NEW YORK STATE | Commission of Correction

Final Report of the New York State Commission of Correction:

In the Matter of the Death of

Loyd Edward Barnes, an incarcerated individual of the Seneca County Jail

December 21, 2021

To: Sheriff W. Timothy Luce
Seneca County Sheriff's Office
6150 State Route 96
Romulus, New York 14541

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 Loyd Barnes who died on March 31, 2020 , as a result of circumstances which occurred while an incarcerated individual in the custody of the Seneca County Sheriff at the Seneca County Jail, the Commission has determined that the following final report be issued.

FINDINGS:

1. Loyd Edward Barnes was a 27-year-old White male who died on 3/31/20 due to a suicide by hanging while in the custody of the Seneca County Sheriff at the Seneca County Jail (CJ). The Medical Review Board has found that there was inadequate mental health care of Barnes prior to his suicide.

2. Barnes was single with no children. Barnes was survived by parents, a grandmother and a brother. [redacted] Barnes reported having difficulty finishing the tenth grade and had reading and writing impairments. At the time of the most recent arrest, Barnes had been living in a Budget Inn hotel room and was employed by a welding company.

3. [redacted] In the instant offense, on 7/27/17, Barnes was arrested for Reckless Endangerment 1st Degree after fleeing from police during a high-speed chase. Barnes was sentenced to 30 months to five years' incarceration. Barnes was re-admitted to NYS DOCCS on 2/15/18 and then released to Parole on 1/21/20. Less than a month later, Barnes was arrested for a parole violation on 2/10/20 and admitted to the Seneca County Jail. Barnes was scheduled to be transfer to NYS DOCCS at Elmira Correctional Facility (CF) two weeks prior to Barnes' death for a re-admission but was held at the Seneca County Jail due to the COVID-19 pandemic.

4. [redacted]

5. [redacted]

6. On 2/10/20, Barnes was arrested for a parole violation and was admitted to the Seneca County Jail (CJ) at 6:45 a.m. At 7:43 a.m., CO K.B. performed the initial suicide screening and risk assessment. The parole officer reported that Barnes had reported during transport that Barnes would attempt to "hang up" while in jail. Barnes scored a 6 on the suicide screening, having answered "Yes" to the following:

   Having a history of counseling or mental health evaluation and treatment;
   Having a previous suicide attempt;
   Detainee has unusual behavior or is acting or talking in a strange manner;
   Detainee is apparently under the influence of alcohol or drugs.

   CO K.B. indicated on the suicide risk assessment that the supervisor was notified, however, no supervisor was listed. Constant supervision was not initiated however, a referral to Mental Health License Mental Health Counselor (LMHC) [redacted] was placed. During an interview with Commission staff, CO K.B. was asked how it was determined for an incarcerated individual to be placed on a constant watch. CO K.B. indicated that the Sergeant would come to booking and determine whether the incarcerated individual (II) was unstable and needed to be placed on watch, otherwise the incarcerated individual gets referred to mental health. Commission staff also asked if CO K.B. remembered which supervisor was notified that day after conducting Barnes' suicide risk assessment, however CO K.B. could not recall.

7. A review of Barnes' suicide risk assessment completed by CO K.B. revealed that contradictory information was documented on the form. CO K.B. entered "No" to question 6; detainee has a history of drug or alcohol abuse despite Barnes reporting having taken Suboxone. CO K.B. failed to list Barnes' last reported use of suboxone, including how much and the date of the last use. During an interview with Commission staff, CO K.B. reported being familiar with Barnes from prior incarcerations. CO K.B stated that Barnes liked to talk and was very needy and attention seeking. Commission staff asked CO K.B. if the officer was able to look back at Barnes' prior incarcerations and see the prior suicide assessments and alerts. CO K.B. answered, "Yes" and recalled a previous incarceration when Barnes had threatened to jump off the mezzanine. CO K.B. did not document this prior attempt to jump from the mezzanine on Barnes' suicide risk assessment under question 10a (Does detainee have a prior suicide attempt). The Medical Review Board finds that the inconsistent information gathered during the suicide risk assessment was not in comportment with the requirements of 9 NYCRR §7013.7(a) & (b)(7) & (9) which states:

   (a) 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.
   (b) A screening instrument(s) shall be utilized to elicit and record information on each

