Final Review of Justice Center Oversight Action
Mental Health Service Review
[redacted] (DIN: [redacted])
JC#: 77010180212

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 42 years old and serving their first NYS bid for Predatory Sexual Assault Against a Child and Rape in the 1st degree. Their sentence was 22 years to life with a parole interview date of September 2039, no Conditional Release (CR) date and Maximum Expiration (ME) date of Life.

According to the individual's Pre-Sentencing Report (PSR), they were not engaged in any mental health services until the trial for their present offense. The individual reported having a previous issue with alcohol, however, they were able to "self-treat" by just stopping. They also noted they started smoking marijuana around age 15 or 16 and was smoking a few times a day to help with pain from an old motorcross injury to their leg and last used the day of or day before the present offense. The individual also reported using cocaine however, had difficulty remembering specifics, they believe they last used months prior to their arrest. According to the PSR, the individual did not appear to ever be in substance abuse treatment.

Per the individual's OMH Chronological Record, they were admitted to OMH services upon their admission to the Downstate Correctional Facility on September 14, 2018, as a Mental Health Service Level (MHSL) 3 and remained a MHSL 3 until their death. They had diagnosises of anti-social personality disorder (ASPD) and adjustment-disorder with mixed anxiety and depressed mood. They arrived to DOCCS custody with an active order of Wellbutrin for anxiety and depression. According to their Core History, the individual denied a history of suicidal ideation, plan or intent, suicidal gesture or engagement in self-injurious behavior. They also denied any mental health treatment in the community however, records show they received outpatient mental health treatment while in transition from the Dutchess County Jail for eight months in 2013.

[1] [redacted] (DIN: [redacted]) is hereinafter referred to as incarcerated individual

The individual was housed in the Sing Sing CF during the Justice Center's entire review period. [2] On December 30, 2024, and January 15, 2025, the individual did not attend their scheduled callout with their primary therapist. [3] They were seen by mental health staff cell side on January 30, 2025. Per the progress note the individual was in protective custody (PC) status. The clinician "informed patient she received his mail and thanked him for writing to her". The progress note does not contain an explanation of what was written in the letter, instead documenting that the individual is upset and feels the justice system "continues to screw with me" and reported "I'm here now. I don't deserve to be here". The individual did not like being placed in PC and wants to leave the Sing Sing CF. They were encouraged to accept a private callout to discuss their concerns and the individual states they would think about meeting with the clinician for a private interview in the future. They didn't report any current experience of psychiatric symptoms and denied any current suicidal ideation, plan or intent. A Comprehensive Suicide Risk Assessment (CSRA) was competed because the individual did not accept a private interview. Some of the risk factors included trauma history, Caucasian, victim of bullying/teasing, convicted of violent offense, borderline/antisocial personality disorder, purposeless, anxiety overwhelmed by prison and gang related threats or fears. They told staff "I wouldn't do that" when asked directly about suicidal ideation, plan, intent, suicidal or self-harm behaviors.

On February 13, 2024, the incarcerated individual did not attend their mental health callout. According to a February 14, 2025, psychiatric progress note, the "patient is not seen". There is no documentation to support if the individual did not show or refused to attend. The note does indicate that due to noncompliance reported by the nursing staff, the individual's psychiatric medications of Cymbalta and Benadryl were to be discontinued at that time.

The individual did not attend their next scheduled mental health callout on April 8, 2025. The clinician saw the individual cell side on April 24, 2025, where they reported "he was fine and he did not want to speak". They did ask about leaving the Sing Sing CF, noting they want to "leave ASAP but would not elaborate". The clinician again requested to meet in private, and the individual declined. The individual did not demonstrate any psychiatric symptoms and denied any suicidal ideation, plan or intent.

On June 2, 2025, the individual was discovered with multiple lacerations to the face during the afternoon meal. They refused to identify their assailant, and no perpetrator or weapon was found. They had four lacerations to the head, face and back consistent with a sharp instrument and they were sent to an outside hospital for treatment. Upon their return to the correctional facility, they were placed in involuntary protective custody

[2] December 21, 2024- [redacted]

[3] Primary Therapist Progress Notes dated December 30, 2024, and January 15, 2025, state "No Show- Patient did not attend his scheduled callout."

(IPC). Their IPC hearing was held on June 16, 2025, and the individual continued to refuse to identify their assailant and refused protective custody, so they were continued on IPC status for their safety as well as the safety and security of the facility.

At 12:08 p.m. on [redacted], the individual was found hanging in their cell by security staff. They had two net bags tied around their neck and a shelf on the cell wall. Security entered the cell and cut the individual down and lay them on the floor. The individual was unresponsive, and the Automated External Defibrillator (AED) was applied at 12:12 p.m. No shock was advised and security staff started (CPR) at 12:13 p.m. Nursing staff responded, and an ambulance was requested at 12:15 p.m. The first dose of Narcan was applied at 12: 17 p.m. with subsequent doses at 12:20 p.m., 12:23 p.m. and 12:25 p.m. in between CPR. The paramedics responded at 12: 36 p.m. and took over medical care and removed the AED at 12:37 p.m. CPR was done for 36 minutes rotating between four facility staff. The individual was pronounced deceased at 12:44 p.m. via telephone by Dr. [redacted] of [redacted] Hospital. The cause of death was noted as unknown and pending at the time. The individual was last seen alive by security staff at 11:10 a.m. during master count.

