NEW YORK STATE | Commission of Correction

Final Report of the New York State Commission of Correction:

In the Matter of the Death of

Troy Conklin, an incarcerated individual of the Orange County Jail

June 28, 2022

To: Sheriff Carl E. DuBois
Orange County Sheriff's Office
110 Wells Farm Road
Goshen, New York 10924

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 Troy Conklin who died on June 10, 2021 , as a result of circumstances which occurred while an incarcerated individual in the custody of the Orange County Sheriff at the Orange County Jail, the Commission has determined that the following final report be issued.

FINDINGS:

1. Troy Conklin was a 26-year-old male who died on 6/10/21, after being released from the custody of the Orange County Sheriff at the Orange County Jail. Conklin died as a result of a suicidal hanging incident that occurred on 6/1/21. The Medical Review Board has found that although Conklin received mental health and psychiatric services while incarcerated, his overall risk for suicide with three attempts within 30 days, was not fully recognized by providers from Wellpath Inc., a contract service provider.

2. Conklin was born in Honesdale, NY. He was survived by his two children, his parents, and three siblings. Conklin received a GED and was employed as a tattoo artist.

3. [redacted].

4. [redacted].

5. [redacted].

6. In the instant offence, on 5/2/21 at 10:40 a.m., Conklin turned himself in to the Port Jervis Police Department in Port Jervis, NY, where he was arrested charged with Kidnapping 2nd Degree, Attempted Kidnapping 2nd Degree, Strangulation 2nd Degree, Reckless Endangerment 1st Degree, Attempted Assault 2nd Degree, Assault 3rd Degree, Act in Manner Injure Child Less Than 17, Criminal Mischief-Intent to Damage Property, and Criminal Mischief 4-Disable Equip to Prevent Request For Emergency Assist. Conklin was held at the Port Jervis Police Department Lockup pending his arraignment.

7. On 5/2/21 at 12:49 p.m., Port Jervis Police Department Officer M.K. was monitoring the security cameras and observed Conklin in the cell slouching on the bench and sliding to the floor. Officer M.K. and Officer D. immediately went to check on Conklin and observed that Conklin had tightened his T-shirt around his neck and rendered himself

unconscious. The T-shirt was removed from Conklin's neck and 911 was called immediately. [redacted]. Conklin was transported to the New Windsor Court and was seen before Judge G.M. Conklin was charged with Kidnapping 2nd Degree, Strangulation, and Assault 3rd Degree. Conklin was committed to the custody of the Orange County Sheriff and ordered to return to court on 5/7/21 at 10:00 a.m. for a preliminary hearing.

8. On 5/2/21 9:22 p.m., Conklin was admitted to the Orange County Jail and was screened by Officer P.C. The Orange County Jail was notified by the Port Jervis officers of Conklin's previous suicide attempt and hospital emergency room (ER) visit. Conklin scored a 15 on the Suicide Prevention Screening and answered "yes" to having family problems, using marijuana, having a past suicide attempt, and showing signs of depression. Conklin was placed on a one on one suicide watch. Officer P.C. placed an emergent referral for mental health and a non-emergent referral for medical. Conklin was housed in POD B1 Cell #14 [redacted].

9. [redacted].

10. [redacted]

11. [redacted]

[redacted]. The Medical Review Board opines that since Conklin had an actual suicide attempt by hanging, consultation with psychiatry should have occurred prior to being removed from constant supervision.

12. During an interview with Commission staff, LMSW [redacted]. reported that on April 1, 2021, Wellpath Care took over the mental health services that were being provided to the jail by Orange County Mental Health. During the time of the transition from the County Mental Health Department over to Wellpath, the patient's mental health records were not readily available to Wellpath and that the records had to be requested from the County Mental Health Department. [redacted]. During an interview with Commission staff, LMSW [redacted]. reported that any Wellpath mental health documentation after April 1, 2021, would have been able to be reviewed by other mental health clinicians. LMSW [redacted] reported that all the mental health clinicians collaborate as a team either verbally or through email, and they would be in communication with each other of what was occurring.

13. [redacted].

14. [redacted].

15. [redacted]

[redacted].

16. [redacted].

17. [redacted].

18. [redacted]

19. [redacted].

20. [redacted].

21. [redacted]

[redacted].

22. [redacted]

23. [redacted].

24. [redacted].

25. [redacted].

26. [redacted]". The Medical Review Board opines that RN [redacted]. failed to document a full assessment on Conklin after attempting to cut himself with glass from a lightbulb that he had broken in his cell. RN [redacted]. also failed to document a nursing progress note on the incident. Conklin was returned to POD D1 and was housed in Cell #11.

27. [redacted].

28. [redacted].

