Final Review of Justice Center Oversight Action
Mental Health Service Review [redacted] (DIN #[redacted])
JC#: 77010170331

The Justice Center's review of the care provided by the Office of Mental Health (OMH) and the Department of Corrections and Community Supervision (DOCCS) to [redacted] (DIN #[redacted]) six months prior to their suicide follows below.

Background

The incarcerated individual was 34-year-old male serving their first NYS bid for Manslaughter in the first degree.[1] They had a 22-year sentence, a parole interview date of August 2038, a conditional release of October 2, 2038, and maximum expiration date of November 24, 2041.[2]

Per the documentation received, prior to entry into NYS custody the individual was receiving verbal therapy for adjustment disorder in the county jail. When they entered reception in September 2022, they were diagnosed with adjustment disorder with depressed mood. The individual was designated as a mental health service level (MHSL) 3 and in July 2023, their diagnosis was changed to antisocial personality disorder.

The individual was housed in general population at the Sing Sing CF during the Justice Center's review period. [3] According to primary therapist progress notes, the individual did not show for their scheduled callouts with their primary therapist on June 13, 2024, and June 20, 2024. They were seen by the primary therapist on June 24, 2024, where staff addressed their request for a callout and their recent missed callouts. The individual was seen by psychiatric staff on June 25, 2024, per "his and his therapist request". They reported having a lot of stress due to family issues and reported poor sleep and increased depression and anxiety. They noted they had not been taking their prescribed psychiatric medications since April 2024, however, feel like they need it now and promised to be medication compliant moving forward. Remeron was prescribed to assist with depression, anxiety and insomnia.

On July 26, 2024, the individual's medications were renewed for continuation of care. The individual did not show to their joint psychiatric and mental health callout on August 14, 2024, and the clinician was also noted to be out sick. On August 22, 2024, the individual attended a callout with mental health staff and updated their treatment plan. The treatment plan noted they had been able to stay away from people for their safety, speak with family and help manage their anger. The individual discussed wanting to get "out of jail as fast as they can" and had concerns related to gaining weight, stating that

[1] [redacted] (DIN #[redacted]) is hereinafter referred to as incarcerated individual.
[2] The individual had two previous Youthful Offender felony adjudications.
[3] The Justice Center's review period was from June 12, 2024, to [redacted].

their medication made them hungry. They have been in contact with their kids and are working towards creating a stronger bond, despite “interference he is running with his ex”.

The individual was involved in an incident on September 11, 2024, and received a Tier II ticket after they had engaged in a physical altercation with another incarcerated individual on the housing block. They received a 21-day loss of packages, commissary and special events. Per a September 17,2024, psychiatric progress note, the “patient was not seen” however, their Remeron was discontinued due to noncompliance. They did not show for their joint psychiatric and mental health callout on September 25, 2024, or their mental health call out on October 15, 2024

The individual was seen cell side by psychiatric staff on October 16, 2024, after missing their appointment. They were seen for “assessment and follow up treatment”. They stated they were doing alright and denied any specific issues. They reported being on and off stressed about being in prison and having a long sentence however denied any hopelessness, paranoia, hallucinations or suicidal/homicidal thoughts. They spend their time reading books, watching tv and using the tablet. The individual also expressed interest in the college program. On October 24, 2024, they did not report for their scheduled mental health callout.

On November 21, 2024, mental health staff responded cell side to see the individual due to recent missed callouts however, they were out of their cell at recreation at the time. Security staff reported the individual had been going out of their cell, including recreation. The primary therapist noted that they would follow up with the individual cell side and continue to schedule callouts.

During rounds on [redacted], at 11:12 a.m., security staff discovered the incarcerated individual with a white bed sheet tied around their neck and a shelf at the rear of the cell. At 11:13 a.m., security entered the cell and used the cut down tool to cut the individual down. The individual was unresponsive, and security staff started Cardiopulmonary resuscitation (CPR) at 11:13 a.m. The Automated External Defibrillator (AED) and first dose of Narcan was applied at 11:14 a.m. The AED advised no shock, and an ambulance was called at 11:14 a.m. Six additional doses of intranasal and two intramuscular doses of Narcan were given between 11:17 a.m. and 11:33 a.m. with the desired effect not achieved. The paramedics responded at 11:33 a.m. and the individual was declared deceased at 11:41 a.m. According to the unusual incident report, the individual was last seen alive by staff at 10:30 a.m. during security rounds.

Justice Center Findings:

1. **The individual was not seen by their primary therapist between August 23, 2024, and their death on [redacted].**

   On August 22, 2024, the individual accepted a call out with their primary therapist. They did not show for their next scheduled callouts on October 15,

2024, and October 24, 2024. The individual's primary therapist attempted to see the individual cell side on November 21, 2024; however, they were out of their cell at recreation. It was documented that the "clinical team will follow up with [redacted] cell side".

Recommendation:

This finding was also addressed in OMH's review of the individual's care. The Justice Center agrees with the OMH determination that clinical staff were reminded of the importance of maintaining regularly scheduled contact with individuals and ensuring face to face contact with them when they do not attend private call outs.

