NEW YORK STATE COMMISSION OF CORRECTION

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| In the Matter of the Death | : | FINAL REPORT OF THE |
| | : | NEW YORK STATE COMMISSION |
| of Bruce Morgan, an inmate of | : | OF CORRECTION |
| the Ontario County Jail | : | |
| | : | |

TO: Sheriff Philip C. Povero
Ontario County Sheriff's Office
74 Ontario Street
Canandaigua, NY 14424

GREETINGS:

WHEREAS, the Medical Review Board has reported to the NYS Commission of Correction pursuant to Correction Law, section 47(1)(d), regarding the death of Bruce Morgan who died on December 25, 2009 while an inmate in the custody of the Ontario County Sheriff at the Ontario County Jail, the Commission has determined that the following final report be issued.

FINDINGS:

1. Bruce Morgan was a 43 year old white male who died on 12/25/09 at 2:28 a.m. from suicidal hanging at the Ontario County Correctional Facility (CF) while in the custody of the Ontario County Sheriff. Despite nearly constant complaints of mental disorder symptoms while incarcerated, he received no mental health diagnosis, evaluation or treatment due to negligent supervision of non-clinical mental health care providers and a failure to observe, i.e., constraints of licensure.

2. [redacted]

3. [redacted]

4. Morgan had been admitted to the Ontario County CF on 7/30/09 [redacted] Morgan was readmitted into the Ontario County CF on 9/19/09. [redacted]

[redacted]

5. On 9/16/09 at 9:25 a.m., Officer C. completed Morgan's initial booking process and suicide screening upon admission to the Ontario County CF. Morgan scored one point on the suicide screen, giving an affirmative answer to "Detainee has a history of drug or alcohol abuse." In the comment section, "alcohol" was listed. [redacted]

6. [redacted] NP D.H. stated she had a movement and activity log completed by the security staff observing inmates who state they are on pain medication on admission. The purpose of this log is to determine whether the inmate's pain is interfering with his/her activities of daily living. Morgan's movement and activity log kept by his housing officer from 9/29/09 to 10/5/09 indicated he did not have any functional limitations. The movement and activity log also reported Morgan did not attend daily exercise. [redacted]

7. [redacted] There does not appear to be a timely review of these forms by mental health. There is no mental health screening completed for Morgan's incarceration commencing on 9/16/09. This is a violation of the Ontario County

CF staff operations procedures entitled Suicide Prevention (IV,E) dated 2/3/09 which states:

> The provisions of all related Bureau Directives including, but not limited to "Inmate Supervision Mental Health/Developmental Disability Screening" and "Admission and Discharge of inmate" shall be complied with at all times.

8. [redacted]

9. [redacted]

10. [redacted]

[redacted]

11. [redacted]

12. [redacted]

[redacted] J.M., LMSW, stated he spends 5 to 10 hours a week at the Ontario County Correctional Facility interviewing and evaluating inmates. K.D., LCSW, spends about 20 hours at the correctional facility reviewing the mental health screens and evaluations and mental health referrals. These services are provided for an average daily population of approximately 210 inmates at Ontario County CF. K.D., LCSW, will also evaluate inmates as needed. Both mental health clinicians stated they review the inmates' suicide prevention screens, however, the suicide screens are not included in the Ontario County CF mental health records. J.M., LMSW, reported about one hour a week in supervision with K.D., LCSW, but K.D. is available on an as-needed basis to discuss any mental health concerns that arise with the inmates. [redacted] The social worker indicated that it may take up to two weeks to address a mental health referral or request.

13. [redacted]

14. [redacted]

15. On 12/24/09, Morgan made a number of phone calls to the telephone number listed for his wife. According to the Ontario County telephone log, the first call was made at 2:18 p.m. at which time he conversed with someone at his home number for fifteen minutes. Morgan made three other telephone calls at 4:55 p.m., 4;56 p.m. and 6:27 p.m. to the same home number. Morgan connected with the same telephone number at 6:29 p.m. and spoke for fifteen minutes. Morgan made eight attempts to connect at 8:26 p.m., 8:27 p.m., 8:41 p.m., 8:42 p.m., 8:43 p.m., 8:50 p.m. (twice without success) and 8:54 p.m. The visitor's log indicated that Morgan's wife visited him regularly in jail with the last visit listed on 12/20/09. Documentation by the Ontario County Sheriff's Department stated that when Morgan's wife was notified of his death, she stated she spoke to Morgan twice on 12/24/09 and he gave no indications of suicidal thoughts. Morgan's wife stated that Morgan had phoned her a third time but she did not answer the phone as she had spoken to him twice earlier.

16. On 12/24/09 at 9:08 p.m., Officer M.B. contacted the Pod #4 housing officer and asked if Morgan was available for a work detail. Officer M.B. stated he usually requested Morgan as he was a good worker. The Officer went to Pod #4 and retrieved Morgan from his cell. Officer M.B. and Morgan went to Pods #7 and #8 and emptied the laundry bins there. Officer M.B. stated he had engaged in conversation with Morgan for the entire time of the work detail. Officer M.B. stated Morgan had said his wife had gotten into an accident with their minivan and she was charged with AUO 3rd. The officer stated that Morgan was not particularly upset about the accident. Officer M.B. stated Morgan did not appear anymore angry or distressed than any other husband would be if they found out their wife had an accident with the car, but was somewhat annoyed with the incident. On the way back to Morgan's housing pod, he asked Officer M.B. if they could stop in the supply room to pick up a book. Officer M.B. agreed and Morgan picked up two books. Morgan told the officer that he was reading a novel a night. Morgan also suggested that he and another inmate be assigned to the supply room to organize the books there. Officer M.B. stated he told Morgan he thought it was a great idea. Officer M.B. returned Morgan at 9:40 p.m. Officer M.B. stated he had used Morgan for work detail at least six times in the last two months and he never appeared depressed to the officer.

17. On 12/24/09 at 11:00 p.m., Officer A.M. reported to duty as the Pod #4 housing officer. Officer D.W. briefed Officer A.M. on the previous shift. Officer A.M. stated Officer D.W. did not speak of Morgan during the briefing. At the beginning of the night shift, Officer A.M. stated that Morgan had asked him if there was any work for him that night. At 12:27 a.m., Officer M.S. made a supervisory round and stated Morgan looked like he was asleep. At 12:56 a.m., when Officer A.M. was making his supervisory round, he observed

Morgan sitting up reading a book. Officer A.M. stated Morgan looked up at him and nodded to him.

18. On 12/25/09 at 1:27 a.m. when Officer A.M. was making his supervisory round, he observed Morgan sitting on the floor with his back facing the cell door. The officer stated Morgan did not look right. Officer A.M. stated he rattled the door and called out Morgan's name but there was no response. Officer A.M. opened Morgan's cell door, and called a Code Blue, pod 4. Code blue is specific for "Officer needs rover and medical assistance." Officer A.M. stated once he was able to open the cell door he was able to observe a piece of sheet around Morgan's neck. The sheet was tied to the handicap bar on his sink. It was tied up like a figure eight. Officer A.M. reported he wrapped his arms around Morgan and lifted him in an attempt to take the pressure off Morgan's neck. Officer V.H. arrived moments later and placed her fingers in between the sheet and his throat. Officers S.C., F.V. and O. arrived at Morgan's cell. Officer F.V. used his keys to cut the sheet from Morgan's neck.