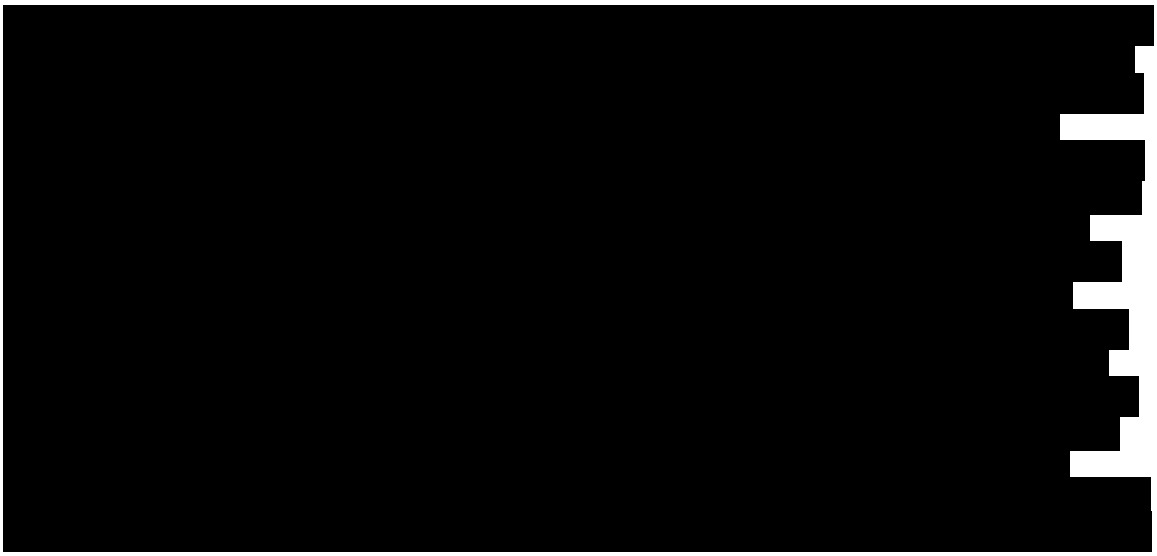
inmate relating to the following:
(7) medication currently being taken
(9) evidence of intoxication by alcohol or drugs or a history of alcohol or substance abuse.

Additionally, Commission staff reviewed the Seneca CJ's Policy on Suicide Prevention Program. Section III(A)(1)(e) which states that a review of existing files (if applicable) to determine if an inmate had a previous suicide attempt(s) or received psychiatric services during prior incarceration and found that CO K.B. did not follow the agency policy with Barnes' admission process.

8. Commission staff reviewed the initial risk assessment of Barnes completed by CO K.B. CO K.B. documented, "Yes" to the following:
Does the incarcerated individual appear to have any mental or physical handicaps?
- Is the incarcerated individual currently taking any medications?
-Does the incarcerated individual appear to be under the influence of drugs or alcohol?
-Has the incarcerated individual had any prior charges or criminal convictions
-Has the incarcerated individual been previously incarcerated?
CO K.B. indicated that Barnes did not have a potential for self-injury and/or suicide, did not have a history of drug and/or alcohol abuse and that Barnes' appearance and behavior were not normal because Barnes was having a hard time staying awake.
CO K.B. left the following questions blank:
-Does the incarcerated individual have a history of mental illness or treatment?
-Does the incarcerated individual have a history of detention or incarceration, including but not limited to hostile relationships with other inmates?

During an interview with Commission staff, CO K.B. was shown the booking documents and was asked why certain areas were left blank. CO K.B. provided that the missing information was an oversight on the officer's part. The Medical Review Board finds that the initial risk assessment was incomplete and not in accordance with 9 NYCRR §7013.7(b)(4) & (6).

9. Barnes was strip searched as per policy due to being under the influence of suboxone when Barnes was admitted. No Contraband was found.

10. 

[redacted]

11. [redacted]

12. [redacted].

13. [redacted]

[redacted]

14. [redacted]

15. [redacted]

16. [redacted]

17. [redacted].

18. [redacted].

19. [redacted],

[redacted]. In an interview with Commission staff, Sgt. R.J. reported dealing with Barnes many times over the years and that Barnes was “needy, attention seeking and a little slow”. Sgt. R.J. reported making it a point to go and spend at least five minutes talking with Barnes each day because then Barnes “would be fine the rest of the night”.

20. [redacted]

21. [redacted]

22. [redacted]

[redacted].

23. [redacted].

24. [redacted].

25. [redacted].

26. [redacted] This was a violation of 9 NYCRR §7010.2(j) which states: *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*.

