Commission of Correction

Final Report of the New York State Commission of Correction:

In the Matter of the Death of

Jamel Ligfhty (aka Lightly) (15B1369), an incarcerated individual of the Great Meadow 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

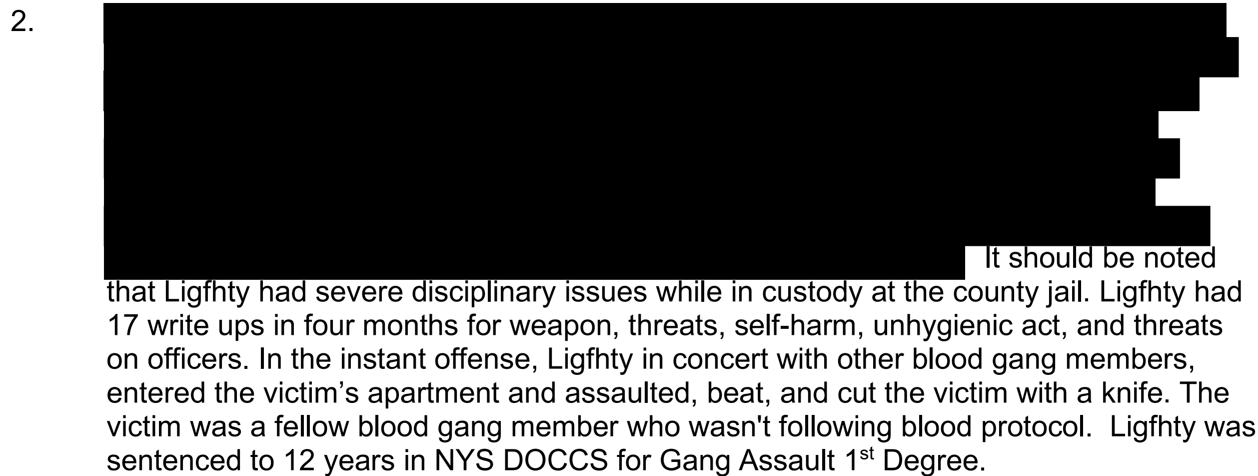
Yolanda Canty
Commissioner

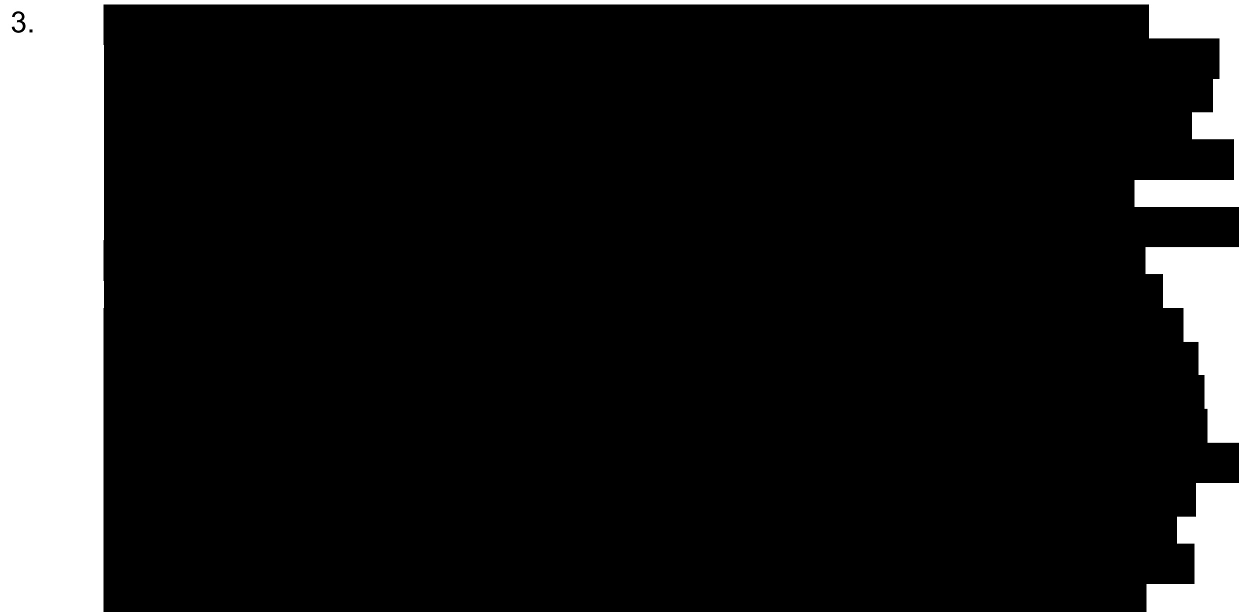
GREETINGS:

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 Jamel Ligfhty aka Lightly who died on January 1, 2020, while an incarcerated individual in the custody of the NYS Department of Corrections and Community Supervision at the Great Meadow Correctional Facility, the Commission has determined that the following final report be issued.

FINDINGS:

1. Jamel Ligfhty, (aka Lightly), was a 33-year-old African American male who died on 1/1/20 due to a suicidal hanging while in the custody of the New York State Department of Corrections and Community Supervision (NYS DOCCS) at the Great Meadow Correctional Facility (CF). The Medical Review Board has found that there was a lack of consideration for re-admission for forensic hospitalization in a patient who had multiple crisis admissions.

2. 
It should be noted that Ligfhty had severe disciplinary issues while in custody at the county jail. Ligfhty had 17 write ups in four months for weapon, threats, self-harm, unhygienic act, and threats on officers. In the instant offense, Ligfhty in concert with other blood gang members, entered the victim's apartment and assaulted, beat, and cut the victim with a knife. The victim was a fellow blood gang member who wasn't following blood protocol. Ligfhty was sentenced to 12 years in NYS DOCCS for Gang Assault 1st Degree.