19. Officer M.D. was in Pod #5 when he heard Officer A.M. call on his radio "Code Blue, pod 4." Officer M.D. responded to the code after Officer M.S. came to cover pod #5. He went to the Sergeant's office to obtain the cut down tool (a curved shaped knife). In the meantime, Sgt. T.D. stated he obtained the cut down tool from the sergeant's office. Officer M.D. stated he looked for an AED and a first-aid kit, and not seeing them, he ran over to the medical unit. Officer M.D. stated both himself and Sgt. T.D. were at the medical unit looking for the AED. Both Officer M.D. and Sgt. T.D. stated they could not find the AED in the medical unit. The Ontario County Correctional Facility Medical Operations policy entitled First Aid Kits and Emergency Bag (A.3) states:

> Locations: Automatic emergency defibrillator (AED): one in the Medical Officer Emergency Supply room and one in the Administrative Area.

Officer D.P. documented she went to the lobby area to retrieve the AED there. Officer M.D. stated he arrived at Pod 4 with Officers D.P., J.S. and Sgt. T.D.

20. CPR for Morgan was initiated by Officers A.M. and F.V. Officer A.M. was having difficulty with the mask seal and another face mask was obtained from the Pod 3 first aid kit which had a better seal. Officers V.H. and F.V. attached the AED to Morgan's chest. Officers A.M., M.D., and F.V. rotated in performing CPR until the Canandaigua Emergency Squad arrived. All resuscitation efforts before the ambulance arrived were completed by security staff as the Ontario County CF does not having nursing staff during the night shift.

21. A review of the computerized security log revealed that the only notation that refers to this event is on 12/25/09 at 1:42 a.m. and is documented by Officer S.C. as "EMT responded." It was reported that log entries can be made at the pod station check point as well as computer at the housing officer's desk in the pod. This is a violation of the NYS Commission of Correction's Minimum Standards, section 7003.3(j)(6)(m), Supervision of prisoners in facility housing areas which states:

> (j) All written records pertaining to facility housing supervision required pursuant to this section shall be recorded in ink in a bound ledger of consecutively numbered pages which shall be maintained in each housing area. Such records shall include, but not be limited to, the following information:
>
> (6) any significant events and activities occurring during supervision, including:
> (i) the date and time of each such event or problem;
> (ii) the names of all prisoners and/or staff involved;
> (iii) facility response to such event or problem, including
> a summary of what occurred; and
> (iv) a description of the condition of any prisoners involved.
>
> (m) Notwithstanding the provisions of this section requiring a bound ledger, records pertaining to facility housing supervision may be recorded on a computerized log.

22. [redacted]

RECOMMENDATIONS:

TO THE SHERIFF OF ONTARIO COUNTY:

1. The Sheriff shall direct the Ontario County Correctional Facility security staff to fully comply with the Commission's Minimum Standard, section 7003.3 entitled Supervision of prisoners in facility housing areas.

2. The Sheriff shall direct the Ontario County Correctional Facility nursing staff to comply with the Ontario County Correctional Facility Staff Operations entitled Suicide Prevention (IV, E) dated 2/3/09 which states:

> The provisions of all related Bureau Directives including, but not limited to "Inmate Supervision Mental Health/Development Disability Screening" and "Admission and Discharge of inmate" shall be complied with at all times.

3. The Sheriff shall direct the Ontario County Correctional Facility administrative staff to issue a memo regarding the location of facility AEDs in the medical area.

4. The Sheriff shall direct the Ontario County Correctional Facility administrative staff to assist the Ontario County Mental Health Department to include the inmates' suicide screens in their mental health Ontario County records.

TO THE DIRECTOR OF THE ONTARIO COUNTY MENTAL HEALTH DEPARTMENT:

1. The Director shall conduct a quality assurance review regarding the mental health evaluation of patients performed by J.M., Licensed Master Social Worker. Such a review should include audit of a representative sample of patient records for quality and propriety including observation of the constraints of licensure.

2. The Director shall conduct a quality assurance review regarding the practice of K.D., Licensed Clinical Social Worker, in the areas of the quality, frequency and attentiveness of supervision of LMSW's. Additionally, there should be an examination into the clinical approach to inmates who make repeated self-referrals and requests for services while reporting mental health symptoms.

3. The Director shall conduct a quality assurance review regarding the response time for mental health clinicians to see inmates who submit mental health referrals.

4. The Director shall develop a written policy regarding referral of inmate/patients who make repeated self-referrals for mental health services citing persistent signs and symptoms of mental health disorder as a basis for referral by social workers to higher levels of care, either a psychologist or psychiatrist.

5. The Director shall develop a patient education tool with associated in-service colloquia regarding the prescription of common psychoactive medications, their usage, actions, benefits, and disadvantages as a basis for patient education during the social workers' evaluations and encounters with inmates at the Ontario County Correctional Facility.

6. The Director shall develop a policy and procedure regarding informed Refusal of Treatment forms to be implemented at the Ontario County Correctional Facility when an inmate refuses further mental health treatment and/or psychotropic medication after patient education.

7. The Director shall provide the documented results of the above requested quality assurance reviews, the patient education tool and colloquia and the policy and procedure regarding the use of the Refusal of Treatment Form to the Commissioner of the NYS Commission of Correction's Medical Review Board by May 25, 2011.

WITNESS, HONORABLE PHYLLIS HARRISON-ROSS, M.D., Commissioner, NYS Commission of Correction, 80 Wolf Road, 4th Floor, in the City of Albany, New York 12205 this 24th day of December, 2010.

Phyllis Harrison-Ross, M.D.
Commissioner

PHR:mj
09-M-181
8/10

cc: William Swingly, Director of Community Services, Ontario County Mental Health Dept.

NEW YORK STATE COMMISSION OF CORRECTION

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| In the Matter of the Death<br><br>of Gary Pfleuger, an inmate of the Clinton CF | :<br>:<br>:<br>:<br>: | FINAL REPORT OF THE NEW YORK STATE COMMISSION OF CORRECTION |

TO: Honorable Brian Fischer
Commissioner
NYS Department of Correctional Services
State Campus, Building #2
Albany, New York 12226

GREETINGS:

WHEREAS, the Medical Review Board has reported to the NYS Commission of Correction pursuant to Correction Law, section 47(1)(d), regarding the death of Gary Pfleuger, who died on September 22, 2009 while an inmate in the custody of the NYS Department of Correctional Services at the Clinton Correctional Facility, the Commission has determined that the following final report be issued.

FINDINGS:

1. Gary Pfleuger was a 38 year old male who died on 9/22/09 from a suicidal hanging that occurred on 9/18/09 while in the custody of the NYS Department of Correctional Services (DOCS) at the Clinton CF. Pfleuger was a mental health patient on the active case load at the time of his death. His mental health was characterized by inattentive case management with multiple changes in treatment regime at a distance without clinical encounters.

2. Gary Pfleuger was born in Buffalo, NY. He was married and had three sons. Due to his arrest and conviction, he was separated from his wife of 19 years and going through a divorce. Pfleuger was employed as a correction officer for DOCS at the time of his arrest.

3. Gary Pfleuger had no prior criminal record. In the instant offense, Pfleuger was convicted at trial of Attempted Criminal Sexual Act 1st and Sexual Conduct - Child 2nd. [redacted] Pfleuger was sentenced to 17 to 20 years in DOCS.

4. Pfleuger was sentenced on 4/6/09 and received at Wende CF on 4/9/09. Pfleuger was transferred to Elmira CF on 4/17/09. Due to his employment as a correction officer, Pfleuger was considered in need of long term protective custody and was placed in the Assessment and Program Preparation Unit (APPU) at Clinton CF on 7/2/09. Pfleuger had no incident reports or disciplinary infractions during his incarceration.