Justice Center Findings:

1. **The individual was only seen by their clinician once between January 30, 2025, and [redacted], the date of their death.**

   According to the progress notes provided to the Justice Center, the individual was seen cell side for a mental health callout on January 30, 2025, after refusing to attend call outs on December 30, 2024, and January 15, 2025. During that cell side interaction, they refused to leave their cell and discussed their need to leave the Sing Sing CF. After refusing to attend call outs on February 13, 2025, and April 8, 2025, the individual was seen cell side on April 24, 2025. They continued to have the same concerns that they needed to leave the Sing Sing CF, refusing a call out with OMH reporting that they would not leave their cell. There are no additional progress notes to support that contact was attempted with the individual between April 24, 2025, and the date of their death [redacted].

   Recommendation:

   This finding was also addressed in OMH's review of the individual's care. The Justice Center agrees with the OMH determination that the OMH Unit Chief have a supervisory discussion with the pertinent staff to review protocols and/or policies regarding missed call outs and progress note completion.

2. **The individual's medications were discontinued even though they were not evaluated by psychiatric staff during the Justice Center's review period.**

   There was only one psychiatric progress note provided for the Justice Center's review, dated February 14, 2025, and it had a check mark next to "Patient is not seen" and "therapist informed" was circled. The note does not provide an explanation as to why the individual was not seen. It does, however, have a check mark next to "nursing staff informed-non-compliant with medication and meds discontinued".

   The two clinical progress notes where the individual was seen cell side, January 30, 2025, and April 24, 2025, it is checked that the individual was not taking their medication. There is no documentation memorializing a conversation as to why they were refusing in January and/or that their medications had been discontinued prior to their April interaction.

   Request:

   The Justice Center requests that the OMH Forensic Program Administrator review the individual's February 14, 2025, psychiatric progress note and provide an explanation as to why the individual did not have the opportunity to meet with psychiatric staff and how and when the discontinuation of medications should have been discussed with the individual.

3. **It is unknown why the individual was considered protective custody (PC) status on January 30, 2025.**

   During a cell side call out with OMH, the individual reported "not liking PC and wants to leave SSCF" (Sing Sing Correctional Facility). During another interaction, on April 24, 2025, the individual reiterated they "wanted to leave asap" and "isn't leaving his cell". It is the Justice Center's understanding that following an altercation with another individual on June 2, 2025, in which they received injuries from an "uncovered cutting type weapon", the individual refused PC and was placed on involuntary protective custody (IPC).

   Request:

   The Justice Center requests that DOCCS provide an explanation and documentation to support the individual's placement in PC as noted in their interaction with OMH on January 30, 2025.

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

August 20, 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 7/20/26 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). A response from the Office of Mental Health (OMH) was not required or requested for Findings #1 and 3. Below is OMH's response to the Justice Center's second finding.

Recommendation for Finding #2:
"The Justice Center requests that the OMH Forensic Program Administrator review the individual's February 14, 2025, psychiatric progress note and provide an explanation as to why the individual did not have the opportunity to meet with psychiatric staff and how and when the discontinuation of medications should have been discussed with the individual."

OMH Response:
As noted in the Corrections-Based Operations (CBO) Risk Management Special investigation, there were numerous issues with [redacted] attending private callouts and staff rescheduling him in accordance with policy, as well as with staff not documenting their follow-up plans for [redacted]. 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, #5.0 Psychiatric Progress Notes, and #5.1 Progress Notes. The pertinent Forensic Program Administrator was involved in the review of this case as part of the Incident Review Committee (IRC), as well as when Risk Management submitted their IRC recommendations to the Unit Chief. Additionally, OMH's internal database indicated that the psychiatrist met with [redacted] on 6/13/25; however, the note was not filed in the chart at the time of [redacted] passing. The psychiatrist submitted the note to Risk Management after his interview and it is enclosed with this response.

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

August 3, 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#: 77010180212

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 the OMH Unit Chief should have a supervisory discussion with the pertinent staff to review protocols and/or policies regarding missed call outs and progress note completion.

Response:

DOCCS will defer to OMH on this recommendation.

2. Request:

The Justice Center requests that the OMH Forensic Program Administrator review the individual's February 14, 2025, psychiatric progress note and provide an explanation as to why the individual did not have the opportunity to meet with psychiatric staff and how and when the discontinuation of medications should have been discussed with the individual.

Response:

DOCCS will defer to OMH on this recommendation.

3. Request:

The Justice Center requests that DOCCS provide an explanation and documentation to support the individual's placement in protective custody as noted in their interaction with OMH on January 30, 2025.

Response:

Incarcerated individual [redacted] (DIN [redacted]) was not housed in protective custody on January 30, 2025. On January 4, 2025, he was moved to a different cell in the same housing unit from cell 0A-PN-62S to cell 0A-PN-60S. He was not moved to the protective custody unit until June 2, 2025, when he went from cell 0A-PN-60S to cell 05-0A-21S. We have attached for your review the IPC documentation from June 2025.

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 DOCCS Office of Special Investigations (OSI), 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 develop 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 - Elmira Correctional Facility
Kathryn Cutter, Supervising Facility Review Specialist, NYS Justice Center