Final Report of the
New York State Commission of Correction:

In the Matter of the Death of

Larry Utter (13B3814),
an incarcerated individual of the
Attica Correctional Facility

December 21, 2021

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
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 Larry Utter who died on February 1, 2019, while an incarcerated individual in the custody of the NYS Department of Corrections and Community Supervision at the Attica Correctional Facility, the Commission has determined that the following final report be issued.

FINDINGS:

1. Larry Utter was a 54-year-old Caucasian male who died on 2/1/19 due to a suicidal hanging while in the custody of the New York State Department of Corrections and Community Supervision (NYS DOCCS) at the Attica Correctional Facility (CF).

2. Utter was born in Newton, NJ. Utter was survived by two children, two brothers, and two sisters. Utter graduated from high school. There was no work history available for Utter.

3. Utter had no criminal history until 2013 at the age of 49. In the instant offense, on 6/13/13 in Forest Port, NY, Utter shot his wife twice with a shotgun causing the wife’s death. Utter spent six months in the Oneida County Jail (CJ) before pleading guilty on 11/4/13 to Murder 2nd Degree and was sentenced to 24 years to life. Utter was received at the Elmira CF on 12/30/13 to begin serving the NYS DOCCS incarceration. This was Utter’s first time in NYS DOCCS’ custody.

4. Utter spent time in Auburn CF from January 2014 through May 2015. During this time, Utter worked as an industries worker. On 4/25/15, Utter received a Tier 3 infraction due to being an alleged accomplice in an escape plan with another incarcerated individual. Utter was sanctioned to 24 days in involuntary protective custody (IPC) confinement.

5. Utter was transferred to Attica CF on 5/19/15 where Utter remained until the terminal event. Utter was housed in general population in Unit 9-16. During this time, Utter worked as a porter, a food assembler, and an administrative clerk.
8. On 1/8/19, Utter received a Tier 3 infraction placement into Involuntary Protective Custody (IPC). Utter was given 24 days confinement in housing unit OB-19 at his hearing on 1/15/19. However Utter was removed from IPC status on 2/1/19 after decision reversal due to the other involved individual was discharged from the facility.

9. On 2/1/19 at 7:05 a.m., while conducting the count on B-Block 19 Company, CO D.M. observed Utter hanging in 0-5-S cell with one end of a state sheet tied around the cell bar and the other end of the state sheet tied around Utter’s neck. CO D.M. notified the block hall Captain who called for an emergency response. CO D.M. retrieved the cut down tool and cut the garrote from around Utter’s neck. Utter was unresponsive and COs D.M. and D.B. moved Utter from the cell to the gallery floor, and with additional staff, lifted Utter onto a gurney. Utter was wheeled to the lobby area. The Medical Review Board finds that the security staff did not apply the AED or initiate CPR in a timely manner after observing that Utter was pulseless.

10. CO M.P. wrote a memorandum on 2/1/19 that the final security round was conducted at 6:02 a.m. on the protective custody (PC)/involuntary protective custody (IPC) unit and CO M.P. observed nothing out of the ordinary. All incarcerated individuals appeared to be alive and well including Utter who was “lying on the bed and appeared to be sleeping”.

11. Utter wrote a suicide note that was discovered in the cell after the terminal event. In summary, the note indicated that Utter had enough of being in jail and being blamed for things. Utter was scheduled to be released from protective custody on 2/1/19 per DOCCS records and was then to be scheduled for a transfer to another facility.

12. DOCCS Office of Special Investigations (OSI) reviewed video surveillance for B Block 19 Gallery on 2/1/2019 and observed that CO M.P. did not perform a meaningful round at approximately 6:00 a.m., as CO M.P. failed to detect the presence of a bed sheet tied to the cell bars of B-19-5 cell housing Utter. NYS DOCCS Bureau of Labor Relations issued CO M.P. a disciplinary sanction as a result of the investigation.

13. The Office of Special Investigations (OSI) reviewed video surveillance for B Block 19 Gallery on 2/1/2019 and observed that Security Staff failed to apply an Automated External Defibrillator (AED) or to start CPR until approximately 5 minutes after discovering Utter. NYS DOCCS Bureau of Labor Relations recommended that COs D.M., D.D., R.K., and D.B. be formally counselled relative to the necessity of conforming to Departmental Directive 4059 “Response to Health Care Emergencies”. The Medical Review Board concurs with the investigation findings and the administrative actions taken.
ACTIONS REQUIRED:

This case be closed as a suicide.

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 21st day of December, 2021.

Thomas J. Loughren
Commissioner & Chair
Medical Review Board

cc: Dr. John Morley, Chief Medical Officer
    Bryan Hilton, Assistant Commissioner for Mental Health
    Superintendent Julie Wolcott, Attica 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