5. [redacted]

6. [redacted]

7. [redacted]

8. [redacted]

9. [redacted]

10. [redacted]

11. [redacted]

12. On 7/2/09, Pfleuger was transferred to Clinton CF to be housed in the APPU. [redacted]

13. [redacted]

14. [redacted]

[redacted]

15. [redacted]

16. [redacted]

17. [redacted]

18. [redacted]

19. [redacted]

20. [redacted]

21. [redacted]

[redacted]

22. [redacted]

23. [redacted]

24. [redacted]

25. [redacted]

26. [redacted]

27. [redacted]

[redacted]

28. [redacted] Commission staff noted during the investigation that Dr. S.G. was the only psychiatrist assigned Clinton CF, (2900 total beds) at the time of Pfleuger's death. The clinical staffing deployment to the facility is grossly inadequate and argues strongly for adjunct services such as telepsychiatry.

29. On 9/17/09 at approximately 10:17 a.m., inmate block porter D.H. found Pfleuger hanging in his cell LH-4-27. Pfleuger had tied off to the front cell bars with a sheet and was in a kneeling position. Inmate D.H. reached through the bars and attempted to hold Pfleuger up while calling for help. Inmate T.K. heard D.H. yelling for help and assisted holding Pfleuger up until help arrived.

30. Officers T.U. and C.H. heard the yelling from 4 gallery and responded to the area. Officer D. opened the cell block and the officers entered the cell. Officer C.H. lifted Pfleuger up while Officer T.U. removed the sheet from around Pfleuger's neck. The officers then laid Pfleuger on the floor outside the cell.

31. Sgt. T.W. responded to the area and called for a medical response. Officers C.H. and T.U. placed Pfleuger on a stretcher and escorted him out to the hallway between galleries three and four. [redacted]

32. [redacted]

33. [redacted]

RECOMMENDATIONS:

TO THE NYS OFFICE OF MENTAL HEALTH, DIVISION OF FORENSIC SERVICES:

1. The Division of Forensic Services should conduct a quality assurance/improvement study on the psychiatric care provided to Gary Pfleuger. [redacted]

2. The Division of Forensic Services should conduct a quality assurance/improvement study on the clinical care provided to Gary Pfleuger by the psychologist. [redacted]

3. The Division should address the inadequate availability of psychiatry at Clinton CF with consideration of adjunct services such as telepsychiatry.

WITNESS, HONORABLE PHYLLIS HARRISON-ROSS, M.D., Commissioner, NYS Commission of Correction, 80 Wolf Road, 4th Floor, in the City of Albany, New York 12205 this 24th day of December, 2010.

Phyllis Harrison-Ross, M.D.
Commissioner

PH-R:mj
09-M-131
8/10

cc: Superintendent Thomas LaValley, Clinton CF
Dr. Carl Koenigsmann, Chief Medical Officer
Elizabeth Ritter, Assistant Commissioner
Richard Miraglia, Division of Forensic Services, NYS Office of Mental Health
Don Sawyer, Executive Director, Central New York Psychiatric Center
Jayne VanBramer, Director, Bureau of Quality Management, OMH

NEW YORK STATE COMMISSION OF CORRECTION

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| In the Matter of the Death<br><br>of Jesse Ramirez, an inmate of<br>the Anna M. Kross Center | :<br>:<br>:<br>:<br>: | FINAL REPORT OF THE<br>NEW YORK STATE COMMISSION<br>OF CORRECTION |

TO: Commissioner Dora Schriro
NYC Department of Correction
75-20 Astoria Blvd, Ste. 100
East Elmhurst, NY 11370

GREETINGS:

WHEREAS, the Medical Review Board has reported to the NYS Commission of Correction pursuant to Correction Law, section 47(1)(d), regarding the death of Jesse Ramirez who died on August 5, 2009 while an inmate in the custody of the NYC Department of Correction at the Anna M. Kross Center, the Commission has determined that the following final report be issued.

FINDINGS:

1. Jesse Ramirez was a 34 year old male inmate who died on 8/5/09 from a suicidal hanging while in the custody of the NYC Department of Correction (NYCDOC) at the Anna M. Kross Center. Ramirez was under the mental health care of Prison Health Services, Inc. (PHS, Inc.), a business corporation holding itself out as a medical care provider. Ramirez received inadequate mental health care, without continuity of care characterized by nine (9) conflicting diagnoses, none of which [redacted] were supported by clinical evidence. Additionally, Ramirez did not receive an adequate suicide risk assessment from a mental health clinician after being referred by correction staff on the date of his death.

2. Jesse Ramirez was born and raised in the Brooklyn, NY area. He completed the 10th grade but obtained his GED during a prior incarceration. Ramirez was engaged to be married and had one child. [redacted] He had a recent family loss when his father died on 1/18/09.

3. [redacted]

4. Jesse Ramirez was admitted into NYCDOC custody at AMKC on 2/8/09. He was initially housed on 2/10/09 in Dorm 4 Main for new admissions. On 2/17/09, he was reassigned to Quad 6 Upper, general population. His last move was to Quad 15 Upper cell #3 on 4/29/09. Ramirez had an uneventful incarceration with no unusual incidents or disciplinary infractions.

5. [redacted]

6. [redacted]

7. [redacted]

8. [redacted]

9. [redacted]

10. [redacted]

11. [redacted]

[redacted]

12. [redacted] This represents an inadequate and inappropriate approach to the patient.

13. [redacted]

14. [redacted]

15. [redacted]

16. [redacted] As noted elsewhere herein, this represents a reckless and cavalier diagnostic approach to this patient.

17. [redacted]

18. [redacted]

19. [redacted]

20. On 8/5/09, Correction Officer G.C. was assigned the A post on Quad Upper 13/15 for the 11:00 p.m. to 7:00 a.m. tour. At approximately 5:00 a.m., Officer G.C. observed Ramirez pacing back and forth in the tier. Officer G.C. called Ramirez over and asked him what was going on. Ramirez stated that he was upset due to family problems, was not sleeping well, and was being seen by mental health for depression. Ramirez began crying and said that his girlfriend didn't want to be with him anymore. Officer G.C. talked with Ramirez and assured him that she would get him sent down to the mental health clinic as soon as she could.

21. Officer G.C. filed a Referral of Inmates to Mental Health Services form on Ramirez noting "unable to sleep," "being depressed" and documenting "inmate is crying profusely and is continuously stating he needs to speak to a psych." Officer G.C. was relieved by Officer L.R. at 7:00 a.m. Officer G.C. debriefed Officer L.R. and informed her of the need to have Ramirez sent to the mental health clinic. Officer L.R. made notification to area Captain A. who took responsibility for processing the referral.

22. Ramirez was observed by Officer L.R. to follow his usual housing unit routine for the rest of the morning. After the count, Ramirez went to the dayroom to use the phone. At approximately 9:30 a.m., he went out to the recreation yard.

23. [redacted]

24. [redacted]

25. [redacted] This represents flagrantly inadequate mental health evaluation and treatment by PHS, Inc. staff.

26. Officer K.P. was assigned supervision of the B post on 8/5/09 for the 3:00 p.m. to 11:00 p.m. tour. Officer L.R. remained the A post officer for overtime. Officer K.P. conducted the count at approximately 3:20 p.m. and had all inmates accounted for. Officer K.P. then conducted a supervisory tour at 3:45 p.m. with all appearing secure.

27. Officer K.P. proceeded to hand out soap supplies to the inmates and began on the 15 side of the unit. At approximately 4:10 p.m., he approached Ramirez' cell (#3) and observed that a sheet was covering the bars on the cell door. Officer K.P. pulled the sheet away and observed Ramirez on the floor with a ligature around his neck and affixed to the cell door. Officer K.P. called to Officer L.R. and ordered cell #3 opened.

