individual engaged in mental health services in the community following their 2019 arrest, with the individual reporting that they received a mental health evaluation after making suicidal statement to a former girlfriend. The Presentence Report states, "It should be noted that both times he was charged with sex offenses he has made statement about suicide. A previous report indicated that the defendant says [they have] a mental health problem with sexual thoughts and urges". The individual disclosed that they "could never commit suicide" but admitted having impulsive thoughts.[1]

Upon reception, the individual was designated a Mental Health Service Level (MHSL) 2 and diagnosed with adjustment disorders, with mixed anxiety and depressed mood, cyclothymic disorder, and alcohol use disorder. During their initial screening with mental health staff, the individual reported experiencing symptoms of anxiety, depression, and paranoia, but denied audio and visual hallucinations, and suicidal and homicidal

[1] Presentence Report dated April 17, 2025.

ideations. [2] They further denied a history of childhood abuse or neglect, and traumatic experiences. They reported no history of inpatient mental health treatment in the community, but disclosed that they received outpatient treatment, “online through Hims and Hers, was on Celexa”. The individual did disclose a history of substance abuse, and having a young child, with whom they did not have contact with. The individual reported being prescribed mental health medications stating, “one was to help my mood, one to help me sleep at night, to shut my brain off, one to help pick me up, get motivated”. According to documentation, they were admitted to state custody with active prescriptions for Zyprexa, Lamictal, and Wellbutrin, with a “Per County” diagnosis of “Bipolar”. The individual was screened for indications of suicide risk via a Patient Safety Screener-3 Modified (PSS-3M) on July 16, 2025, to ensure the individual’s safety and implementation of timely interventions. The individual answered “no” to all questions, therefore an additional assessment was not warranted at that time.

On August 5, 2025, the individual received an initial psychiatric assessment via Video Teleconferencing (VTC) where “OMH staff was present with the patient during the appointment”. The individual reported being on “Lamictal for nine months for sleep and mood swings”, while “Zyprexa was prescribed for sleep”. They denied acute stressors but discussed difficulties with not “being there” for their son and was documented as becoming tearful when discussing the topic. Although the individual denied suicidal ideation and anxiousness, they reported feeling “’blah’ most of the time” and feeling they sleep and eat too much. The record does not document any further discussion regarding the individual feeling “blah” and what that means. The group discussed the individual’s Zyprexa, where it appeared they assessed there was “no indication for its use”. The individual agreed to taper and discontinue the medication as a result and agreed to start Zoloft to replace the Wellbutrin.[3] It was noted that the individual had no evidence of “psychosis or mood lability”, and the diagnosis given was “adjustment disorders with mixed anxiety and depressed mood and ETOH use disorder, severe”.

The individual transferred from the Elmira CF to the Five Points CF on August 12, 2025. The individual’s next mental health contact occurred on August 25, 2025, when they met with their clinician for a private session. They discussed stressors which included, “[Their] whole situation and [their] charge is [their] current stressor.” They further denied having any coping skills to address such stressors, and that they had “recently” been started on medications. During the contact they reported no history of self-harm, or previous suicide attempts, and denied suicidal and homicidal ideations. They disclosed their substance abuse history, that a cousin had previously committed suicide, and that they feel “purposeless, anxiety on a daily basis, hopeless at times, anger, overwhelmed, and in a sense of transition”.[4] A PSS-3M was completed during this contact, with the individual answering yes to “Over the past two weeks, have you felt down, depressed, or hopeless?” and “Do you feel that you have nothing to offer others, either from inside or outside of prison?” Given the nature of their answers, a Comprehensive Suicide Risk Assessment was completed to allow the clinician to assess and document warning signs as well as risk and protective factors to capture the level of risk for suicide. The

[2] July 16, 2025, Admission/Screening Form and Screening/Admission Note
[3] Initial Psychiatric Progress Note dated August 5, 2025.
[4] Primary Therapist Progress Note dated August 25, 2025.

individual was determined to “not appear to be in acute distress at the present time and does not appear to be presenting with warning signs of imminent suicide risk”. Additionally, a Corrections-Based Treatment Plan was created on August 25, 2025. The individual had one goal which stated, “Incarcerated individual will develop and utilize effective coping strategies to handle the stressors related to general population. He will identify factors that contributed to his placement- specifically mood disturbances, develop insight into how behavior plays into the past consequences and seek alternative behaviors to prevent behavior sanctions. He will be ready for discharge from mental health services when they are able to manage problematic symptoms independently-specifically depression and anxiety. He will be able to demonstrate adequate adjustment to this setting as evidenced by behavioral control”. Although it is documented that the individual agreed with their treatment plan, only the clinician signed the document, and did not provide a date that it was signed.

