



**Commission of
Correction**

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

In the Matter of the Death of

**Colin Same (16B2978),
an incarcerated individual of the
Elmira Correctional Facility**

March 29, 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 Colin Same who died on April 12, 2019, while an incarcerated individual in the custody of the NYS Department of Corrections and Community Supervision at the Elmira Correctional Facility, the Commission has determined that the following final report be issued.

FINDINGS:

1. Colin Enos Same was a 22-year-old Caucasian, Non-Hispanic male who died on 4/12/19 from a suicidal hanging while in the custody of New York State Department of Corrections and Community Supervision (NYS DOCCS) at Elmira Correctional Facility (CF).
2. Same was single with no children and lived at home prior to incarceration. Same was survived by Same's parents and a sister, who had been supportive during the incarceration. Same was Catholic and turned to religion at times while incarcerated.
3. Same had dropped out of school in the 10th grade [REDACTED] and was unemployed. Same obtained a High School Equivalency Diploma while incarcerated in 2017.
4. Same was serving a first state prison sentence of 1 to 3 years at the time of his death. Same's criminal history commenced at the age of 19 after being arrested on 7/8/16 for Robbery 3rd Degree. In the instant offense, Same gestured as if having a gun in a pocket and forcibly stole money from a clerk at a Nice-N-Easy grocery store. Same was originally received by NYS DOCCS at Elmira CF on 10/17/16. During the intake interview, Same admitted guilt and reported being high and drunk and didn't realize that he had committed the crime. No weapon was recovered from Same and the motive appeared to be drug related.
5. [REDACTED]
6. [REDACTED]
7. Same transferred to the Lakeview CF Shock Program on 11/1/16 and was released to Parole on 5/18/17.
8. On 1/16/18, Same was incarcerated at the Onondaga Justice Center on a Parole Violation.
9. On 1/17/18, Same was in a dry cell for suspicion of drug possession. The officer observed Same making a motion as if Same was pushing something into his anus.

- Same's cell was searched and plastic wrap, wax paper, seeds and a deck shoe with white powder on it were recovered. On 1/25/18, Same arrested by the Onondaga County Sheriff's Office and was charged with Possession of Contraband in Prison 2nd Degree and Tampering with Physical Evidence: Conceal/Destroy. Same was sentenced to a conditional discharge on 4/18/18.
10. On 6/25/18, Same was returned to NYS DOCCS's custody at Elmira CF for the parole violation. On 7/6/18, Same was transferred from Elmira CF to Greene CF. Same was released from Greene CF to Parole on 8/30/18.
 11. On 3/13/19, Same violated parole again for drug use and absconding for 90 days. Same was incarcerated at the Onondaga Justice Center for the parole violation. Same was placed on a constant watch for possible possession of contraband when Same was observed by staff motioning to remove something from his rectum and place it in his mouth. Same would not respond to security staff when they had asked Same what Same was in possession of. Same was placed in the restraint chair to prevent further self-harm or ingesting something that could lead to a medical emergency. When Same was released from the restraint chair, Same became resistant and was placed back in the restraint chair until transported to the hospital for an advance medical evaluation.
 12. [REDACTED]
 13. On 3/15/19, Same made statements to security staff about wanting to die and then went face first in the toilet and attempted to inhale toilet water. Staff attempted to stop Same from self-harm but Same resisted. Same was placed in the restraint chair to prevent Same from further self-harm until seen by medical staff.
 14. On 3/16/19, Same, [REDACTED], stood up on the bed and refused to comply when the officers ordered Same to get down. Security staff believed that Same was attempting to hurt oneself by jumping off the bed. Same was sprayed with a chemical agent to get compliance. Same got down to the floor and was decontaminated by medical staff. [REDACTED] Same [REDACTED] was transported to the Elmira CF on 3/28/19.
 15. On 3/28/19, Same arrived at the reception center at Elmira CF. [REDACTED]
 16. [REDACTED]

[REDACTED]

In a response to the Commission's preliminary report, Office of Mental Health Provided documentation that indicated mental health staff completed the screening from. It is noted this was not part of original records received by the Commission at the time of review.

17.

[REDACTED]

[REDACTED]

18.

[REDACTED]

[REDACTED]

19. [REDACTED]

20. [REDACTED]

21. [REDACTED]

22.

[REDACTED]

This is a violation of 9 NYCRR §7651.19(c) which states: *Medical records shall contain sufficient information to justify the diagnosis and warrant treatment and results.*

23.

[REDACTED]

24.

[REDACTED]

25.

[REDACTED]

26.

[REDACTED]

27.

[REDACTED]

28.

[REDACTED]

[REDACTED]

29.

[REDACTED]

30.

[REDACTED]

31.

[REDACTED]

32.

[REDACTED]

[REDACTED]

33. [REDACTED]

34. [REDACTED]

35. [REDACTED]

[REDACTED]

36.

[REDACTED]

37.

[REDACTED]

38.

[REDACTED]

39.

[REDACTED]

40.

[REDACTED]

[REDACTED]

41. [REDACTED] Same was transferred to B-Block. The B-Block extended Reception area is for any mental health patients that need increased observation and support while they wait for a transfer to their owning facility. At 12:00 p.m., the [REDACTED] CO logbook for the 7:00 a.m. to 3:00 p.m. shift indicated that Same was transferred out from [REDACTED] cell 5 to B-Block, 5 gallery, cell 2.

42. [REDACTED]. The Medical Review Board opines that the RCTP dorm should have been considered for further observation and monitoring of Same's behavior to more adequately address and evaluate Same's mental health needs given the extended placement Same had in observation prior to and during Same's admission into DOCCS.

43. [REDACTED]

44. [REDACTED]

45. [REDACTED]

[REDACTED]

46.

