Commission of Correction

Final Report of the New York State Commission of Correction:

In the Matter of the Death of

Patrick Dennis (16B1094), an incarcerated individual of the Auburn Correctional Facility

March 29, 2022

To: Honorable Anthony Annucci
Acting Commissioner
NYS Department of Corrections
And Community Supervision
The Harriman State Campus
1220 Washington Avenue
Albany, New York 12226

Allen Riley
Chairman

Thomas J. Loughren
Commissioner

Yolanda Canty
Commissioner

80 South Swan Street, 12th Floor, Albany, New York 12210 │ 518-485-2346 – phone │ 518-485-2467 – fax │ www.scoc.ny.gov

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 Patrick Dennis who died on December 6, 2018, while an incarcerated individual in the custody of the NYS Department of Corrections and Community Supervision at the Auburn Correctional Facility, the Commission has determined that the following final report be issued.

FINDINGS:

1. Patrick Allen Dennis was a 27-year-old White, Non-Hispanic male who died on 12/6/2018 from a suicidal hanging while in the custody of the Department of Corrections and Community Supervision (DOCCS) at the Auburn Correctional Facility (CF). The Medical Review Board has found that Dennis had a complex mental health history and was in need of psychiatric hospitalization to be stabilized.

2. Dennis was born in Auburn, New York. Dennis's family history is unclear due to the multiple different stories told by Dennis, but all accounts included family dysfunction, [redacted]. Dennis was single, had an 8th grade education, and had no record of employment. DOCCS' information concerning Dennis indicated that Dennis's father was deceased, and that Dennis had been survived by his mother, 5 brothers, 3 sisters, and 1 child.

3. [redacted] Dennis was serving his [redacted] NYS DOCCS prison sentence for Burglary 2nd Degree at the time of his death. In the instant offense, Dennis unlawfully entered a building with the intent to commit a crime in which the motive had been monetary gain.

4. [redacted].

5. [redacted]

6.

7. On 4/18/16, Dennis was received by DOCCS at Downstate CF for his NYS prison incarceration. On 4/21/16, Dennis had his receiving medical history and physical done with no problems noted at Elmira CF Reception center. Dennis throughout the transfers to Wallkill CF, Fishkill CF, and Bare Hill CF. There was nothing of significance medically or psychologically noted in Dennis' chart from 4/21/16 through 10/12/16.

8. On 10/12/16, Dennis transferred from Bare Hill CF to Clinton CF. No medical or mental health incidents were noted for Dennis from 10/12/16 through 1/23/17.

9. .

10.

[redacted].

11. [redacted]

12. [redacted].

13. [redacted]

14. On 5/30/18, Dennis was transferred from general population to SHU 200. [redacted]

15. [redacted]

16. On 6/29/18, Dennis was transferred from SHU 200 to Fishkill CF [redacted]

17. [redacted]

18. On 7/5/18, [redacted] was transferred from [redacted] back to SHU 200.

19. [redacted]

20. [redacted]. On 2/22/17, Dennis attempted suicide by hanging himself in the bathroom while housed in Midstate CF's general population. This was identified during OMH's Quality Assurance Review and was addressed with the clinical staff at Wende CF with corrective action taken. [redacted]

21. [redacted].

22. [redacted]

23. [redacted].

24. On 9/20/18, Dennis had been an active transfer as an [redacted] from Wende CF to Auburn CF. [redacted]

25.

26.

27.

. This was a violation of *Corrections Based Operations Manual, Policy #4.0, (B)(3) Psychiatry which requires an Initial Psychiatric Evaluation Progress Note be completed on the first business day of admission to Observation Cell if Incarcerated Individual is being admitted to services, when a psychiatrist/nurse practitioner is available on site.* This issue was also identified and addressed by OMH during the Quality Assurance Review which acknowledged that due to a lack of available psychiatric coverage, only video teleconference psychiatric visits were available. The Medical Review Board opines that for crisis-level services, onsite psychiatric services are necessary for optimal care.

28. This is a violation of *Corrections Based Operations Manual, Policy #1.0, Comprehensive Suicide Risk Assessment procedures, B. Comprehensive Suicide Risk Assessment (CSRA) Form.* This was also identified during OMH's Quality Assurance Review and was addressed with the clinical staff at Auburn CF with corrective action taken. Security staff reported that Dennis had been eating, drinking, and interacting with them only when necessary.

29. The Medical Review Board opines that Dennis was psychiatrically unstable and required an expedited follow-up.

30. .

31.