28. Officer K.P. had difficulty opening the cell door as the sheet was jammed in the door mechanism. Officer K.P. ordered Officer L.R. to release a nearby inmate to assist him. Officer K.P. and an inmate finally forced the door open and were able to enter the cell. Ramirez was found seated on the cell floor with his back against the cell door. Officer K.P. utilized his cut down tool to remove the ligature from Ramirez' neck. Ramirez was checked for a pulse and breathing, found none, and started CPR.

29. [redacted]

[redacted]

RECOMMENDATIONS:

TO THE DEPUTY COMMISSIONER, DIVISION OF HEALTH CARE ACCESS AND IMPROVEMENT, NYC DEPARTMENT OF HEALTH AND MENTAL HYGIENE:

1. The Division shall require PHS, Inc. to conduct a comprehensive quality improvement review of the psychiatric care provided to Ramirez by PHS, Inc. while in the custody of the NYC Department of Correction. Specifically, the review shall focus on:

   a. [redacted]

   b. [redacted]

   c. [redacted]

2. The Division shall require PHS, Inc. to conduct a comprehensive quality improvement review of the mental health care provided to Ramirez by the mental health clinicians while in the custody of the NYC Department of Correction. Specifically, the review shall focus on:

   a. Verification of continuity for patients who are recommended for group therapy as part of their treatment plan have been afforded the opportunity to attend such programs;

   b. [redacted]

3. The Division shall require PHS, Inc. to conduct training for all clinical staff on suicide risk assessment, as approved by the State Commission of Correction.

4. The Deputy Commissioner, in consultation with the Health Commissioner, should ask the NYC Corporation Counsel's Office to inquire into the status of PHS, Inc. to lawfully hold itself out as a medical care provider in New York State.

WITNESS, HONORABLE PHYLLIS HARRISON-ROSS, M.D., Commissioner, NYS Commission of Correction, 80 Wolf Road, 4th Floor, in the City of Albany, New York 12205 this 24th day of December, 2010.

Phyllis Harrison-Ross, M.D.
Commissioner

PH-R:mj
09-M-114
8/10

cc: Eric Berliner, Executive Director
of Health Services
Lewis Finkelman, General Counsel
Archana Jayaram, Chief of Staff
Louise Cohen, Deputy Commissioner
Correctional Health Services, NYC
Department of Health & Mental Hygiene
Robert Berding, Deputy Executive Director
Policy and Planning, NYC Department
of Health & Mental Hygiene
George Axelrod, Deputy Executive Director,
NYC Department of Health & Mental Hygiene

NEW YORK STATE COMMISSION OF CORRECTION

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| In the Matter of the Death | : | FINAL REPORT OF THE |
| | : | NEW YORK STATE COMMISSION |
| of Clifford Renshaw, an inmate | : | OF CORRECTION |
| of the Chautauqua County Jail | : | |
| | : | |

TO: Sheriff Joseph Gerace
Chautauqua County Sheriff's Office
15 E. Chautauqua Street
Mayville, NY 14757

GREETINGS:

WHEREAS, the Medical Review Board has reported to the NYS Commission of Correction pursuant to Correction Law, section 47(1)(d), regarding the death of Clifford Renshaw who died on July 2, 2009 while an inmate in the custody of the Chautauqua County Sheriff at the Chautauqua County Jail, the Commission has determined that the following final report be issued.

FINDINGS:

1. Clifford Renshaw was a thirty year old white male who died on 7/2/09 at the Erie County Medical Center from a suicidal hanging at the Chautauqua County Jail while in the custody of the Chautauqua County Sheriff. His mental health evaluation, care and treatment was characterized by gross incompetence and professional misconduct as part of an overall systemic failure of care at the Chautauqua County Jail. The Board found that had Mr. Renshaw received adequate care, his death may have been prevented. Medical and mental health services at the Chautauqua County Jail are deficient and violative of State regulations to an extent that makes the Chautauqua County Jail unsafe for some or all of its inmates.

2. [redacted]

3. In the instant offense, Renshaw was arrested on one count of Criminal Contempt 2nd, a misdemeanor, and one count of Trespass, a violation. His bail was set at $5,000/$10,000 cash/bond. This charge involved a complaint filed by an ex-girlfriend.

4. Renshaw was separated from his wife and was the father of three children. He completed special education classes up to 8th grade. He was collecting social security disability and was working as a handyman for his landlord.

5. [redacted]

6. Renshaw had been followed in the community by various community services for a period of several years. [redacted]

[redacted]

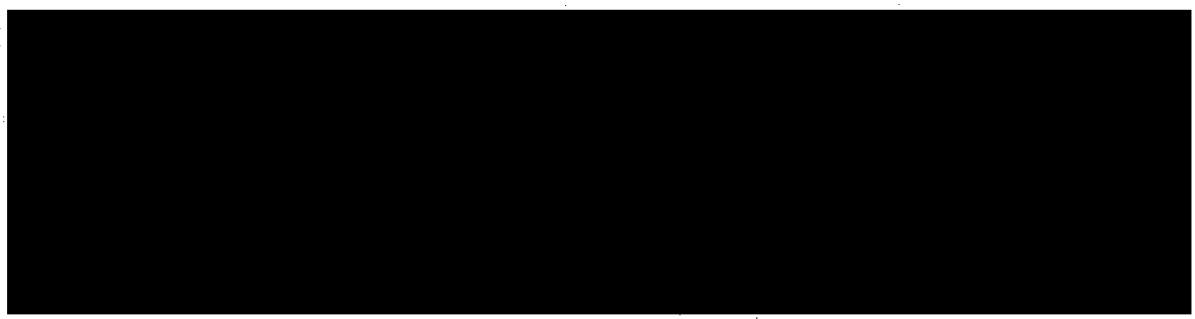
7. [redacted]

8. In the month prior to Renshaw's incarceration, he had established a relationship with a former girlfriend. Renshaw stated that the girlfriend had a child a few years ago that may have been his or his brother's. [redacted]

9. On 6/9/09, Renshaw was arrested by the Jamestown PD for Harassment 2nd. The charges were filed by his girlfriend who alleged that he had assaulted her. She had obtained an Order of Protection. [redacted]

10. [redacted]

11. [redacted]



12. Clifford Renshaw was arrested by the Jamestown Police Department on 6/21/09 on one count of Criminal Contempt 2nd and one count of Trespass following a violation of the Order of Protection. He was arraigned by Judge P. in the Jamestown City Court and remanded to the Chautauqua County Jail in lieu of $5,000 cash/$10,000 bond.

13. Renshaw was booked into the facility by Officer L.B. who completed Renshaw's Suicide Prevention Screening Guidelines. Renshaw scored a "5" giving affirmative answers to:

    4. #4 Detainee is very worried about major problems other than legal situation: stating he was worried about his family's well being.
    5. #5 Detainee's family member or significant or other has attempted or committed suicide: stating his brother committed suicide 15 years ago.
    6. #7 Detainee has history of counseling or mental health evaluation/treatment: Renshaw was currently an active participant in the ACT Program.
    7. #10 a,b, Detainee has previous suicide attempt/attempt within the last month: stating he took a drug overdose three weeks ago.

    Question #10 is a shaded area on the screening form designed as an automatic notification to the supervisor and for the imposition of constant supervision.

    The supervisor was notified and Renshaw was referred to medical and mental health. Renshaw was *not* placed on constant supervision and was not evaluated by a mental health clinician until 6/23/09.

    This practice is not in accordance with either the written suicide prevention screening guidelines or the associated training. Moreover, since it was clear that Renshaw needed additional supervision, the failure by jail managers and staff to order and implement it is a violation of 9 NYCRR section 7003.3(h), *Supervision of Prisoners in Detention Areas*.