27. [redacted]

[redacted]

28. [redacted]

29. [redacted]

30. [redacted]

31. During an interview with Commission staff, CO Z.P. reported knowing Barnes for three years during Barnes' incarcerations at the Seneca CJ. CO Z.P. reporting having a good rapport with Barnes and often was assigned to housing the Unit B segregation area where Barnes was housed. CO Z.P. stated that there were numerous times that staff at the jail had to deal with Barnes being aggressive, fighting and for disciplinary reasons. CO Z.P. stated that Barnes was an II who CO Z.P. needed to talk to everyday. CO Z.P. reported that during the weekend of 3/21/20 and 3/22/20, Barnes had been locked in the cell and flooded it. CO Z.P. had been one of the officers called down to help deal with

Barnes. When CO Z.P. got to Barnes' cell, Barnes was wrapped in blankets and towels. CO Z.P. indicated that some incarcerated individuals would do this in order to avoid being tazed or pepper sprayed. Throughout the incident, CO Z.P. stated that Barnes kept saying that "he was suicidal and attempted to put something in the vent to hang himself". CO Z.P. indicated all this was captured on CO Z.P.'s body camera and that CO Z.P. had reported it to mental health staff. However, a review of Barnes' mental health record available to the Commission revealed there was no indication of this incident being referred to mental health.

In a response to the Commission's preliminary report dated 11/10/21, the Seneca County Sheriff indicated that the cited incident of Barnes attempting to hang himself from the vent was a separate incident that occurred in 2017. The Commission acknowledges this however notes that the finding was based on testimony provided directly to Commission staff during the investigation.

32. On 3/21/20, Barnes was involved in a disciplinary incident. Barnes had been taken outside of the housing unit to booking to make a "visitation" phone call. At that time due to the state of emergency related to the COVID pandemic, incarcerated individuals were allowed to make visitation phone calls in booking. When Barnes was being returned to the housing unit, Barnes broke free of the escorting officer, ran across the housing unit and tackled, then subsequently attempted to punch another II. Barnes then actively resisted the officers who had been trying to intervene. During an interview with Commission staff, Sgt. J.S. recalled the incident and reported that during past incarcerations, Barnes wrapped things around the neck making suicidal gestures. Sgt. J.S. would always err on the side of caution and put Barnes on constant watch. Sgt. J.S. told Commission staff that Barnes could be violent at times and recalled many violent outbursts from Barnes over the years that resulted in uses of force.

33. [redacted].

34. [redacted]

[redacted].

35. [redacted] The Medical Review Board opines that Barnes' repeated endorsements of suicidal ideation, regardless of passive or active, and escalating behaviors warranted an immediate referral to psychiatry and an increased level of supervision until a psychiatric assessment could be completed.

36. On 3/28/20 at 9:29 a.m., Barnes spoke with his mother on the phone for the last time. On 3/30/20 at 4:27 a.m., Barnes' last letter was sent to his mother.

37. [redacted].

38. [redacted]

39. [redacted].

40. [redacted]

[redacted]. The Medical Review questions why there was a delay in follow-up by the jail physician regarding Barnes' headaches where the follow-up was ordered on 3/4/20 and Barnes had been present for other sick call encounters prior to this encounter.

41. On 3/31/20 at 3:10 p.m., CO Z.P. had started the shift and was speaking to the off going day shift officer, CO J.P., at the officer's station. Together they spoke to Barnes through the intercom after Barnes had asked them about parole issuing releases. They informed Barnes that they didn't know and that 51 IIs had been let out of Monroe County Jail.

42. At 3:15 p.m., CO Z.P. and CO J.P. started rounds for the shift's beginning formal count. CO Z.P. conducted the rounds on the lower tier and CO J.K. conducted rounds on the top tier. Barnes was housed in protective custody on housing Unit B in cell 19. Barnes had been locked in for disciplinary issues and did not come out of the cell.

43. At approximately 5:15 p.m., after dinner, Barnes came out of the cell to return the dinner tray and the cell was searched by CO Z.P. for contraband or anything dangerous. No contraband was found in Barnes' cell and the two sheets were accounted for with no modifications noted. CO Z.P. noticed that a piece of paper was over one of the air vents in the cell which was common for the incarcerated individuals to do. CO Z.P. told Commission staff that every time they talked to Barnes; Barnes had asked about parolees getting released. After the search, Barnes was locked back in the cell.

44. At 8:00 p.m., CO H.H. gave Barnes the evening medications. At 8:15 p.m., while conducting rounds, CO Z.P. spoke to Barnes and Barnes said that Barnes was going to use the toilet. On the next round at 8:45 p.m., CO Z.P. noticed that Barnes had a sheet over the door, which was common for incarcerated individuals to do when using the toilet. CO Z.P. knocked on the door and called for Barnes to open the door three times but received no response. CO Z.P. opened the cell door and the sheet fell revealing that Barnes had hung himself by the neck with a sheet woven through and tied to the air vent above the sink and toilet. CO Z.P. immediately called a code blue and attempted to pick Barnes up to free the head from the sheet but Barnes was too heavy. CO Z.P. stood up on the toilet for leverage and was able to lift and push Barnes' head out of the noose. Once Barnes was free of the noose, CO Z.P. was unable to hold Barnes and Barnes fell to the cell floor hard, hitting feet first, then falling backward striking the head against the wall. CO Z.P. performed a sternal rub with no response, tried to feel for a pulse, and then started CPR compressions.