. This is a violation of *Corrections Based Operations Manual, Policy #1.0, Comprehensive Suicide Risk Assessment procedures, B. Comprehensive Suicide Risk Assessment (CSRA) Form.*

32. DOCCS staff noted that Dennis hadn't been speaking much and was withdrawn. .

33.

34.

35.

36. .

37.

38. .

39. .

40.

. The Medical Review Board finds that there was an unacceptable delay in obtaining a psychiatric hospital placement for Dennis who had multiple suicide gestures, unresolved suicidal ideation, and no substantive therapeutic medication compliance.

41.

42. .

43. The Medical Review Board opines that Dr. . should have put Dennis on a 1 to1 watch in consideration of his recent extended RCTP stays and history of self-harm incidents.

44.

45. At 9:50 a.m., CO W.P. gave Dennis his clothes and informed Dennis that he would be taken back to E-Block. Dennis refused to go and informed CO W.P. that he wanted to be

taken to SHU. CO W.P. notified Sgt. J.P., who was unable to address Dennis' refusal to return to E-Block until after the count was complete. Dennis made no threats of harming himself or staff, so he remained in observation at that time.

46. At 11:30 a.m., Dennis was observed walking around observation cell 6 by RN [redacted]. and CO W.P. At 12:00 p.m., CO W.P. was making his next infirmary round and discovered Dennis sitting on the floor unresponsive with a shoestring tied around his neck with the other end tied around the fire alarm cover. At 12:03 p.m., CO W.P. and CO R.M. entered the room and CO W.P. lifted Dennis's body to take the weight off the shoestring while CO R.M. used a personal knife to cut the shoestring from Dennis' neck and the fire alarm cover. CO W.P. laid Dennis on the floor and immediately started CPR. Sgt. J.P. and COs J.C., M.C., and M.M. arrived to assist as needed.

47. [redacted]

48. At 12:18 p.m., TLC Ambulance arrived on scene, and Paramedics [redacted]. and [redacted]. assumed care of Dennis. [redacted]

49. [redacted]

ACTIONS REQUIRED:

TO THE DEPUTY COMMISSIONER OF THE NYS DEPARTMENT OF CORRECTIONS AND COMMUNITY SUPERVISION, DIVISION OF HEALTH SERVICES:

The Medical Review Board requests the Deputy Commissioner conduct a review of Dr. [redacted] regarding why Dennis was not placed on a 1 to1 watch in consideration of the recent extended RCTP stay and history of self-harm incidents.

In a response to the Commission's preliminary report dated 2/3/22, DOCCS Deputy Commissioner of Health Services indicated that the requested reviews were completed.

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

1. The Medical Review Board requests that the Division conduct a quality assurance review with clinical staff at Auburn CF as to why Dennis' 11/4/18 incident of self-harm was not reflected on an updated CSRA form.

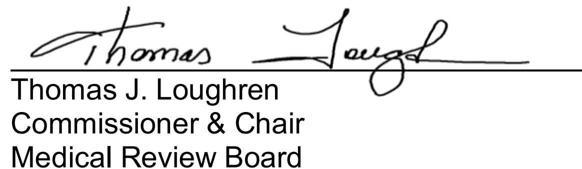
2. The Medical Review Board requests the Division conduct of review of the psychiatric care provided to Dennis with a review regarding the unacceptable delays for obtaining a forensic hospitalization which had been identified as clinically indicated by OMH providers.

3. The Medical Review Board requests the Division provide a report and update regarding the level of psychiatric service available at Auburn CF and the efforts to establish an on-site provider.

A report of findings and corrective actions shall be forwarded to the Medical Review Board upon completion.

In a response to the Commission's preliminary report dated 1/10/22, the Office of Mental Health indicated that the requested reviews were completed.

WITNESS, HONORABLE THOMAS J. LOUGHREN, Commissioner, NYS Commission of Correction, Alfred E. Smith State Office Building, 80 South Swan Street, 12th Floor, in the City of Albany, New York 12210 on this 29th day of March, 2022.



Thomas J. Loughren
Commissioner & Chair
Medical Review Board

TJL:JW:jdb
2018-M-0161
March 2022

cc: Dr. Carol Moores, Acting Deputy Commissioner, Chief Medical Officer
Bryan Hilton, Assistant Commissioner for Mental Health
Superintendent Joseph Corey, Auburn CF
Dr. Li-Wen Lee, Associate Commissioner
Division of Forensic Services, NYS Office of Mental Health
Danielle Dill, Executive Director, CNYPC
William Vertoske, Deputy Director of CBO, CNYPC
Meaghan Bernstein, Director of CBO Risk Management, CNYPC