14. The Chautauqua County Jail's medical policy and procedure states that immediately following recognition that an inmate is at risk for suicide, placement in a housing area that affords the closest monitoring, i.e., constant surveillance, is appropriate until the inmate can be further assessed by a mental health professional or psychiatrist.

15. This lapse by jail management and staff also shows the Chautauqua County Jail's operations policy and procedure to be inadequate, in that it fails to require that those inmates scoring high and/or having a scored shaded area on the screening guideline shall be automatically assigned constant supervision until the inmate can be examined by an appropriately licensed mental health professional.

16. The Chautauqua County Sheriff, Chautauqua County Director of Health and the Chautauqua County Director of Mental Health failed to develop and/or implement adequate policies and procedures for inmates entering the facility who are considered to be at high risk for self harm. No coherent system exists at the Chautauqua County Jail whereby all departments are trained according to the suicide prevention and crisis intervention and to comply with all suicide prevention and risk assessment policies and procedures.

The lack of adequate policies and procedures for inmates entering the facility who are considered to be at high risk for self harm is a violation of 9 NYCRR §7013 *Classification*, *§7013.3 Facility Policies and Procedures* which states in pertinent part: *The chief administrative officer of each correctional facility shall develop and implement written policies and procedures which provide for the assessment and classification of inmates and comply with the requirements of this Part. Such policies and procedure shall include, but are not limited to*

*(2) completion of initial screening and risk assessment including, but not limited to, the determination of security and supervision requirements and inmate special needs;*
*(3) use of formal risk assessment instructions and other appropriate admissions forms in the classification process;*

Section 7013.7 *Initial Screening and Risk Assessment*, which states in part:

*(b) Each inmate upon admission to a facility shall undergo an initial screening and risk assessment which shall consist of a screening interview, visual assessment, and review of commitment documents. Such screening and risk assessment shall occur immediately upon an inmate's admission. A screening instrument(s) shall be utilized to elicit and record information on each inmate relating to the following:*

*(4) history of mental illness or treatment*
*(6) prior attempts at self-0injury or suicide;*

*(b) An immediate decision concerning the disposition of each inmate shall be made on the basis of information gathered during initial screening and risk assessment. Such disposition may include, but is not limited to, referrals to outside medical and mental health providers.*

17. [redacted]

18. Renshaw was admitted to B block on active supervision to await primary classification. Officer L.B. noted on Renshaw's initial classification that Renshaw was cooperative, claiming that he was not suicidal or a past behavioral problem in the facility. She *did* mark under "Special Conditions" that Renshaw was "mentally slow."

19. [redacted]

20. The Chautauqua County Jail does not maintain an integrated medical/mental health record. There is no documentation that this information was forwarded to the mental health providers.

21. The clinical encounter that should have resulted in a thorough medical history and physical exam pursuant to state regulations was inadequate.

[redacted]

[redacted]

This represents an inadequate and poorly documented history and physical. There are no recorded vital signs or any recorded physical assessment. The review of systems was inadequate. The signature on the note is not legible.

When interviewed regarding this exam, the PA incorrectly stated that the nurses generally have completed an extensive history and physical when he conducts his clinical encounter. The nurses had not completed the history and physical. According to the PA, his sole objective was to prescribe mental health medications until Renshaw was seen by the psychiatrist.

The gross inadequacy of this examination is a violation of 9 NYCRR section 7010.2(b)(1), *Health Services.*

22. The PA was not able to recall whether a Suicide Prevention Screening Guideline was available in Renshaw's medical record. It was subsequently learned that the Suicide Prevention Screening Guidelines are not placed in the medical record at all, only in the mental health record. The jail administration stated that this information is readily available to the medical staff on the jail's computer management system. Use of the jail management system is not contemplated in either the jail's written suicide prevention screening guidelines or the associated training.

This is also a violation of §7013.2(j) *Health Services* which states in part, *Adequate health service and medical records shall be maintained which shall include but shall not necessarily be limited to such data as: date, name(s) of inmate(s) concerned, diagnosis of complaint medication and/or treatment prescribed. A record shall also be maintained of medication prescribed by the physician and dispensed to a prisoner by a staff person.*

The Chautauqua County Jail was previously cited for violation of this standard in health care evaluations conducted by the Commission in 2007 and 2009.

23. The Chautauqua County Jail's mental health services are provided by the Chautauqua County Mental Health Services. The service providers include K.N., a Baccalaureate level social worker employed full time at the jail, and Dr. C.T., psychiatrist, who is allotted 3-4 hours weekly at the jail during which time she sees approximately 15 patients. Approximately one-third of the Chautauqua County inmates are prescribed psychotropic medication.

24. [redacted]

25. [redacted]

26. [redacted]

27. [redacted]

28. On 6/25/09, Inmate B.S. reported to Officer B.S. that Renshaw was "talking about hanging up." An incident report states that at approximately 1:07 p.m. on 6/25/09, Officer B.S. was making a supervisory round and overheard Renshaw say that he was going to end it all by hanging up. Renshaw was escorted to booking and placed on constant supervision.

29. [redacted]

[redacted]

30. [redacted] K.N. is not sufficiently credentialed to discontinue an inmate's constant supervision. [redacted] No physician had seen Renshaw in reference to his continuance from suicide prevention precautions.

31. The facility failed to establish a supervisory log for Renshaw's constant supervision. This is a violation of 9 NYCRR §7003.3(j), *Security and Supervision* which states in part:

> *(j) All written records pertaining to facility housing supervision required pursuant to this section shall be recorded in ink in a bound ledger of consecutively numbered pages which shall be maintained in each housing area. Such records shall include, but not be limited to, the following information:*
>
> *(1) the name of the facility housing area in which the supervision is being maintained;*
> *(2) the name(s) of facility staff conducting the supervision;*
> *(3) when active supervision is conducted, the date and time supervision is initiated and the date and time it ends;*
> *(4) when general supervision is conducted, the date and time each supervisory visit is performed pursuant to the requirements of subdivision (b) of section 7003.2 of this Part and the signature of facility staff conducting the supervisory visit;*
> *(5) when the chief administrative officer and/or the facility physician determine a prisoner requires additional supervision pursuant to subdivision (h) of this section:*
> *(i) the reasons underlying such determination;*

*(ii) orders made requiring such additional supervision, including the dates and times when the supervision is to be initiated and end;*

*(iii) the name(s) of the individual(s) making such determination and/or ordering the supervision;*

*(iv) the dates and times when supervision was initiated and ended;*

*(v) the name(s) of facility staff conducting the supervision; and*

*(vi) periodic facility staff observations of the prisoner's condition or behavior;*

*(6) any significant events and activities occurring during supervision, including:*

*(i) the date and time of such event or problem;*

*(ii) the names of all prisoners and/or staff involved;*

*(iii) facility staff response to such event or problem, including a summary of what occurred; and*

*(iv) a description of the condition of any prisoners involved.*

32. [redacted]

[redacted]

33. [redacted]

34. [redacted]

35. [redacted]

[redacted]

36. On 6/27/09 Officer B.S. was scheduled to work a double shift that started at 3:00 p.m. He was assigned to the first floor where Renshaw was housed for both shifts. He stated he recalled speaking to Renshaw at approximately 6:00 p.m., 7:50 p.m. and 8:55 p.m., concerning repeated loss of wristband, bail bond and exercise the following day. According to Officer B.S., Renshaw showed interest in the next day's activities and made good eye contact.

37. At approximately 9:15 p.m., while making a supervisory visit, Officer B.S. discovered Renshaw hanging from a bed sheet tied through the bars of his cell. Officer B.S. stated that he called for assistance, then unlocked the A-Block doors for responders.