On [redacted], at 12:51 p.m. the incarcerated individual’s cellmate alerted security staff of a medical emergency, informing them that the individual was hanging in the cell. Security staff called medical response to the cell, and the cell door was ordered to be opened. At 12:52 p.m. security staff entered the cell, and observed the individual in the attached recreation pen, hanging from the grating with a state sheet tied around their neck, fashioned into a garotte. Security staff were able to lift the individual up, and untie the sheet, removing it from around their neck. Security staff then placed the individual down on the floor. At 12:53 p.m. security staff checked for vitals, calling for an AED, and immediately began chest compressions. Additional responding security staff arrived at the cell at 12:55 p.m., at which time the first dose of nasal Narcan was administered to the right nostril, without the desired effect. A second dose of nasal Narcan was administered at 12:56 p.m. to the individual’s right nostril, without the desired effect. At 12:58 p.m. security staff administered a third, and final, dose of nasal Narcan to the individual’s left nostril, without the desired effect. At 12:59 p.m. additional security staff responded with the AED, and upon application no shock was advised. Facility medical staff responded and requested EMS services to respond to the facility. Security staff called for an ambulance to respond to the facility at 1:00 p.m. While waiting for emergency services to arrive at the facility, security staff, National Guardsmen, and facility medical staff provided continuous BVM respirations and chest compressions. ambulance services arrived at the facility at 1:30 p.m. At 1:33 p.m. responding EMS directed CPR be stopped and the facility AED be removed, to be replaced by an EMS owned AED. Once placed no shock was advised. Life saving measures were discontinued, and a doctor from Cayuga Medical Center pronounced the incarcerated individual deceased at 1:51 p.m.[5]

Per the September 2, 2025, OMH Termination Transfer Progress Note, completed following the individual’s death, their *Most Recent Mental Status (from last clinical contact)* notes that the individual’s mood was calm and engaging while their affect was “congruent with mood”. The note, although it indicates an area for other observations, does not document that the individual reported during their August 25, 2025, call out

[5] Unusual Incident Report dated [redacted].

that they “feel purposeless, anxiety on a daily basis, hopeless at times, anger, overwhelmed and in a sense of transition”.

Justice Center Findings:

1. **An initial psychiatric evaluation was not conducted within the timeframes designated in OMH Policy 5.0.[6]**

   The incarcerated individual was admitted to the mental health caseload on July 16, 2025, as a MHSL- 2. Their initial psychiatric evaluation, documented on the Initial Psychiatric Progress Note did not occur until August 5, 2025. OMH Policy 5.0, *Psychiatric Progress Notes*, indicates that the initial psychiatric evaluation for individuals who are a MHSL 1 to 4, and in a reception unit, must be completed within two weeks of their admission to mental health services.

   Request and Recommendation:

   The Justice Center requests an explanation for why an initial psychiatric assessment was not conducted with the individual within the timeframes designated in OMH Policy 5.0, while housed at the Elmira CF.

   In addition, it is recommended that OMH clinical staff at the Elmira CF be retrained to ensure the timely completion of the initial psychiatric progress note, specifically at the time an individual enters DOCCS reception.

2. **Mental health and psychiatric staff did not thoroughly explore the concerns presented by the incarcerated individual.**

   The individual spent a significantly short time in state custody before their death, having spent approximately three weeks in the Elmira reception center, and another three weeks at the Five Points CF; a marked period of transition.

   According to the individual’s presentence investigation report, the individual reported receiving mental health services in the community following their 2019 arrest and had to engage in a mental health evaluation after making suicidal statement to a former girlfriend. The presentence report also makes note that this individual has made suicidal statements both times they were charged with sex offenses. Additionally, they reported having been prescribed medications for bipolar disorder, however, they were unable to provide the name of the medication or when and where they were diagnosed with bipolar disorder.

