Commission of Correction

Final Report of the New York State Commission of Correction:

In the Matter of the Death of

Jose Hernandez (18A2361), an incarcerated individual of the Clinton Correctional Facility

September 27, 2022

To: Honorable Anthony Annucci
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 Jose Hernandez who died on June 27, 2019 while an incarcerated individual in the custody of the NYS Department of Corrections and Community Supervision at the Clinton Correctional Facility, the Commission has determined that the following final report be issued.

FINDINGS:

1. Jose Hernandez was a 37-year-old Hispanic male who died on 6/27/2019 at 3:56 a.m., from a suicidal hanging while in the custody of the NYS Department of Corrections and Community Supervision (DOCCS) at the Clinton Correctional Facility (CF). The Medical Review Board has found there was an inadequate assessment of suicide risk and premature release from observation by the Office of Mental Health (OMH) providers before having Hernandez's safety concerns addressed by DOCCS. The Medical Review Board opines that this may have been a preventable death had Hernandez been properly assessed and referred to DOCCS for safety concerns.

2. Hernandez was born in Central Islip, New York. Hernandez reported having a good up bringing with both parents in the home along with a brother and a sister. Hernandez was unemployed. Hernandez completed his GED in 2010. Hernandez was married but had multiple relationships over the years with "female friends". Hernandez had a history of domestic violence in relationships in which he was charged three times but was never convicted. Hernandez admitted that he was a member of the Latin Kings gang. Hernandez was survived by his parents, brother, sister, wife and three or five children (documentation contradict the number of children Hernandez had).

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5. On 5/28/19, Hernandez was transferred from Franklin CF to Upstate CF for housing in the Special Housing Unit (SHU) due to receiving a tier 3 ticket for violent conduct and fighting.

6. [redacted].

7. [redacted].

8. On 5/30/19, Hernandez was transferred from Upstate CF to Clinton CF. [redacted].

9. [redacted].

10. [redacted].

11. [redacted]

[redacted] The CSRA offered minimal information as to why the CSRA was being updated. This was a violation of OMH Clinical Based Operations Policy #9.16 Comprehensive Suicide Risk Assessment, which highlights the importance of ensuring that the most up to date information is provided. There was corrective action taken to address this issue with OMH staff and RC2 [redacted]. on 9/23/19. [redacted]. Based upon a review of the available documentation however, it was unknown whether DOCCS was ever made aware of Hernandez's gang related fears in accordance with OMH CBO Policy #10.2 Information Reported to DOCCS which states:
Possible Security Concerns - The Unit Chief will notify the Superintendent of any statements made by inmate-patients that indicate the possibility of a security concern.

12. [redacted]. The Medical Review Board opines that Hernandez was released from observation prematurely given he was still endorsing suicidal ideation. The Board also opines that Hernandez safety concerns should have been reviewed with DOCCS prior to his release from observation.

13. On 6/27/19 at 2:00 a.m., Hernandez was observed alive in his cell, D-2-22, by CO D.F. during his 2:00 a.m. rounds.

14. On 6/27/19 at 2:57a.m., per the DOCCS Unusual Incident Report, CO T.V. was making security rounds on D-2 company and observed Hernandez hanging from the cell clothes hook by a state sheet towards the right rear of the cell. Hernandez was propped up on his bed with his feet touching the floor. Hernandez had tied a state sheet around his neck with the other end fixed to the cell clothes hook. CO T.V. yelled to CO D.F. to call a medical emergency. CO D.F. called the emergency to the chart Sgt.'s office, which was then announced over the facility radio.

15. At 2:58 a.m., area supervisor Sgt. J.H., RN [redacted]., CO C.B. and CO D.T. responded to Hernandez's cell. Sgt. J.H., CO C.B. and CO D.T. entered the cell. CO C.B. and CO D.T. lifted Hernandez's body up to relieve the pressure on the sheet while Sgt. J.H. used the D-Block cut down tool to cut the sheet off the cell clothes hook. COs C.B. and D.T. placed Hernandez on a backboard on 2 company. CO J.B. immediately loosened and removed the bed sheet and a green state towel that was under the sheet from Hernandez's neck.

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19. At 3:30 a.m., Champlain Valley Physicians Hospital (CVPH) Emergency Medical Services (EMS) arrived and assumed care of Hernandez. Hernandez's cell was searched, and no contraband was found.

20. .

21. . Dr. indicated that this type of behavior was not out of the ordinary. Dr. also reported that suicidal threats can be manipulative in order to avoid going to SHU but if the Incarcerated Individual is presenting and behaving well, then the individual must be discharged as they cannot be housed in RCTP. Dr. . indicated that an incarcerated individual's mood, mental status, eating and sleeping habits are taken into consideration when determining is a person should be discharged from RCTP.

22. Hernandez's last visit from his wife was on 11/11/2018. Hernandez's last visit from his "female friend" was on 4/20/2019. Hernandez's last phone calls were from his "female

friend" on 5/27/19 and his daughter on 5/26/19. OSI reviewed Hernandez's phone calls that took place one month preceding Hernandez's suicide and were unable to develop any additional information.

ACTIONS REQUIRED:

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

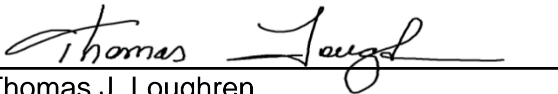
1. The Division of Forensic Services shall conduct a quality assurance review on the mental health care provided to Hernandez with a focus on whether security concerns expressed by Hernandez in relation to his suicidality were properly relayed to DOCCS administration per OMH CBO Policy #10.2 Information Reported to DOCCS.

2. The Division of Forensic Services shall conduct a focused professional practice evaluation with psychiatrist Dr. ███. and the clinical decision to remove Hernandez from observation while he was still endorsing suicidal ideation.

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

In a response dated 7/22/22 to the Commission's preliminary report, the Division of Forensic Services indicated that a review was completed with no violation of policy noted as DOCCS was informed of Hernandez's safety concerns ███ The Medical Review Board remains opined that there was insufficient documentation to indicate Hernandez's current fears for safety, as expressed two days before his suicide, were adequately communicated to DOCCS. Additionally, regarding his discharge from observation, the Board remains opined that Hernandez was still endorsing suicidal ideation related to safety concerns during a psychiatric encounter a day prior to his suicide, whereby step-down options should have been considered.

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 27th day of September, 2022.



Thomas J. Loughren
Commissioner & Chair
Medical Review Board

TJL:JW:jdb
2019-M-0067
September 2022

cc: Dr. Carol Moores, Chief Medical Officer

Bryan Hilton, Assistant Commissioner for Mental Health
Superintendent Donita McIntosh, Clinton CF
Dr. Li-Wen Lee, Associate Commissioner
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Danielle Dill, Executive Director, CNYPC
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