Officers S., G., F., K., A. and P responded. Officers S. and F. held Renshaw up while Officers A. and K. tried unsuccessfully to get the knots out of the ligature. The sheet had been wetted and tied through the bars and double knotted at the front of his neck. Sgt. M. arrived and cut the knot with a pocket knife. Renshaw was without pulse and apneic. CPR was immediately started and the AED applied with no shockable rhythm. [redacted]

38. [redacted]

39. The Medical Review Board found that Mr. Renshaw's medical and mental health care was grossly and flagrantly inadequate, stemming from the nearly complete systemic failure of the Chautauqua county Jail's health and mental health care delivery system.

a. [redacted]

b. Correction officers deliver all medications at the Chautauqua County Jail with the exception of controlled substances. The Commission requires that the jail's registered nurses manage the medication delivery system within the jail, however, it would appear that there is a fundamental breakdown in that system as illustrated by this case. The Commission has in the past recommended that a registered nurse make the initial medication pass in the morning which would alert the medical providers of the effectiveness of medication, medications not available, refusals, etc. This practice has never been implemented.

c. The jail currently employs only two full-time registered professional nurses through the Chautauqua County Health Department for a population of approximately 300 inmates, including 65 boarded-in federal inmates.

A 2006 health Services staffing analysis for the Chautauqua County Jail requires at a minimum <u>three</u> full time RN positions. Two RNs are required on the 7:00 a.m. to 3:00 p.m. shift and a full time RN position is required for the 3:00 p.m. to 11:00 p.m. shift. The analysis does not prescribe a formal coverage factor but clearly indicates that the facility make the necessary arrangements to ensure these positions are covered at all times seven days a week (additional full-time, part time, per diem coverage). The jail does not meet this staffing requirement.

Consequently, the Chautauqua County Jail is in violation of 9 NYCRR §7041.2 *<u>Staffing Requirements</u>* which states in part: *<u>Facility functions and formulation of daily staffing needs</u>*.

*(a) The State Commission of Correction shall, in determining the minimum facility staffing requirement for each local correctional facility, ascertain the functions to be performed by facility staff including, but not limited to:*

*(5) medical services;*

*(b) The State Commission of Correction shall, in determining the minimum facility staffing requirement for each local correctional facility, consider the following factors, among others:*

*(1) the physical plant of the facility;*
*(2) the maximum prisoner capacity of such facility established pursuant to Part 7040 of this Subtitle; and*
*(3) any other factors including those unique to a particular facility.*

*(c) The State Commission of Correction shall, upon compliance with subdivisions (a) and (b) of this section, determine the number of man hours necessary to perform each facility function during each shift regularly scheduled within a 24-hour period. Upon making such determination, the State Commission of Correction shall determine the total number of persons necessary to perform such functions during each such shift.*

d. Currently a contracted physician's assistant examines inmates at the facility twice a week. The two contracted physician's assistants work under the supervision of Dr. R.B., former Commissioner of Public Health and currently a medical consultant for the Chautauqua County Health Department. During an interview with Commission investigators, it was determined that Dr. R.B. only reports to the facility on limited occasions in his capacity as a public health consultant for TB control matters. He does not review charts nor is he involved in the day-to-day supervision of the physician's assistants or any health services operations at the jail.

Consequently, this is a violation of New York State Correction Law §501 and 9 NYCRR §7010.2(a) *Health Services requiring the county legislature, board of supervisors, or similar county governing unit appoint a properly registered physician for the local correctional facility. It should be understood that this contracted appointee is the health authority responsible for all aspects of inmate health services as well as supervising all facility health care professionals. The appointee is required, in conjunction with the chief administrative officer to develop and implement medical/mental health policies and procedures consistent with this part.*

e. During the investigation, the Commission questioned R.H., PA, as to the supervising physician's review of the PA's practice

at the jail. He reported that he occasionally takes records from the jail to the doctor for review but "that hasn't occurred in a few years."

In consultation with the Executive Secretary for the NYS Board of Medicine, the Board found that, although there are no specific requirements regarding physicians' supervision of physician's assistants, it is accepted community practice for supervising physicians to periodically review the records and performance of a supervised physician's assistant.

f. During the investigation, it was determined that on 6/27/09, the day Renshaw died, he had a physician's assistant appointment. This is documented in the supervisory log and on a printed callout list. According to the supervisory log and the housing officer, Renshaw and two other inmates were sent from A-Pod to the medical unit, returning ten minutes later. The PA has no recollection of this encounter and there is no documentation of an encounter in the record. No sick slips were maintained and the Commission was unable to verify what occurred when Renshaw went to the medical department callout that day. No medical record was made.

g. Renshaw had five clinical encounters with medical providers from 6/22/09 through 6/24/09, yet his history and physical was never completed.

RECOMMENDATIONS:

TO THE SHERIFF OF CHAUTAUQUA COUNTY, THE CHAUTAUQUA COUNTY EXECUTIVE, THE CHAUTAUQUA COUNTY PUBLIC HEALTH DIRECTOR AND THE CHAUTAUQUA COUNTY DIRECTOR OF MENTAL HYGIENE:

The Sheriff of Chautauqua County should enlist the assistance of the Chautauqua County Commissioner of Health as the chief public health officer in the county, together with the Chautauqua County Director of Mental Hygiene, with the Chautauqua County Executive directing the provision of such assistance, to undertake a top-to-bottom review of the quality and availability of medical and mental health care and of the qualifications and professional conduct of the health care professional entrusted with the care of jail inmates in the Chautauqua County Jail. A comprehensive overhaul of organization and administration, from both the structural and process standpoints, health and mental health services support elements, a credible integrated medical records system, effective procedures for the safety of those inmates admitted to the facility who are at risk of self-harm, quality improvement, professional staffing levels, personnel qualifications and credentialing and quality and availability of direct care services should take place, with priority implementation of recommended improvements.

TO THE SHERIFF OF CHAUTAUQUA COUNTY:

1. The Sheriff shall conduct a review of admission screening at booking, specifically the process of administering the ADM 330 Suicide Prevention Scrceening Guidelines with focus on the failure of the supervisor to institute the appropriate level of supervision until Renshaw was evaluated by a qualified mental health professional in accordance with both the written suicide prevention screening guidelines and the relevant training.

2. The Sheriff shall comply with 9 NYCRR §7041.2 *Staffing Requirements*, specifically, the required February 2006 Health Services Staffing Analysis.

3. The Sheriff shall comply with 9 NYCRR §7003.3(j) *Security and Supervision*, specifically, the establishing of supervisory logs for constant supervision.

4. The Sheriff shall comply with 9 NYCRR §7010.2(j) *Health Services*, specifically adequate health service and medical records shall be maintained.

5. The Sheriff shall establish a credible, accountable and verifiable medication delivery system at the Chautauqua County Jail.

6. The Sheriff shall comply with 9 NYCRR Part 7013 *Classification*, §7013.3 *Facility Policies and Procedures* and §7013.7 *Initial Screening and Risk Assessment*.

TO THE CHAIRMAN OF THE CHAUTAUQUA COUNTY LEGISLATURE:

The Legislature shall comply with 9 NYCRR §7010.2(a) *Health Services*, specifically, requiring the county legislature, board of supervisors, or similar county governing unit to appoint a properly registered physician for the local correctional facility.

TO THE CHAUTAUQUA COUNTY DIRECTOR OF MENTAL HEALTH:

1. As part of the quality and availability review on conjunction with other county officials set forth herein, the Director of Mental Health should undertake a quality assurance review of the adequacy of the mental health evaluation and treatment of Clifford Renshaw, specifically the failure to evaluate him in a timely manner for a medication regimen in view of his history of mental health treatment, anxiety and depression. In addition, the propriety of deferring any consideration of a medication regimen until records of prior treatment are received should be revised. Finally, provisions for on-call emergency services should be established.

