



**Commission of
Correction**

**Final Report of the
New York State Commission of Correction:**

In the Matter of the Death of

**Antwoine Fort (14B0136),
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 Antoine Fort who died on November 29, 2018, 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. Antwoine Fort was a 31-year-old African American male who died on 11/29/18, from 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. Fort was born in Brooklyn, NY. Fort was survived by a wife, a mother, a father, a sister, and two brothers. Fort finished the 11th grade and did receive a GED. Fort was not employed.
3. [REDACTED]
4. [REDACTED]
5. [REDACTED]. In the instant offense, on 9/21/2011 in Binghamton, NY while Fort was on parole supervision, Fort entered a taxicab and displayed a handgun and told the driver that if the driver moved, the driver was going to die. Fort then opened the door, put the gun to the driver's head, pushed the driver out of the taxi, and drove away. Fort was found guilty of Attempted Robbery 1st Degree and was sentenced to 11 years in NYS DOCCS. [REDACTED]
6. Fort was admitted into NYS DOCCS at Elmira CF on 1/16/14. Fort spent time at Attica CF, Upstate CF, Five Points CF, and Great Meadow CF [REDACTED], before being transferred to Attica CF [REDACTED] on 11/13/18. This is

where Fort remained until the terminal event.

7. During Fort's incarceration, Fort accrued eleven Tier 2 and five Tier 3 infractions for charges including Violent Conduct, Interference, Harassment, Unhygienic Act, Failed Urinalysis Test, Threats, Weapon, Smuggling, Search/Frisk, Unauthorized Exchange, Out of Place, Creating a Disturbance, and Out of Place.

8. Fort was transferred into the Great Meadow CF on 4/23/18 for general confinement. On 8/17/18 at 2:15 p.m., Fort received a Tier 3 infraction for Violent Conduct, Creating a Disturbance, Assault on Staff, Interference, and Direct Order. [REDACTED]

[REDACTED] Fort was escorted by the facility officers to F-Block which houses the Special Housing Unit (SHU). [REDACTED]

9. [REDACTED]

10. [REDACTED]

11. [REDACTED]

12. [REDACTED]

13.

[REDACTED]

14.

[REDACTED]

15.

[REDACTED]

16.

[REDACTED]

This was in violation of 9 NYCRR

§7651.19(b)(c) which states:

(b) All health care services provided to inmate by facility health care staff or independent health care providers shall be permanently recorded in the medical record

(c) Medical records shall contain sufficient information to justify the diagnosis and warrant the treatment and results.

17.

[REDACTED]

18.

[REDACTED]

19.

[REDACTED]

20.

[REDACTED]

21.

[REDACTED]

22.

[REDACTED]

23.

[REDACTED]

24.

[REDACTED]

25.

[REDACTED]

26.

[REDACTED]

[REDACTED]

27.

[REDACTED]

28

[REDACTED]

29.

[REDACTED]

30.

[REDACTED]

31.

[REDACTED]

32.

[REDACTED]

33.

[REDACTED]

[REDACTED]

34. On 11/14/18, Fort was transferred from Great Meadow's [REDACTED] to Attica's [REDACTED]. Fort had a pending disciplinary hearing for receiving a Tier 3 infraction on 8/17/18, while in Great Meadow CF for Violent Conduct, Creating a Disturbance, Assault on Staff, Interference, and Direct Order. After receiving the Tier 3 infraction, Fort was facing a facility transfer to serve time in the Special Housing Unit (SHU). [REDACTED]

[REDACTED]

35. [REDACTED]

36. [REDACTED]

37. [REDACTED]

[REDACTED] . A suicide note was found in Fort's cell. [REDACTED]

[REDACTED]

[REDACTED]

38.

[REDACTED]

39.

[REDACTED]


40.

[REDACTED]

The Medical Review Board finds that there was an unacceptable delay in obtaining a psychiatric hospital placement for Fort who was clinically unstable and persistently endorsing suicidal ideation.

41.

