NEW YORK STATE | Commission of Correction

Final Report of the New York State Commission of Correction:

In the Matter of the Death of

Richard Wright (88B1791), an incarcerated individual of the Five Points Correctional Facility

June 28, 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 Richard Wright who died on November 4, 2020, while an incarcerated individual in the custody of the NYS Department of Corrections and Community Supervision at the Five Points Correctional Facility, the Commission has determined that the following final report be issued.

FINDINGS:

1. Richard James Wright was a 52-year-old, White, non-Hispanic male who died on 11/4/20 from a suicidal self-inflicted laceration to the neck while in the custody of the Department of Corrections and Community Supervision (DOCCS) at Five Points Correctional Facility (CF).

2. Wright was born in Cohoes, New York. Growing up, Wright lived in a peaceful household with both parents and a sister. Wright had never married and had no children. [redacted]. Wright obtained his GED in 1992. Wright's family had been supportive and remained in contact with Wright throughout his incarceration. Wright had no known history of any childhood abuse or trauma. Wright was survived by his mother and sister. Wright's father died in 2013 of Lupus. Wright was arrested on 1/27/1987 at age 18 and had been incarcerated for approximately 34 years at the time of his death.

3. [redacted]. Wright's criminal history commenced in 1/21/87 at the age of 18. In the instant offense, on 1/21/87, Wright set fire to an occupied dwelling resulting in the death of several individuals and recklessly endangering the lives of others. Wright was arrested by Troy Police Department and later sentenced to 25 years to Life for Murder 2nd and 25 years to Life for Arson 1st in which the sentences were to run concurrently. Wright was originally received by DOCCS on 9/28/88. Wright was received at Five Points Correctional Facility (CF) on 10/1/20 temporarily, pending disciplinary action after attempting to escape from Marcy CF. Wright had refused multiple direct orders to stop and scaled Marcy's perimeter fence to the razor wire.

4. [redacted].

5. [redacted]

[redacted]

6. [redacted].

7. [redacted]

8. [redacted]

[redacted].

9. [redacted].

10. [redacted].

11. [redacted]

12. [redacted].

13. [redacted].

14. [redacted].

15. [redacted]

16. [redacted]

17. [redacted]

18. [redacted]

[redacted].

19. [redacted].

20. On 8/11/20 at 3:00 p.m., after arrival at Midstate CF, [redacted].

21. [redacted].

22. [redacted].

23. [redacted]

[redacted].

24. [redacted]

25. [redacted]”.

26. [redacted]

27. [redacted]

28. [redacted]

[redacted].

29. [redacted].

30. [redacted].

31. [redacted]

[redacted].

32. [redacted].

33 [redacted].

34. [redacted].

35. [redacted].

36. [redacted].

37. On 10/1/20 at 10:30 p.m., Wright was transferred to Five Points CF from Marcy CF. The transfer to Five Points CF was temporary pending disciplinary action at Marcy CF after the escape attempt. [redacted]

38. [redacted]

39. [redacted]

40. [redacted]

[redacted].

41. [redacted]. The Medical Review Board has found that there was a pattern of inconsistency in Wright's medical chart in listing his blood pressure medications as HCTZ and Propranolol. Per the medical chart, Wright's HCTZ had been discontinued on 7/23/20 by DOCCS Dr. [redacted] and Wright had been started [redacted] twice daily.

42. [redacted].

43. [redacted].

44. [redacted].

45. [redacted].

46. [redacted].

47. [redacted].

48. [redacted].

49. [redacted].

50. Wright's disciplinary hearing started on October 8, 2020 and was finalized on October 18, 2020. Wright had received a significant sanction of 723 days in the SHU, 723-day loss of packages, commissary, and phone, as well as the loss of 6 months of good time. During Wright's hearing, Wright reported that he had been having panic attacks, dealing with mental health issues, and having nightmares at the time of the incident. Wright stated that he blacked out and came to on the ground after the incident. The hearing disposition noted that Wright could participate in the hearing and Wright's mental health status led to less good time loss. It was also noted in the disposition that Wright did not have a history of this type of offense and had very little disciplinary history.

51. [redacted]

[redacted].

52. [redacted]. The Medical Review Board opines that Wright had clinical evidence of an anxiety disorder that went undiagnosed and untreated.

53. [redacted]

54. On 11/4/20 at approximately 2:35 p.m., security staff started showers and providing state issued equipment to the incarcerated individuals on the block. A review of the video recording shows that at 2:57 p.m., Correction Officer (CO) N.A. issued Wright a state razor as part of the personal hygiene routine. The log notes indicated that rounds were completed at 3:00 p.m. and 3:35 p.m. Another entry was made in the logbook at 3:10 p.m. from the institutional steward conducting an unannounced round. During the rounds that were completed at 3:35p.m. it was documented that security staff collected the state-issued razors and nail clippers and then the medical emergency was called for Wright. A review of the logbook for 12 Block revealed that the 3:00 p.m. round and count was documented after the 3:10 p.m. entry from the institutional steward. There was no indication of a late entry being documented. After review of the documentation, it is questionable if the state-issued razors were properly collected after the individuals completed their showers in accordance with the requirements Departmental Directive 4933 "*Special Housing Units*" DOCCS section 304.6.