   Prior to their arrival into state custody, the individual was prescribed Zyprexa, Lamictal, and Wellbutrin for “Per County: Bipolar”. Following their transition into state custody on July 16, 2025, psychiatric staff made several changes to the

[6] OMH Policy 5.0, *Psychiatric Progress Notes* states, “**Initial Psychiatric Evaluation Progress Note:** To be completed when the patient is first admitted to services as a Level 1-3: … 2. **Reception Units:** Must be completed within two weeks of admission to services on Level 1-4 incarcerated patients.”

individuals prescribed medications. At their initial screening, the individual was opened to mental health services to evaluate symptoms of mood dysregulation, anxiety, and depression.[7] At that time they were diagnosed with adjustment disorders, with mixed anxiety and depressed mood, cyclothymic disorder, and alcohol use disorder. On August 5, 2025, the individual met with psychiatric staff for their initial evaluation where it is documented, “He feels ‘blah’ most of the time.” Despite this, there is no further documentation that the individual feeling “blah” was explored more deeply by psychiatric staff. Per the progress note, there is no documentary evidence that the diagnosis of cyclothymic disorder was reviewed, even though the individual was prescribed Lamictal to manage their mood swings. In addition, the psychiatrist increased the Lamictal dosage “for mood stability” while also noting, “There is no evidence of psychosis or mood lability so Zyprexa will be tapered and discontinued.” The progress note does not document that insight into behavior or mood changes was discussed with security staff to confirm this may be occurring. According to the progress note, the individual’s diagnosis was “adjustment disorders with mixed anxiety and depressed mood and ETOH use disorder, severe”, therefore cyclothymic disorder was no longer considered a diagnosis.

On August 25, 2025, the individual met with their primary therapist following their transfer to the Five Points CF. They presented as future oriented, discussing positive support, and what things will look like upon their release to the community. However, concerningly they are documented as reporting that a cousin had committed suicide, and that they felt “purposeless, anxiety on a daily basis, hopeless at times, anger, overwhelmed and in a sense of transition.” They reported having no coping skills. The progress note fails to demonstrate that these concerns were explored in any depth, or that mental health staff inquired whether or not the individual felt the medication changes made earlier in the month were improving the symptoms the individual had been experiencing.

Recommendation:

Given the documentation presented, clinical staff were provided with a great deal of information pertaining to the individual’s history and current mental health status. Although it appears that the individual’s risk factors were identified, they were not thoroughly explored, and after only one psychiatric contact, medication changes were made to increase one medication, discontinue another and introduce a new medication. In addition, the individual was provided a diagnosis of cyclothymic disorder during the admission/screening process, however it was removed and there is no documentation to support that psychiatric staff explored that diagnostic option even though they increased the dosage of the individual’s mood stabilizer.

The Justice Center recommends that the OMH Clinical Director complete a review of the individual’s treatment course, specifically the interviews,

[7] Screening/Admission Note dated July 17, 2025.

documented diagnoses, and medication changes. In addition, it is recommended that psychiatric staff document in their initial psychiatric progress note, any disagreement or removal of a diagnosis, to have assist in creating a comprehensive mental health treatment record.

Review conducted by:
Stephanie Diamond, Facility Review Specialist

NEW YORK STATE | Office of Mental Health

KATHY HOCHUL
Governor

ANN MARIE T. SULLIVAN, M.D.
Commissioner

June 29, 2026

Jody Signoracci
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. Signoracci:

We received your letter dated 5/14/26 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 Five Points Correctional Facility (CF). Below are the Office of Mental Health's (OMH) responses to the Justice Center's findings.

Request and Recommendation for Finding #1:
"The Justice Center requests an explanation for why an initial psychiatric assessment was not conducted with the individual within the timeframes designated in OMH Policy 5.0, while housed at the Elmira CF.

In addition, it is recommended that OMH clinical staff at the Elmira CF be retrained to ensure the timely completion of the initial psychiatric progress note, specifically at the time an individual enters DOCCS reception."

OMH Response:
The number of incoming incarcerated individuals, and subsequently made active mental health caseload patients, arriving at Elmira CF Reception exceeds the number of psychiatric providers available for the entire facility. Additionally, when initial assessments are conducted by providers via Videoteleconferencing (VTC), equipment malfunctions can result in cancelled assessments. Similarly, when there are not enough security staff available to escort incarcerated individuals to the VTC suite, the callout must be cancelled. OMH is aware of the importance of assessing incarcerated individuals within a timely manner. OMH's recruitment efforts continue in earnest as do their ongoing conversations with the Department of Corrections and Community Supervision (DOCCS) to ensure all possible private mental health callouts can be made. Given this issue is the result of environmental barriers at Elmira CF Reception, staff retraining is not indicated.