29. [redacted]

30. [redacted]

31. [redacted].

32. [redacted].

33. [redacted].

34. [redacted]

35. [redacted]

36. [redacted].

37. On 5/20/21, facility documentation indicated that Conklin was moved to Medical 1 Cell #5 for Classification and safety reasons.

38. [redacted].

39. [redacted].

40. [redacted].

41. [redacted].

42. [redacted].

43. [redacted]

[redacted].

44. [redacted].

45. [redacted].

46. [redacted]eted. A review of Conklin's records revealed that LPN [redacted]. failed to follow the New York Correct Care Solutions (NYCCS) Orange County New York Correctional Policies & Procedures Reference #73380, 6. Procedure, 6.9.2. - High-Priority Medications - If a patient refuses or misses a High-Priority Medication, the patient is referred to the prescribing provider for chart review and the determination if face to face encounter is needed. 6.10 - Patients currently receiving mental health treatment services and refusing scheduled treatment after three (3) documented refusals shall be referred to a Qualified Mental Health Professional (QMHP). The Medical Review Board has found that LPN [redacted]. did not submit a Mental Health Referral for Conklin after refusing three consecutive days of the prescribed medications [redacted]. Additionally, the Medical Review Board opines that the prescribed medications did not have enough time to achieve therapeutic efficacy, and with Conklin's recent history of suicide attempts and self-harm, the refusals to take the medication should have been cause to elevate his level of suicide risk.

47. On 6/1/21 at 2:55 p.m., Officers M.P. and D.S. conducted a shift change supervisory round and a physical headcount on the Medical 1 Housing Unit. As the officer's approached cell #5 where Conklin was housed, they observed Conklin's legs sticking out of the shower. Officer M.P. knocked on the cell door without a response from Conklin. Officer M.P. opened the cell door and entered the cell with Officer D.S. and they both observed Conklin sitting in the shower with a sheet tied around his neck and the other end of the sheet tied around the shower head. Officer D.S. used the cutdown tool to cut the sheet from the shower head as Officer M.P. call a medical emergency. Staff immediately responded to the scene and Sgt. M.S. observed a secondary sheet tied around Conklin's neck with the other end of the sheet affixed to the shower faucet handle. Sgt. M.S. cut the ligature from Conklin's neck and he was placed supine on the floor. Conklin was unresponsive, his skin was pale, and he was pulseless and not breathing. CPR and rescue breaths were initiated immediately and 911 was called. The AED was applied without any shocks advised. Facility Dr. [redacted]. responded immediately to the scene [redacted].

48. [redacted].

[redacted]

ACTIONS REQUIRED**:**

TO THE JAIL PHYSICIAN AT THE ORANGE COUNTY JAIL:

The Jail Physician shall conduct an investigation into:

- Why RN [redacted]. failed to document a full assessment on the Medical Incident Report for Conklin after attempting to cut himself with glass from a lightbulb that he had broken in his cell.
- Why RN [redacted]. failed to document a nursing progress note on Conklin after attempting the above-mentioned incident.
- Why LPN [redacted]. failed to submit a Mental Health Referral for Conklin after he refused three consecutive days of the prescribed medications [redacted].
- Why psychiatry was not consulted prior to removing suicide watch precautions for Conklin on 5/4/21.

A report of the findings and any actions taken shall be provided to the Medical Review Board when completed.

In a response dated 5/9/22 to the Commission's preliminary report, the Regional Medical Director for NY Correct Care Solutions indicated the following:
-On 5/10/21 the nurse generated a medical incident report but did not generate a full assessment in a progress note. NYCCS developed a Process Improvement Plan and training was administered to all staff on appropriate documentation where patients sustain an injury or attempt self-injurious conduct.
-NYCCS clinical staff utilize a collaborative team approach and meets daily to discuss potentially suicidal patients. This includes a consultation with psychiatry. [redacted] *The Medical Review Board remains opined that these are critical clinical decisions that require clear documentation in the patient's chart with all associated consultations indicated.*
- A training of all medical staff was completed on Policy & Procedures Reference #73380, 6. Procedure, 6.10, including that three refused mental health medications will result in a referral to the mental health provider. The EMAR/POCC process was modified to automatically notify nursing when three missed doses have occurred via a "pop-up" notification. A weekly report is sent to the Health Service Administrator and Director of Nursing to ensure continuous monitoring.

TO THE CHAIR OF THE LEGISLATURE OF ORANGE COUNTY:

As the appointing authority for the delivery of jail incarcerated individual health services pursuant to Correction Law section 501, the County Legislature shall review the above findings and conduct an inquiry into the fitness of the currently designated provider.

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
Special Investigation
June 2022