[REDACTED]

47.

[REDACTED]

48. [REDACTED]

49. [REDACTED]

50. [REDACTED]. However, there were no corresponding medical notes indicating that these labs results were reviewed by a medical provider. This was a violation of 9 NYCRR §7651.19(c).

51. [REDACTED]

52. [REDACTED]

53. [REDACTED]

54. Same's death was reviewed by OMH's Corrections Based Operations Risk Management and noted that *Policy #3.13 Medication Orders "PRN Agitation"* which required that *the nurse is to evaluate the in-patient's status at 15-minute intervals for the first hour following administration of PRN medications for patients housed in RCTP and document each observation with a date, time and signature* was not properly followed. [REDACTED] OMH took corrective action regarding this identified issue by having the Elmira CF's Nursing Administrator (NA) or designee review Policy #3.13 Medication Orders "PRN Agitation" with all staff.

55. [REDACTED]

[REDACTED]

56.

[REDACTED]

57.

[REDACTED]

58.

[REDACTED]

59.

[REDACTED]

[REDACTED]

60.

A [REDACTED]

In OMH's Corrections Based Operations (CBO) Risk Management review, it was noted that the psychiatric progress note dated [REDACTED] by PNP [REDACTED] was incomplete and the [REDACTED]. The review also found that the psychiatric progress note dated [REDACTED]

The recommendations for both of the psychiatric progresses note errors were that the CBO Clinical Director would review Policy #9.27 Psychiatric Progress Notes with staff, with a focus on the importance of accurately documenting the correct information in progress notes.

61.

[REDACTED] At 10:16 a.m., it was documented in the [REDACTED] CO log that Same had been moved from OBS 7 to B-5-1.

62.

At 10:23 a.m., per the B-Block logbook entry, Same was received on B-Block housing. A review of the logbook indicates that officer rounds were made every 15 minutes.

63.

At 1:23 p.m., CO A.S. was going to escort Same to view the Prison Rape Elimination Act (PREA) video and complete paperwork. CO A.S. opened Same's cell and observed that Same was hanging and unresponsive. Same was found face down kneeling with the head resting against the front of the cell bars. CO A.O. observed that Same had tied a sleeve from a white state issued long sleeve shirt around the neck with the other sleeve tied to the 4th rung of the cell bars. CO A.S. immediately called a medical response over the two-way radio and yelled out to other CO's nearby for assistance.

64.

CO M.E. and CO D.B. arrived with the AED and untied the shirt from Same's neck and lowered Same to the floor. Same was pulseless and not breathing. CO M.E. began CPR and CO D.B. applied the AED which advised no shock.

65.

At 1:23 p.m., RN [REDACTED] RN [REDACTED] and the A/B block area Sgt., S.P., arrived and EMS was alerted. [REDACTED]

[REDACTED]

66. At 1:29 p.m., Erway Ambulance crew [REDACTED] and [REDACTED] arrived and assumed care of Same.

67. [REDACTED]

68. [REDACTED]

69. Same's cell was searched by New York State Police BCI and no contraband, suicide note, or additional evidence was found. Same had written on the wall above the cell door, "Watch how you swim there's sharks in the water."

70. A review of the phone logs showed that there were no phone calls on record for Same from 12/14/18 through the date of death on 4/12/19. Same had no visits from anyone in 2019.

71. [REDACTED]

72. When Same's death was investigated by OMH's Corrections Based Operation Risk Management, [REDACTED]

[REDACTED]

The absence of documenting such as discussion brings into question whether all relevant information was included in the comprehensive risk assessment. Corrective action was recommended that clinical supervision would be conducted with all clinical staff by the Elmira CF Unit Chief or designee using Policy #9. 16 Comprehensive Suicide Risk Assessment as a guide with a focus on the importance of documenting all relevant clinical information when conducting a CSRA during callouts. Per the Elmira CF Unit Chief, this review was completed.

ACTIONS REQUIRED:

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

The Deputy Commissioner shall conduct a quality assurance review with medical staff regarding why RN [REDACTED] did not go to Same's observation cell on 3/29/19 at 11:15 p.m. to assess Same's complaints of chest pain, increased anxiety and suicidal thoughts and statements?

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 1/19/22, the Deputy Commissioner for Health Services indicated that the requested review was completed and corrective action was taken.

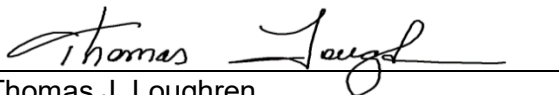
TO THE OFFICE OF MENTAL HEALTH, DIVISION OF FORENSIC SERVICES:

1. The Division of Forensic Services shall conduct a quality assurance review on the mental health care provided to Same with a focus on:
 - a. Why OMH SWII [REDACTED] left sections of the CNYPC Mental Health Screening Structured Interview form blank on 3/29/19?
 - b. Why the 4/11/19 entry on the MAR did not indicate that RN [REDACTED] had given Same the PRN dose of [REDACTED]?
 - c. Why a consideration for placement in the RCTP dorm was not made given Same's extensive need for observation placement. .

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 10/14/21, the Office of Mental Health indicated that the requested reviews were completed with corrective action taken.

WITNESS, HONORABLE THOMAS J. LOUGHREN, Commissioner, NYS Commission of Correction, Alfred E. Smith State Office Building, 80 South Swan Street, 12^h Floor, in the City of Albany, New York 12210 on this 29th day of March, 2022.



Thomas J. Loughren
Commissioner & Chair
Medical Review Board

TJL:JW:jdb
2019-M-0037
March 2022

cc: Dr. Carol Moores, Acting Deputy Commissioner, Chief Medical Officer
Bryan Hilton, Assistant Commissioner for Mental Health
Superintendent James Donahue, Elmira 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