Recommendation for Finding #2:
"Given the documentation presented, clinical staff were provided with a great deal of information pertaining to the individual's history and current mental health status. Although it appears that the individual's risk factors were identified, they were not thoroughly explored, and after only one psychiatric contact, medication changes were made to increase one medication, discontinue another and introduce a new medication. In addition, the individual was provided a diagnosis of cyclothymic disorder during the admission/screening process, however it was removed and there

is no documentation to support that psychiatric staff explored that diagnostic option even though they increased the dosage of the individual's mood stabilizer.

The Justice Center recommends that the OMH Clinical Director complete a review of the individual's treatment course, specifically the interviews, documented diagnoses, and medication changes. In addition, it is recommended that psychiatric staff document in their initial psychiatric progress note, any disagreement or removal of a diagnosis, to have assist in creating a comprehensive mental health treatment record."

OMH Response:
This case was reviewed by the Morbidity Review Committee (MRC) in early 2026, which included the OMH Clinical Director as well as other members of the Corrections-Based Operations (CBO) administration. While OMH disagrees with the Justice Center's claim that mental health staff did not thoroughly explore [redacted]'s stressors, what was noted in MRC was that documentation did not accurately reflect staff's knowledge of [redacted]'s potential risk or their preliminary considerations for his plan of care. As such, through both MRC and the CBO Risk Management Special Investigation, staff were reminded of the importance of completing thorough documentation. Particular emphasis was placed on ensuring that suicide risk assessments are consistent throughout the progress note and that staff clearly document a risk mitigation plan when an individual presents with warning signs for suicide.

As to [redacted]'s diagnoses and medication: It is not uncommon for psychiatric providers to adjust the medication regimen that an individual received at county jail. This occurs for numerous reasons such as the county jails prescribing nonformulary medications, prescribing medications incongruent with diagnoses, prescribing medications such as Wellbutrin which have a high potential for abuse or trade value in prison and can put an individual at risk of extortion, prescribing medications primarily for sleep which is not permitted by OMH, or the individual's presentation in DOCCS is different than it was at county jail. The psychiatrist's progress note clearly indicates that an alternative to Wellbutrin was discussed with and accepted by [redacted] due to the concerns with prescribing this medication in corrections. She further documents that [redacted] reported using Zyprexa solely for sleep, and that due to his dysphoric presentation, Lamictal would be increased. In addition to being a mood stabilizer, Lamictal has been used by psychiatrists as an augmentation agent for patients who do not receive the full effect from their antidepressant. The prescriber also listed her preliminary diagnosis of Adjustment Disorder with Mixed Anxiety and Depression. This was evidently her working diagnosis after her initial encounter with the patient. Regardless of the diagnosis at that time, the psychiatrist was clearly focused on the management and treatment of the patient's symptoms. Staff are regularly reminded of the importance of ensuring their documentation is accurate.

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 | Department of Corrections and Community Supervision

KATHY HOCHUL
Governor
DANIEL F. MARTUSCELLO III
Commissioner

June 10, 2026

Jody Signoracci
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 [redacted] (DIN [redacted])
JC #: 77010180532

Dear Deputy Director Signoracci:

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 Five Points Correctional Facility.

1. Recommendation:

Given the documentation presented, clinical staff were provided with a great deal of information pertaining to the individual's history and current mental health status. Although it appears that the individual's risk factors were identified, they were not thoroughly explored, and after only one psychiatric contact, medication changes were made to increase one medication, discontinue another and introduce a new medication. In addition, the individual was provided a diagnosis of cyclothymic disorder during the admission/screening process, however it was removed and there is no documentation to support that psychiatric staff explored that diagnostic option even though they increased the dosage of the individual's mood stabilizer.

The Justice Center recommends that the OMH Clinical Director complete a review of the individual's treatment course, specifically the interviews, documented diagnoses, and medication changes. In addition, it is recommended that psychiatric staff document in their initial psychiatric progress note, any disagreement or removal of a diagnosis, to assist in creating a comprehensive mental health treatment record.

Response:

DOCCS will defer to OMH for additional comments related to their clinical assessment, diagnostic impression, medication regimen and documentation related to incarcerated individual [redacted]. 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 include 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.

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 had 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

Attachments
cc: Timothy Carroll, Superintendent - Five Points Correctional Facility
Stephanie Diamond, Facility Review Specialist, NYS Justice Center