2. **The individual was documented as "does not present at imminent risk of harm for suicide".**

According to the two clinical contacts that the individual had with their primary therapist in the six months leading up to their death, "ongoing assessment will be utilized to mitigate any changes to his presentation which suggest an elevation of risk". This would include "undergo routine evaluation for suicide risk based on chronic and protective risk factors". The individual's Treatment Plan, completed in March 2024, documented their problematic symptoms were anger issues, depression, and self-isolation. Per the records received, a Patient Safety Screener-3 Modified (PSS-3M) was never completed, even though they requested medications for increased depression and anxiety in June 2024, discussed concerns related to family issues, and received a disciplinary ticket for fighting in September 2024.[4]

Recommendation:

While suicide is unpredictable, the individual appeared to have endorsed risk factors during their clinical contacts, however, it was not determined to have met the criteria as per CNYPC Corrections Based Operations Policy #1.0 Screening and Assessment of Suicide Risk.[5] The Justice Center recommends that that Sing Sing CF Unit Chief complete routine checks of clinical progress notes, specifically the *Risk Mitigation Section*, to ensure that the documentation is current, and provides individualized information.

3. **Clinical staff never acknowledged the individual's weight concerns related to their medication regimen and whether that played a factor in their non-compliance.**

[4] 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.
[5] **The PSS-3M will be utilized when increased risk is evident**: routine contacts with primary therapist.

On June 25, 2024, the individual reported stress due to family issues, poor sleep and increased depression and anxiety. Although they had not taken prescribed psychiatric medications since April 2024, “he feels now he needs medication” and promised to be medication compliant. Remeron was prescribed to assist with depression, anxiety and insomnia. On August 22, 2024, the individual was noted to be medication compliant, but voiced concerns related to gaining weight, stating that their medication made them hungry. Per a September 17, 2024, psychiatric progress note, the “patient was not seen” however, their Remeron was discontinued due to noncompliance. When the individual had the opportunity to discuss their medication concerns during a October 16, 2024, psychiatric call out, there was no indication that it was discussed. The only notation regarding medications was that they were “not on any psychiatric medications as they were discontinued due to non-compliance”.

Recommendation:

Given the clinical understanding that Remeron is an antidepressant that frequently causes weight gain, due to increased appetite and drowsiness, it is important that psychiatric and clinical staff engage in documented exploratory discussions with individuals that discuss their weight gain, in an effort to offer support and suggestions prior to an individual becoming non-compliant with their medication regimen.

Review conducted by: Kathryn Cutter
Kathryn Cutter, 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 Sing Sing Correctional Facility (CF). Below are the Office of Mental Health's (OMH) responses to the Justice Center's findings.

Recommendations for Findings #2-3:
"While suicide is unpredictable, the individual appeared to have endorsed risk factors during their clinical contacts, however, it was not determined to have met the criteria as per CNYPC Corrections Based Operations Policy #1.0 Screening and Assessment of Suicide Risk. The Justice Center recommends that that Sing Sing CF Unit Chief complete routine checks of clinical progress notes, specifically the Risk Mitigation Section, to ensure that the documentation is current, and provides individualized information…

Given the clinical understanding that Remeron is an antidepressant that frequently causes weight gain, due to increased appetite and drowsiness, it is important that psychiatric and clinical staff engage in documented exploratory discussions with individuals that discuss their weight gain, in an effort to offer support and suggestions prior to an individual becoming non-compliant with their medication regimen."

OMH Response:
Both of these matters were addressed with the unit on 7/25/25 as part of the Morbidity Review Committee (MRC) examination of the case. As noted in the Corrections-Based Operations (CBO) Risk Management Special investigation, there were numerous issues with [redacted] attending private callouts and medication administration, and staff rescheduling him in accordance with policy. As part of their investigation, which the Justice Center received, Risk Management recommended that staff review CBO Assessment Policies #1.0 Screening and Assessment of Suicide Risk, #2.4 Cancelled/Refused/Missed Callouts, #5.1 Progress Notes, and CBO Medication Policy #4.8 Medication Not Administered/Returned to Nurse's Station.

Via the MRC review, staff were encouraged to review their process for communicating medication refusals and the expectation of each staff member to respond to continued medication refusals or no shows. They were also reminded that all notes must be an accurate representation of the current callout and should not simply include information from previous callouts. It was discussed

that progress notes are what future teams utilize to understand the timeline of events and all efforts made to provide care; therefore, accuracy is crucial.

OMH staff at Sing Sing CF received clinical skills training in June 2025, which also addressed matters pertaining to completing comprehensive suicide risk assessments and thorough documentation. Further training opportunities in suicide risk assessment skills are being developed for future implementation in CBO.

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

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

Review of Justice Center Oversight Action
Mental Health Service Review [redacted] (DIN [redacted])
JC#: 77010170331

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 Sing Sing Correctional Facility.

1. Recommendation:

This finding was also addressed in OMH's review of the individual's care. The Justice Center agrees with the OMH determination that clinical staff were reminded of the importance of maintaining regularly scheduled contact with individuals and ensuring face to face contact with them when they do not attend private call outs.

Response:

DOCCS will defer to OMH for this recommendation.

2. Recommendation:

While suicide is unpredictable, the individual appeared to have endorsed risk factors during their clinical contacts, however, it was not determined to have met the criteria as per CNYPC Corrections Based Operations Policy #1.0 Screening and Assessment of Suicide Risk. The Justice Center recommends that Sing Sing Correctional Facility's Unit Chief complete routine checks of clinical progress notes, specifically the *Risk Mitigation Section*, to ensure that the documentation is current, and provides individualized information.

Response:

DOCCS will defer to OMH for this recommendation.

3. Recommendation:

Given the clinical understanding that Remeron is an antidepressant that frequently causes weight gain, due to increased appetite and drowsiness, it is important that psychiatric and clinical staff engage in documented exploratory discussions with individuals that discuss their weight gain, to offer support and suggestions prior to an individual becoming non-compliant with their medication regimen.

Response:

DOCCS will defer to OMH for this recommendation.

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: Marlyn Kopp, Superintendent - Sing Sing Correctional Facility
Kathryn Cutter, Supervising Facility Review Specialist, NYS Justice Center