Justice Center Oversight Action
Final Mental Health Service Review [redacted] (DIN# [redacted])
JC#: 1-AVN3HX4

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.

Background:

At the time of their death, the incarcerated individual was 56 years old, and this was their 5th incarceration for Criminal Mischief in the 3rd Degree. Their conditional release date was March 13, 2027, and their maximum expiration date was November 21, 2028.

Prior to their incarceration, the individual had an extensive history of receiving services for inpatient and outpatient services for mental health treatment, including a history of multiple suicide attempts, and substance abuse treatment. Specifically, they were treated for cocaine, amphetamines, alcohol, and marijuana. According to the records provided to the Justice Center, the individual was incarcerated between April 2023 and July 2023 as a mental health service level (MHSL) 1S, diagnosed with bipolar II disorder, antisocial personality disorder (ASPD), and cocaine use disorder, and was paroled July 17, 2023.

Per their Pre-Sentence Report, the individual's parole was revoked for the sixth time in April 2024 because they "had been given multiple chances at treatment but he continues to not comply". They entered DOCCS reception at the Emira CF on July 9, 2024, from the Niagara County Jail. According to the OMH clinical case record, the individual had transferred into DOCCS custody on July 9, 2024, assigned a MHSL 1S, and was prescribed Abilify, Remeron, and Prazosin. During their OMH screening at reception, it was noted that their previous mental health records had been reviewed, including their history of depression and mania. The individual was described as entering the room calmly and reporting their mood was "good". They requested to not be a MHSL 1S, claiming they had been compliant with their medication and stable in county jail. It was explained that they would have the opportunity to "work towards a level change with [their] primary therapist/psychiatrist". The individual discussed concerns related to where they would be transferred, noting their frustration with the Midstate CF, but indicated if they had to go there, could they go to the Intermediate Care Program (ICP). They denied any anxiety or depression, reporting their stability with medications. The individual was informed that they would be scheduled to meet with a psychiatrist to discuss their medications. A Patient Safety Screener – 3 Modified (PSS-3M) was also completed on July 9, 2024.[1] They reported that they had not had any concerns of feeling depressed or thoughts of killing

[1] The PSS-3M is a tool which was modified for use in the forensic setting and guides clinical decision-making regarding an individual's risk for suicide. Depending on the outcome of this screening, the clinician may then complete a CSRA and/or provide additional mental health assessment.

themselves in the past two weeks. They did answer affirmatively that they had attempted to kill themselves in 2005 and 2006 “VIA OD”. Based on the answers provided, a Comprehensive Suicide Risk Assessment (CSRA) was not warranted.

On [redacted], at approximately 2:17 PM, during rounds on A- Block, security staff observed a sheet on the cell bars that was obstructing visibility into the individual’s cell. Upon removing the sheet, security staff observed the individual to be unresponsive and hanging in the cell from a boot lace that was tied into a garrote around their neck, that was attached to the in-cell heater. Security staff called a medical emergency via radio communication. Another security staff arrived with state issued cut down tools. A third security staff opened the cell at the lock box, and the fourth and fifth security staff members entered the cell. The individual was cut down while supported by the security staff that found him, and he was lowered to the floor. Security staff began performing CPR on the unresponsive individual. At 2:18pm, the second responding security staff responded with the A-Block AED 110-04 and a first aid kit containing Narcan. Security staff utilized the bag valve mask as CPR continued. One of the security staff members applied AED pads to the incarcerated individual and powered the unit. No shock was advised. The Area Sergeant arrived at the scene and requested an ambulance via radio communication and recovered the garrote. At 2:18PM, security staff administered nasal Narcan to the individual’s left nostril; they remained unresponsive. A facility nurse arrived on the scene and applied a C collar to the incarcerated individual. At 2:22 PM, a nurse administered intermuscular Narcan to the individual’s right thigh; however, the incarcerated individual remained unresponsive, and CPR continued with the officers. At 2:25 PM, the nurse administered intermuscular Narcan in the left thigh; he remained unresponsive, and CPR continued. At 2:27 PM, the ambulance and one of the EMT’s arrive to the scene and assumed care. At 2:30 PM, the other EMT arrived at the scene, and at 2:36 PM, the individual is pronounced dead by the doctor via phone call with the ambulance crew. The cell was secured at 2:40 PM, and the crime scene log was secured by security staff. They were last seen alive by security staff during rounds at 2:00 PM.

Justice Center Findings:

The incarcerated individual’s mental health treatment met the standard of care set forth by CNYPC.

The Justice Center’s review found that the individual received appropriate mental health treatment and that their actions prior to their death gave no indication that there was any acute risk that they were planning to complete suicide. The individual was future-oriented, arguing their stability on their medication, and advocating for themselves regarding their OMH Level and regarding ICP placement.

Review conducted by: _____
Angelina LoCascio
Supervising Facility Review Specialist

NEW YORK STATE | Office of Mental Health

KATHY HOCHUL
Governor

ANN MARIE T. SULLIVAN, M.D.
Commissioner

July 13, 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 7/13/26 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 Elmira Correctional Facility (CF). We would like to acknowledge there were no recommendations made to the Office of Mental Health regarding this case.

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

July 15, 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

Justice Center Oversight Action
Draft Mental Health Service Review [redacted] (DIN [redacted])
JC#: 1-AVN3HX4

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 the Elmira Correctional Facility.

There were no recommendations from the Justice Center pertaining to DOCCS.

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.

Commissioner Martuscello created 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 developing new strategies designed to assist in reducing suicidal behaviors.

DOCCS also continues to request consultations from various national experts in Suicide Prevention to improve our Suicide Prevention efforts.

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: Kevin McCarthy, Superintendent - Elmira Correctional Facility
Angelina LoCascio, Supervising Facility Review Specialist, NYS Justice Center