45. At 8:46 p.m., Sgt. J.S. and CO M.H. arrived at cell 19 and relived CO Z.P. from CPR. Sgt. J.S. ordered staff to get an AED and call control to have them call 911 and get an ambulance. Sgt. J.S. was able to palpate a pulse in Barnes' neck. The AED arrived and CO J.K. worked on getting it applied while Sgt. J.S. performed compressions and CO M.H. administered rescue breaths. The AED did not advise any shocks. Sgt. J.S., CO J.K., CO M.H. and CO N.O. rotated throughout performing CPR.

46. At 9:00 p.m., South Seneca EMS arrived and EMTs [redacted]. assumed care of Barnes. Security staff continued to help with CPR while EMS switched Barnes over to

their equipment and rendered care. Road patrol Sgt. J.S. and Deputy J.M. arrived on the scene and assisted with CPR. [redacted]

47. [redacted]

48. [redacted].

49. [redacted].

50. [redacted]

51. [redacted].

52. Barnes had written suicide notes to his mother and to a fiancé. Both suicide notes said Barnes loved them, wanted peace, didn't want to be in pain anymore, that Barnes had been planning on taking his life for a while and that everything was Barnes fault and not theirs. Barnes had thanked them for their love and all they had done.

In a response to the Commission's preliminary report dated 11/10/21, the Seneca County Sheriff indicated that the letters cited in the finding were documented by Barnes during a previous incarceration in 2017. The Commission acknowledges this however notes that the cited documents did not included or indicate any time or date.

53. [redacted]

54. The Medical Review Board's review of the mental health care provided to Barnes by LMHC [redacted]. revealed that LMHC [redacted] failed to report Barnes' lethality assessments to Psychiatrist Dr. [redacted]. on 2/18/20, on 3/13/20, and on 3/27/20. Additionally, on 3/23/21, LMHC [redacted]. failed to report to Dr. [redacted]. that Barnes had behavioral outbursts and problems over the weekend and had requested that the medications be increased. LMHC [redacted]. also failed to report on 3/27/20 that Barnes again had requested the medications be increased. There was no documentation that indicated that Dr. [redacted] was ever notified or updated on Barnes' visits with mental health staff or that Barnes had requested medication increases.

55. During the investigation into Barnes' death, Commission staff reviewed the mental health services for the Seneca County Jail. The Seneca County Jail directly employs a Licensed Mental Health Counselor and a Licensed Mental Health Counselor -CASAC. . During an interview with Commission staff, LMHC [redacted]. stated that Dr. [redacted]. did not have remote access to review the metal health progress notes and that communication with the psychiatrist was done primarily through email. LMHC [redacted]. also reported that a suicide risk assessment scale was not used during the lethality assessments and that LMHC [redacted]. was not familiar with the accepted models such as the Columbia Suicide Risk Assessment.

56. [redacted]

ACTIONS REQUIRED:

TO THE SENECA COUNTY JAIL PHYSICIAN:

1. The Jail Physician shall conduct a quality assurance review to ensure that all medical staff understand that all medical documentation needs to contain the full date and time as well as initials and/or signatures of attending staff in accordance with 9 NYCRR §7010.2(j).

2. The Jail Physician shall conduct a quality assurance review on the health care provide to Barnes with a focus on:

a. Why Barnes was not seen for a follow-up exam with Dr. [redacted]. on 3/9/20 after the results of Barnes' urine CG/chlamydia test came back negative, why a clinical urinalysis was not completed and why Barnes' complaints of painful urination were not addressed?

b. Why Barnes's suicide attempt witnessed by CO Z.P. on 3/21/20 was not documented or addressed by mental health staff?

c. Why LMHC [redacted] failed to notify Dr. [redacted]. of Barnes' requests on 3/23/20 and 3/27/20 to have the medications increased?

d. Why LMHC [redacted]. failed to notify Dr. [redacted] that Barnes displayed passive suicidal ideation prior to Dr. [redacted]. examining Barnes's on 2/18/20,, that Barnes was displaying passive suicidal and homicidal ideations on 3/13/20 and that Barnes has passive suicidal ideations on 3/27/20?

e. Why LMHC [redacted] gave Barnes approval to have the composition notebook to journal for the purpose of processing daily mental health stressors on 2/18/20, but the journal was never reviewed as part of Barnes' care plan?

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

A response to the Commission's preliminary report dated 11/10/21 was provided by the Seneca County Sheriff.

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

TJL:JW:jdb
2020-M-0026
December 2021