Final Report of the New York State Commission of Correction:

In the Matter of the Death of

Kieran Bunce (16A3510), an incarcerated individual of the Midstate Correctional Facility

June 28, 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

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 Kiernan Bunce who died on February 4, 2020, while an incarcerated individual in the custody of the NYS Department of Corrections and Community Supervision at the Midstate Correctional Facility, the Commission has determined that the following final report be issued.

<u>FINDINGS</u>:

1. Kieran Bunce was a 52-year-old male who died on 2/4/20, from a suicidal hanging while in the custody of the New York State Department of Corrections and Community Supervision (NYS DOCCS) at Midstate Correctional Facility (CF).

2. Bunce was born in Manhattan, NY. He was survived by his parents. Bunce received a high school diploma. There was no further demographic or social history information available for Bunce.

3. [redacted].

4. [redacted].

5. [redacted].

6. In June 2016, in the town of Riverhead, NY, Bunce was arrested on a Warrant and charged with a Violation of Sex Offender Registry Requirement-1st Offense. Bunce was sentenced to 1 to 3 years in the NYS DOCCS.

7. Bunce was admitted into NYS DOCCS at Downstate CF on 8/29/16. Bunce was transferred to Mohawk CF on 10/16/16. NYS DOCCS' documentation indicated that Bunce spent time in Gowanda CF until being transferred to Midstate CF on 5/11/18. This

is where Bunce remained until the terminal event.

8. During Bunces' incarceration, Bunce received one Tier 2 infraction for violent conduct and fighting. Bunce received sanctions that included keeplock, no packages, no phone, and no commissary.

9. [redacted].

10. [redacted].

11. [redacted].

12. [redacted].

13. [redacted].

14. [REDACTED].

15. On 5/24/19, Sergeant (Sgt.) J.B. documented on a OMH referral that he was interviewing Bunce and Bunce kept changing his story, would not make eye contact, and claimed that "unidentified flying objects (UFO's)" were real. Sgt. J.B. submitted a regular mental health referral for Bunce.

16. [REDACTED].

17. [REDACTED]. The Medical Review Board opines that with Bunce having four separate referrals to OMH in a three-month period, he should have been considered for Active Screening Status to monitor him and ascertain if Bunce had a diagnosis and need for services.

18. [REDACTED].

19. [REDACTED].

20. [REDACTED].

21. [REDACTED].

22. On 2/4/20, Sgt. R.B. documented in a memorandum that on 2/4/20 at 1:55 p.m., he was

instructed by Acting Captain K. to interview Bunce for involuntary protective custody (IPC). Documentation indicated that Bunce was not cooperative with the interview and denied needing protective custody. Sgt. R.B. contacted Assistant Deputy Superintendent of Programs (ADSP) M.D. who reported that Bunces' family had been calling and saying that the facility was not protecting Bunce. Documentation indicated that due to Bunces' inability to live in housing units without being extorted for possessions, sex, or money, it was believed that Bunce needed to be in protective custody. Bunce was moved to Special Housing Unit (SHU) 10-14 cell while his IPC application was pending.

23. On 2/4/20 at 2:10 p.m., Sgt. R.B. completed the suicide prevention screening for SHU admission with Bunce. Bunce answered "no" to all the questions and there were no triggers that Bunce had any thoughts of hurting himself.

24. [redacted].

25. On 2/4/20 at 6:12 p.m., Corrections Officer (CO) S.M. was conducting rounds on SHU 10-1 with the Deputy Superintendent of Security (DSS) W.B. When they approached cell# 14, they observed a sheet tied around the window bar of the cell. As CO S.M. and DSS W.B. looked into the cell, they observed Bunces' feet. Bunce was in a sitting position on the floor with one the end of the sheet tied to the lower portion of the window grate and the other end of the sheet tied around Bunces' neck. Bunce did not respond to CO S.M. and an emergency medical response was called as DSS W.B. ordered for the cell door to be opened. CO S.M. cut the sheet in half and laid Bunce down on the ground and removed the garrot from Bunces' neck. Bunce was pulseless and not breathing. CO S.M. initiated Cardiopulmonary Resuscitation (CPR) and the Automated External Defibrillator (AED) was applied with no shock advised. Lieutenant R.H. called 911 at 6:14 p.m. Security and medical staff arrived at the scene. [redacted].

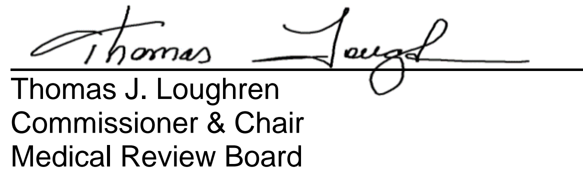
ACTIONS REQUIRED:

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

The Division shall conduct a quality assurance review on Bunces' referrals and evaluations by OMH clinicians with a review regarding why Active Screening Status was not considered after 4 separate referrals.

In a response dated 4/26/22 to the Commission's preliminary report, the Office of Mental Health indicated that they identified and addressed the cited issue during their review of the incident.

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 28th day of June, 2022.



Thomas J. Loughren
Commissioner & Chair
Medical Review Board

TJL:BB:jdb
2020-M-0013
June 2022

cc: Dr. Carol Moores, Acting Deputy Commissioner, Chief Medical Officer
Bryan Hilton, Assistant Commissioner for Mental Health
Superintendent Mark Passage, Midstate 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, Advocacy Letter Coordinator, CNYPC