2. The Director of Mental Health should establish a service delivery plan whereby a psychiatrist is directly responsible for all mental health patients' medication orders, monitoring and follow ups.

3. The Director of Mental Health should provide adequate psychiatry and social worker services with appropriate licensures to meet the mental health needs of the inmate population at the Chautauqua County Jail.

TO THE CHAUTAUQUA COUNTY PUBLIC HEALTH DIRECTOR:

As part of the quality and availability review in conjunction with other county officials as set forth herein, the Director of Health shall review the nursing duties and practices at the Chautauqua County Jail relevant to medication delivery practices, transcription of physician's orders, nursing documentation and the completion of Histories and Physical Assessments in a timely manner.

WITNESS, HONORABLE PHYLLIS HARRISON-ROSS, M.D., Commissioner, NYS Commission of Correction, 80 Wolf Road, 4th Floor, in the City of Albany, New York 12205 this 24th day of December, 2010.

Phyllis Harrison-Ross, M.D.
Commissioner

PHR:mj
09-M-97
8/10

cc: Gregory Edwards, Chautauqua County Executive
Keith D. Ahlstrom, Chair, Chautauqua County Legislature
Christine Schuyler, BSN, MHA, Public Health Director, Chautauqua County Health Department
Patricia Brinkman, Director of Mental Hygiene, Chautauqua County Mental Health Department

NEW YORK STATE COMMISSION OF CORRECTION

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| In the Matter of the Death<br><br>of Adam Wheeler, an inmate of the Downstate CF | :<br>:<br>:<br>:<br>: | FINAL REPORT OF THE NEW YORK STATE COMMISSION OF CORRECTION |

TO: Honorable Brian Fischer
Commissioner
NYS Department of Correctional Services
State Campus, Building #2
Albany, New York 12226

GREETINGS:

WHEREAS, the Medical Review Board has reported to the NYS Commission of Correction pursuant to Correction Law, section 47(1)(d), regarding the death of Adam Wheeler who died on March 12, 2010 while an inmate in the custody of the NYS Department of Correctional Services at the Downstate Correctional Facility, the Commission has determined that the following final report be issued.

FINDINGS:

1. Adam Wheeler was a 19 year old white male who died on 3/12/10 at 9:35 a.m. at St. Luke's Hospital from a suicidal hanging while in the custody of the NYS Department of Correctional Services (DOCS) at Downstate Reception Center. Wheeler received grossly inadequate mental health evaluation, treatment and case management characterized by a nearly complete breakdown in continuity of care between two successive incarcerations August 2007-October 2009 and February 2010-March 2010 in which his mental health status changed from seriously mentally ill to not in need of services with an associated failure to examine extensive documentation of his history and prior courses of treatment. Had Adam Wheeler received adequate and appropriate mental health care and treatment, his death may have been prevented.

2. [redacted]

3. [redacted]

4. [redacted]

5. [redacted]

6. [redacted]

7. [redacted]

[redacted]

8. [redacted]

9. [redacted]

10. On 10/1/07, Wheeler was transferred from Downstate Reception to Great Meadow CF. [redacted]

11. [redacted]

12. [redacted]

13. [redacted]

[redacted]

14. [redacted]

15. [redacted]

16. [redacted]

17. On 8/7/08, Wheeler was transferred from Great Meadow CF to Mid-State CF's Sex Offender Program (SOP). Wheeler remained in Mid-State CF's Sex Offender Program (SOP) until his discharge to parole on 10/23/09. [redacted]

18. [redacted]

19. [redacted]

[redacted]

20. [redacted]

21. On 10/23/09, Wheeler was granted a conditional release to the custody of the NYS Division of Parole. According to Parole records, Wheeler's parole was violated when he failed to follow directives from Washington County Department of Social Services to secure housing. Specifically, Wheeler failed to provide adequate housing contacts violating his Independent Living Plan Program. Documentation states attempts were made by Parole Officer T. to seek alternative housing for Wheeler without success. The Salvation Army program located in Glens Falls does not accept sex offenders. Wheeler was a un-domiciled sex offender and posed a threat to the community. A warrant was issued on 11/10/09 and Wheeler was taken into custody without incident.

22. On 11/10/09, Wheeler was placed in custody at the Washington County CF as a parole violator. [redacted] Wheeler was released from the custody of the county jail on 2/9/10.

23. On 2/9/10, Wheeler was admitted as a parole violator to Clinton Reception CF from the Washington County CF. [redacted]

[redacted] RN R.L. From Washington County CF verified that Washington County CF completes the Health Transfer Information Form in triplicate as advised by the NYS Commission of Correction.

24. [redacted] However, the current OMH policy entitled Referral, Admission, Transfer & Discharge Processes, (A) presently dictates that all inmates who arrive in a reception center are initially screened within two days of arrival by OMH clinicians who completed the CNYPC Mental Health Screening-Structured Interview Form and a Suicide Prevention Screening Form. Additionally, RN J.C. stated she leaves questions 3, 5, 8 and 14 blank as she stated this was what she was told to do when she was originally trained many years ago on the suicide screening form. However, she is trained on a yearly basis on suicide prevention with DOCS.

25. [redacted]

[redacted]

26. L.L., OMH Assistant Psychologist III, stated she had been employed in her OMH position for less than a year, though she had been employed by other mental health organizations previously. Additionally, she stated she did not receive training on completing the CNYPC Mental Health Screening-Structured Interview form. [redacted]

27. On 2/12/10, Wheeler was transferred from Clinton Reception to Downstate Reception. [redacted]

[redacted] The DOCS nursing staff at the correctional facilities, including the reception centers, do not have the knowledge or access of the incoming incarcerated populations' crimes and unless the inmate chose to disclose a child sex abuse crime to a DOCS nurse, the question would be answered with a "no" answer, when the question should have been answered with a "yes." If RN C.S. had knowledge of the inmate's crime and had given Wheeler an affirmative answer to question #3, which would have indicated the inmate's crime was shocking in nature, a mental health referral would have been generated to the OMH clinicians. The OMH clinicians would have had to re-evaluate Wheeler and would have been able to identify him as a sex offender, which is a well-known high risk factor for suicide. The current practice of having DOCS nurses completing and rescreening incoming inmates with the Suicide Screening Form without knowledge of their crime is completely ineffective and was shown to skew the results of Wheeler's suicide screen. OMH clinicians who have access to the FPMS screen that reports the inmate's crime would be better suited to re-complete the suicide screen and obtain more accurate results with the firm.

28. Downstate Reception OMH Unit Chief T.U. stated that once an inmate is screened by an OMH clinician with the Suicide Screening Form and CNYPC Mental Health Screening-Structured Interview form and are classified as an OMH Level 6, this procedure does not have to be repeated at the second reception processing by OMH. He stated he receives an e-mail notification from other reception areas with the names and the OMH levels of incoming inmates. If an inmate is classified as an OMH Level 1 through 4, an appointment is made on the same day they arrive with an OMH clinician. Also, OMH Unit Chief T.U. stated all completed CNYPC Mental Health Screening-Structured Interview forms are available to review as they are copied on the OMH computer system. OMH Unit Chief T.U. could not recall specifically Wheeler's Health Transfer Information form completed by Washington County CF's mental health staff. OMH Unit Chief T.U. stated he reviews all the mental health information that comes to the facility with the inmate.