3. 

4. On 5/4/15, Ligfhty was received at the Elmira CF. .
During the NYS DOCCS incarceration, Ligfhty incurred 11 Tier II and nine Tier III infractions.

5. On 5/19/15, Ligfhty was transferred to Attica CF. .

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7. On 8//27/15, Ligfhty was transferred to Wende CF
On 1/5/16, Ligfhty was transferred to Attica

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10. On 8/27/16, Ligfhty was admitted to the Attica CF .

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14. On 12/15/16, Ligfhty was admitted to Long Term Keeplock (LTK) following a Tier III infraction for Direct Order and Urinalysis testing.

15. On 12/27/16, Ligfhty was transferred to Wende Ligfhty continued to serve the SHU sanctions.

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18. On 2/22/17, Ligfhty was transferred to Marcy CF

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20. On 10/17/17, Ligfhty was discharged to Attica . This issues was addressed in the Office of Mental Health Quality Assurance report and recommendations were made to all facilities and providers.

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24. On 2/9/18, Ligfhty was admitted to the Attica [redacted] until 2/15/18 [redacted]. On 2/15/18, Ligfhty was transferred to Attica SHU until 3/12/18.

25. [redacted]

26. On 3/13/18, Ligfhty was transferred to Five Points [redacted]

27. [redacted]

28. On 5/17/18, Ligfhty was transferred to Great Meadow [redacted] Ligfhty remained there until 2/8/19.

29. [redacted].

30. [redacted]

31. [redacted]

32. [redacted]

33. [redacted]

34. [redacted].

35. From 2/8/19 until 2/25/19, Ligfhty was housed in the Great Meadow SHU following infractions for violent conduct, fighting, creating a disturbance, and direct order.

36. On 2/26/19, Ligfhty was transferred to Wende

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60. On 9/16/19, the transfer form was completed for a transfer from Wende to Sullivan

61. On 9/19/19, Ligfhty was transferred to Sullivan .

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79. The Medical Review Board opines that given Ligfhty's recurrent imminent suicidal risk factors along with medication noncompliance and a refusal to engage with mental health staff, forensic inpatient treatment at CNYPC should have been considered.

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87. Ligfhty received a Tier III infraction for two charges of violent conduct, two charges of assault on staff, unhygienic act, two charges of creating a disturbance, and direct order. Ligfhty's sanctions included one year of SHU time which would expire in March of 2021 and Ligfhty already had SHU time until March of 2020 due to previous tickets.

88. On 12/10/19 1:30 p.m., Per the sergeant., the clothing was never tied tight and the sergeant. was able to fit fingers between noose but couldn't cut off as it was braided. Ligfhty was combative, agitated, and angry. Ligfhty had a use of force that morning after going to the hearing and upon returning to the cell, smeared feces and covered the camera. Per the officer, Ligfhty cleaned the camera in order to receive the lunch meal.

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101. The Medical Review Board opines that Ligfhty's continued endorsement of wanting to die was a serious suicide risk factor and should have prompted consideration for admission to a forensic hospital for extended treatment.

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104. On 12/30/19, Ligfhty was transferred from Sullivan CF and arrived at the Great Meadow CF . At 1:25 p.m., Ligfhty was escorted to BHU B-8.

105. On 1/1/20 at 3:30 p.m., CO T. was making rounds and noted Ligfhty standing on the top of the toilet with a sheet tied around the neck and was to tie it to the air vent. CO T. continued the rounds and then CO T. entered the sergeant's office to report the findings to Sgt. G. The office and sergeant responded to the cell where they observed Ligfhty hanging and unresponsive. At 3:35 p.m., a medical emergency was called, staff immediately entered the cell, and cut Ligfhty down. They placed Ligfhty on the bed, checked for a pulse, felt a pulse, and then rolled Ligfhty on the side. Ligfhty was checked a second time and a pulse was not felt. Ligfhty was moved to the cell floor and Cardiopulmonary Resuscitation (CPR) began. At 3:40 p.m., 911 was contacted.

106. As a result of CO T. actions, CO T. was suspended without pay and a Notice of Discipline for dismissal from state service was issued.

ACTIONS REQUIRED:

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

1. The Deputy Commissioner shall convene a comprehensive quality assurance review with all providers in the facilities that Ligfhty was housed in to assure the medical problem list is up to date with accurate diagnosis listed for medical conditions being treated.

2. The Deputy Commissioner shall convene a comprehensive quality assurance review with the providers at Great Meadow CF to assure medication review and compliance is standard practice for chronic care appointments.

A copy of the reviews and findings shall be provided to the Medical Review Board upon completion.

In a response to the Commission's preliminary report dated 10/29/21, DOCCS Deputy Commissioner of Health Services indicated that the requested reviews were completed with corrective action taken.

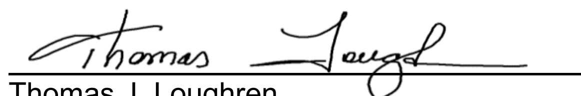
TO THE NYS OFFICE OF MENTAL HEALTH DIVISION OF FORENSIC SERVICES:

The Forensic Services Division shall conduct a quality assurance review with clinical staff at Sullivan CF to determine why consideration for re-admission to CNYPC was not considered for Ligfhty given his recurrent suicide risk factors.

A copy of the reviews and findings shall be provided to the Medical Review Board upon completion.

In a response to the Commission's preliminary report dated 10/25/21, Office of Mental Health indicated that the requested review was 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:DC:jdb
2020-M-0002
December 2021

cc: Dr. John Morley, Chief Medical Officer
Bryan Hilton, Assistant Commissioner for Mental Health
Acting Superintendent Joseph Corey, Great Meadow 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