On 11/29/18 at 12:45 a.m., CO W.V. was performing the 15-minute rounds in the [REDACTED] unit when CO W.V. observed Fort hanging by a state shirt which had one end tied to the cell vent on the ceiling and the other end tied around Fort's neck. CO W.V. immediately called a medical emergency and alerted CO R.P. COs, W.V. and R.P. retrieved the AED and gurney and placed it outside of Fort's Cell #3. They entered Fort's cell at 12:49 a.m., prior to the response team arriving, in order to remove the shirt from around Fort's neck. Fort was cut down and lowered to the floor. Fort was unresponsive but breathing. CO W.V. applied the AED with no shock advised. At 12:53 a.m., while Fort was being transferred from the floor to the gurney, Sgt. G.W. observed that Fort was not breathing. CO W.V. was instructed to initiate CPR and Fort was transported to the Facility ER room. [REDACTED]

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42. DOCCS Office of Special Investigations (OSI) completed an investigation into Fort's death and revealed sufficient evidence to substantiate that Fort committed suicide at Attica CF. Fort was observed hanging above the toilet with a state shirt weaved into the ceiling vent and Fort's camera was covered with toilet paper. OSI's Investigation produced evidence of staff misconduct committed by Sgt. G.W., CO R.F., and CO N.B.
 43. On 12/10/18, Sgt. G.W. was placed on Administrative Leave by the Bureau of Labor Relations. On 1/7/19, Sgt. G.W. was demoted to Correction Officer, issued a Notice of Discipline and was suspended without pay for not stopping and assessing Fort or Fort's cell, and for not addressing Fort's cell camera being obstructed during rounds on 11/29/18 at 12:12 a.m. On 12/23/19, CO G.W. was found guilty of all charges and it was deemed that the appropriate penalty was for termination from NYS DOCCS.
 44. On 1/17/18, CO R.F. was placed on Administrative Leave by the Bureau of Labor Relations. CO R.F. was found guilty of the charges outlined in the Notice of Discipline. The Arbitrator deemed that the appropriate penalty was for a six-month suspension without pay.
 45. On 12/24/18, CO N.B. was issued a Notice of Discipline by the Bureau of Labor Relations and was suspended without pay. On 12/19/19, CO N.B. was found guilty of charges outlined in the Notice of Discipline. The Arbitrator deemed that the appropriate penalty was for a six-month suspension without pay.
 46. On December 17, 2018, CO R.P. was placed on Administrative Leave by the Bureau of Labor Relations. CO R.P. stated being briefed by CO W.V. and CO N.B. on 11/28/18 at the beginning of the shift. CO R.P. made the first security round in the [REDACTED] but did not assess the situation in Fort's cell. CO R.P. reported leaving the AED lockbox and the cut-down tool lockbox unsecured for any potential medical emergency with Fort. CO R.P. did not engage Fort in conversation or assess the situation in Fort's cell. CO R.P. stated that CO W.V. yelled that Fort was hanging, and CO R.P. grabbed the medical equipment and cut down Fort's body but did not commence CPR. On 1/2/19, CO R.P. retired from NYS DOCCS.
 47. The Medical Review Board concurs with the findings of the investigation and the administrative actions taken.

ACTIONS REQUIRED:

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

The Deputy Commissioner shall convene a comprehensive quality assurance review on the failure of the author of the AHR dated 9/4/18 to provide a location of the event, time, signature,

provider number, and a plan for Fort's medical needs and to assure comportment with the requirements of 9 NYCRR §7651.19(b) & (c).

In a response to the Commission's preliminary report dated 10/22/21 the DOCCS Deputy Commissioner for Health Services indicated the requested review was completed with corrective action taken.

TO THE NEW YORK STATE OFFICE OF MENTAL HEALTH DIVISION OF FORENSIC SERVICES

1. The Division shall conduct a review into the forensic hospitalization process for Fort with an inquiry as why a patient with active suicidal ideation and history of multiple attempts was not expedited for admission.
2. The Division shall conduct an investigation into the author of the RCTP Observation/Dorm Initial Progress Notes dated from 8/29/18 through 11/13/18 which are not identifiable and assure that clinical notes are properly legible and identifiable.

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

In a response to the Commission's preliminary report dated 10/19/21, 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 21st day of December, 2021.



Thomas J. Loughren
Commissioner & Chair
Medical Review Board

TJL:BB:jdb
2018-M-0158
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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