29. [redacted]

30. [redacted]

31. [redacted]

32. On 3/4/10, Officer M.M. was the assigned 2D housing officer for the day shift. At this time, Officer M.M. had less than one month of on-the-job training and reported it was his third day as day housing officer. At approximately 11:45 a.m., Officer M.M. reported he completed an inmate count and observed Wheeler as "healthy and breathing at this time."

33. On 3/4/10 at 12:15 p.m., Officer M.M. announced "get ready for chow" over the intercom to the 2D housing unit. Officer M.M. stated he opened all eligible cells and twice again announced chow. Officer M.M. counted 28 inmates and reported he repeated once more. Officer M.M. stated he had five inmates who were keep-locked in their cells. Officer M.M. documented "Wheeler must have been hiding because he was not visible in his cell." Officer M.M. stated he also believed he may have miscounted the inmates as he was new at his job. Officer M.M. stated he left for chow from the 2D housing unit with 28 inmates. This is a violation of DOCS Directive #4945: A,3 dated 11/21/01, entitled Inmate Counts. This directive states:

> An employee assigned to supervise inmates is responsible for knowing the number of inmates assigned and the whereabouts of the inmates authorized to be absent, and for keeping an accurate count of the inmates under supervision. The Master Counts must be performed at the prescribed times: Unscheduled Counts are to be performed as circumstances dictate .... Inmates

> locked in cells during the program day must be counted at least hourly. The counting employee is solely responsible for the accuracy of count, that is, for reporting the absence of any inmate on an "out"count (i.e., an inmate, normally assigned to the area being counted by the employee, who is absent for a known purpose, such as temporary release or a visit), and for reporting immediately any inmate who absence is not accounted for.
>
> A "Check Count" is an unscheduled, informal count .... Typically counts of this kind are made while inmates are working, engaged in daily activities within the housing unit, or engaged in recreational or other activities ... When a Check Count is high or low, indicating an absent or out of place inmate, the fact shall be reported to the immediate supervisor and the Watch Commander for investigation. It is particularly important that an employee in charge of an outside gang or escorting or transporting inmates check frequently to assure that none of the inmates in his or her charge have left the group.

34. Officer M.M. stated that, upon returning to the 2D housing unit about 45 minutes later, he had the inmates line up in front of the security bubble on the numbers written on the floor and counted 28 inmates. At this time M.M. made a supervisory round and discovered Wheeler hanging from a ligature. Officer M.M. stated he immediately pulled his radio pin. Officer M.M. then ran down to the front door of the housing unit to unlock it.

35. At approximately 1:02 p.m., Sgt. D.V. heard a Red Dot Alarm for 2D, responded, and was told there was a problem in cell 20. Sgt. D.V. stated he responded immediately. A Red Dot Alarm signals that an officer needs immediate assistance. Sgt. D.V. stated upon approaching he did not see an inmate in the cell. Sgt. D.V. stated that Officer A.J. was also a responder and assisted the sergeant with Wheeler. Wheeler had tied a shoelace on the door closer mechanism and then had made a ligature. Sgt. D.V. called a Code Blue at 1:05 p.m. A Code Blue is an immediate medical emergency and the officer needs rovers' assistance. Upon entering the cell, Sgt. D.V. cut the ligature with his personal pocket knife resulting with Wheeler falling behind the door. Sgt. D.V. stated he and Officer A.J. moved Wheeler from behind the cell door to get a better look at him. It became apparent that Wheeler was not breathing nor had a pulse. Sgt. D.V. stated he also cut the ligature from around Wheeler's neck. Then the sergeant called to Officer

M.M. to get the AED. At this time, Officer T.C. entered the cell and checked for a pulse. Sgt. D.V. and Officer T.C. both stated neither could palpate a pulse for Wheeler.

36. Sgt. D.V. stated he was just about to start CPR when PA N.D., PA E.Y. and Officer P.D. entered the cell. [redacted]

37. [redacted]

38. [redacted]

39. There was no suicide note found, through a letter found in Wheeler's cell was addressed to his correction counselor asking for a unit with less inmate traffic or protective custody. He had indicated in the note that other inmates from his county knew about his crime.

40. [redacted]

RECOMMENDATIONS:

TO THE NYS DEPARTMENT OF CORRECTIONAL SERVICES, DIVISION OF HEALTH SERVICES, AND THE NYS OFFICE OF MENTAL HEALTH, DIVISION OF FORENSIC SERVICES:

1. The Department and the Division shall review the practice of the NYS Department of Correctional Services' nurses completion of the Reception Suicide Screening Form on incoming inmates with limited information available to them. The OMH clinicians should be considered to perform this screen as they have access to additional crime information for a more accurate scoring and identification of inmates with high risk suicide factors.

2. The Department and the Division should conduct a comprehensive review of reception suicide risk assessment regarding actual policies, practices, and procedures at the New York State Reception Centers with particular attention to high risk sex offenders and patient information provided by the county mental health clinicians on the Health Transfer Information Form.

TO THE NYS OFFICE OF MENTAL HEALTH, DIVISION OF FORENSIC SERVICES:

1. The Division of Forensic Services should conduct a peer quality review regarding the mental health treatment of patients under the care of L.L., OMH Assistant Psychologist III, specifically focused in the areas of initial evaluations, the completion of CNYPC Mental Health Screening-Structured Interview format, and assignment of OMH service classification levels of those inmates.

2. The Division should provide the documented results of the above quality assurance review to the Commissioner and Chair of the State Commission of Correction's Medical Review Board by April 30, 2011.

TO THE COMMISSIONER OF THE NYS DEPARTMENT OF CORRECTIONAL SERVICES:

The Department should review the conduct of Officer M.M. who failed to comply with DOCS Directive #4945: A,3 dated 11/21/01, entitled Inmate Counts which states:

> An employee assigned to supervise inmates is responsible for knowing the number of inmates assigned and the whereabouts of the inmates authorized to be absent, and for keeping an accurate count of the inmates under supervision. The Master Counts must be performed at the prescribed times: Unscheduled Counts are to be performed as circumstances dictate .... Inmates locked in cells during the program day must be counted at least hourly. The counting employee is solely responsible for the accuracy of count, that is, for reporting the absence of any inmate on an "out"count (i.e., an inmate, normally assigned to the area being counted by the employee, who is absent for a known purpose, such as temporary release or a visit), and for reporting immediately any inmate who absence is not accounted for.

TO THE NYS DEPARTMENT OF CORRECTIONAL SERVICES, DIVISION OF HEALTH SERVICES:

The Department will conduct in-service training on completion of the Suicide Screening Form to their professional nursing staff for the duration of their responsibility to complete such.

TO THE NYS COMMISSION ON QUALITY OF CARE AND ADVOCACY FOR PERSONS WITH DISABILITIES:

The Commission is asked to conduct an investigation into the mental health evaluation and mental health classification provided to Adam Wheeler through the NYS Office of Mental Health while at the NYS Department of Correctional Services.

WITNESS, HONORABLE PHYLLIS HARRISON-ROSS, M.D., Commissioner, NYS Commission of Correction, 80 Wolf Road, 4th Floor, in the City of Albany, New York 12205 this 24th day of December, 2010.

Phyllis Harrison-Ross, M.D.
Commissioner

PH-R:mj
10-M-40
8/10

cc: Superintendent Ada Perez, Downstate CF
Dr. Carl Koenigsmann, Chief Medical Officer
Elizabeth Ritter, Assistant Commissioner
Richard Miraglia, Division of Forensic Services, NYS Office of Mental Health
Don Sawyer, Executive Director, Central New York Psychiatric Center
Jayne VanBramer, Director, Bureau of Quality Management, OMH
Jane C. Lynch, Chief Operating Officer, NYS Commission on Quality of Care & Advocacy for Persons with Disabilities