55. At 3:06 p.m., Wright was last seen alive in his cell by CO N.A. during the standing count security rounds.

56. At 3:41 p.m., CO R.B. was escorting OMH RN [redacted]. on medication rounds when Wright was found unresponsive lying face down on the cell floor in front of the bunk. CO R.B. called for a medical emergency via the radio. CO R.B. gave an order to RN [redacted]. to leave. In an interview with Commission staff, CO R.B. reported that it was procedure to ask all civilians to leave the area until correction staff had the situation secured. Sgt.

W.A., and COs T.N., N.A., and B.E. responded immediately to the medical emergency with a gurney and Wright's cell door was opened. Sgt W.A. observed Wright bleeding profusely from a laceration to the left side of the neck. A 1 ½ x ¼ inch razor blade had been found on the floor of Wright's cell. Due to the large amount of blood and a large laceration to Wright's neck, Wright was placed onto a gurney by CO R.B., CO T.N. and CO N.A. Wright was rushed to the infirmary by CO B.E. and CO N.A. RN [redacted] and RN [redacted]. were headed to the emergency response when they met up with the security staff on the 12 Block corridor at the T Junction. Wright was transferred to an ER stretcher from the gurney and brought to the infirmary.

57. [redacted].

58. [redacted].

59. At 3:55 p.m., South Seneca Ambulance EMTs [redacted] and [redacted] arrived on scene and assumed care of Wright. [redacted].

60. [redacted]

61. At 6:00 p.m., OSI had conducted a search of Wright's cell. A 1 ½ x ¼ inch razor blade from a state issued razor had been found on the floor of Wright's cell. Broken up plastic of the state issued razor had been in the toilet and on the cell floor. There was no suicide note found.

62. RN [redacted]. was noted to have called 911 to notify EMS of the medical emergency. Protocol is for medical staff to notify the facility Watch Commander of the need for the ambulance. The Watch Commander is to notify EMS of the medical emergency. The error in the EMS notification procedure did not have a negative impact on Wright's outcome. The protocol for activating EMS was reissued to all facility superintendents on 11/19/20 in a memo from Deputy Commissioner/Chief Medical Officer Dr. [redacted].

63. On November 11, 2020, a NYS DOCCS Facility Quality Improvement Committee Mortality Review of Unexpected Death was completed. Per the report, the review committee recommended corrective action related to Wright's medical problem list not being up to date or accurate. The problem list should contain all current medical diagnoses. The review of the problem list showed a lack of medical diagnoses to include hypertension, asthma and gastroesophageal reflux disease(GERD). The deficiency in the problem list did not affect the outcome of Wright's medical emergency.

ACTIONS REQUIRED:

TO THE ACTING COMMISSIONER OF THE DEPARTMENT OF CORRECTIONS AND COMMUNITY SUPERVISION:

The Commissioner shall conduct an investigation into why the 12 Block SHU Logbook was not current when signed by the steward, without late entry being indicated and whether the state-issued razors were properly collected after the incarcerated individuals had completed their showers.

In a response dated 5/11/22 to the Commission's preliminary report, DOCCS has indicated that there was late entry in the logbook that was not properly indicated but did not impact the terminal event. DOCCS also indicated that agency Directive for issuing razors in SHU does not require immediate removal of them upon completion of use. The Medical Review Board acknowledges this however in view of Wright's terminal event opines that a review of policy and procedures for issuing and retrieving razors in SHU would be appropriate to prevent future occurrences.

TO THE DEPUTY COMMISSIONER FOR HEALTH SERVICES:

The Deputy Commissioner shall conduct a review into the pattern of inconsistency in documentation of Wright's blood pressure medications [redacted].

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

In a response dated 5/11/22 to the Commission's preliminary report, DOCCS has indicated that there was inaccurate medication documentation by nursing staff that was identified and had corrective action taken.

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

The Division of Forensic Services shall conduct a quality assurance review on the mental health care provided to Wright with a focus on:

-Why Wright's consistent reports of anxiety and suicidal ideation did not prompt a referral to psychiatry for follow-up after Wright was released from the RCTP on 8/12/20;

-Whether Wright had a proper diagnosis given his escalating behaviors including a bizarre escape attempt on 10/1/20 prompting his transfer to Five Points CF and admission into SHU.

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

In a response dated 4/26/22, the Office of Mental Health Indicated that the requested quality assurance reviews were completed. A review was completed regarding Wright's diagnosis with similar findings that were addressed with the clinical staff. Although Wright was referred to and seen by psychiatry within the requirements of CNYPC policy, the Board remains opined that Wright's presentation necessitated a prompt follow-up.

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:DC:jdb
2020-M-0117
June 2022

cc: Dr. Carol Moores, Acting Deputy Commissioner, 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
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