NEW YORK STATE | Commission of Correction

Final Report of the New York State Commission of Correction:

In the Matter of the Death of

Fred Williams, an incarcerated individual of the Cayuga County Jail

September 27, 2023

To: Sheriff Brian P. Schenk
Cayuga County Sheriff's Office
7445 County House Road
Auburn, New York 13021

Allen Riley
Chairman

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 Fred Williams who died on November 25, 2022 , as a result of circumstances which occurred while an incarcerated individual in the custody of the Cayuga County Sheriff at the Cayuga County Jail, the Commission has determined that the following final report be issued.

FINDINGS:

1. Fred Williams was a 35-year-old male who died on 11/25/22 from a suicide hanging and self-inflicted laceration while in the custody of the Cayuga County Sheriff at the Cayuga County Jail (CJ). The Medical Review Board has found that there were failures by Cayuga County Mental Health to provide continuity of care, to properly assure a referral to a psychiatric provider, and to provide a proper diagnosis and treatment during Williams' incarceration. The Medical Review Board opines that had Williams received a psychiatric assessment and had appropriate mental health treatment provided in a timely manner, his death may have been preventable.

2. [redacted]

3. [redacted]

[redacted]

4. On 6/23/22, Williams was arrested by the Cayuga County Sheriff's Office and charged with Criminal Possession of a Weapon 3rd Degree and a parole warrant. Williams was remanded to the Cayuga CJ and held without bail. Williams was booked in at 8:10 a.m. Williams' first suicide screen was completed at 8:50 a.m. where he scored a 'one'. A follow-up screening was completed at 1:43 p.m. where he scored a 'two'.

5. [redacted]

6. [redacted]

7. [redacted]

8. [redacted]

9. [redacted]

10. [redacted] During an interview with Commission staff, [redacted] LCSW-R [redacted] added that there is not a documented or formal request she submits when an II wants to see the psychiatric provider. Rather, she would ask Dr. [redacted] the next time he was at the facility if he would see the II and it is up to the psychiatric provider to see the patient. [redacted] The Medical Review Board opines that there was a failure by LCSW-R [redacted] to obtain Williams' mental health records from NYS Office of Mental Health and a failure to review the Cayuga County Community Mental Health records to assure continuity of care. [redacted] The Medical Review Board also opines that there was a failure to properly refer Williams to a psychiatric provider which included an inadequate referral process that lacks for accountability. It is the Medical Review Board's opinion that had Williams had been properly assessed, timely referred to a psychiatric provider and had a full review of his recent mental health history, his mental illness could have been properly managed, and his death prevented.

11. On 7/7/22, Williams assaulted another II and received a keep separate order. Williams also refused to lock-in. This was documented in the facility inmate misbehavior report Williams received from the incident.

12. [redacted]

13. [redacted]

14. [redacted]

[redacted]

15. [redacted]

16. [redacted]

17. [redacted]

18. [redacted]

19. [redacted] During an interview with Commission staff, LCSW-R [redacted] maintained that their system does not make or record appointments. LCSW-R [redacted] added that there was not a documented or formal request she submits when an II wants to see the psychiatric provider, rather she would have asked Dr. [redacted] the next time he was at the facility if he would see the II and it is up to the psychiatric provider to see the patient. [redacted]

20. On 8/15/22 at 3:57 p.m., Williams threatened to throw his meal tray at the officers. This was documented in the facility inmate misbehavior report Williams received from the incident. At 5:00 p.m., Williams threw ripped papers, garbage, and wet wadded up toilet paper out of his cell into the dayroom and in the direction of officers. Additionally, Williams also spread water and soap in the dayroom in front of his cell causing a hazardous environment for others to walk through.

21. On 8/16/22 at 7:25 a.m., Williams threatened an officer, stating "I'm going to punch you in the head next time you come in here." This was documented in the facility inmate misbehavior report Williams received from the incident. At 7:30 a.m., Williams flooded the B block day room by plugging and flushing the toilet. At 5:35 p.m., Williams threatened to throw what appeared to be a plastic coffee bag with fecal matter in it at officers. Williams also blocked the officer from closing the tray slot by putting his foot inside the slot.

22. [redacted]

23. [redacted]

24. [redacted] The Medical Review Board concludes that Cayuga County Mental Health failed multiple times over a seven week period to provide even minimal psychiatric care to Mr. Williams who suffered from chronic and serious mental disease. Despite being aware of his long psychiatric history and his prior psychiatric treatment, LCSW-R [redacted]. did not request any prior medical or mental health records which would have provided detail of critical clinical information including diagnosis, treatment and medications. This represents a complete failure to continue his necessary psychiatric care. Despite their awareness of his serious mental health condition and prior treatment with psychiatric medications, including Mr. Williams personal requests for specific medications, the staff did not refer him to a psychiatric provider for assessment and prescription of a medication regimen during the entire time of the incarceration.

25. [redacted]

26. On 8/24/22 at 8:30 a.m., Williams was moved to cell 3 from cell 2 during a cell search. The cell search revealed that Williams had no trash bag, two extra blankets and his light fixture was covered with papers. [redacted] Williams subsequently threatened officers that he would throw feces on them the following morning. [redacted]

27. [redacted] On 8/30/22, Williams had

a scheduled court appearance but refused to go.

28. On 9/4/22 at 7:15 a.m., when the D block door was keyed open after morning recreation, Williams exited the sub-dayroom and began throwing punches at another II. Williams received a keep separate order for fighting. [redacted]

29. On 9/5/22 at 6:35 a.m., immediately upon being let out for morning recreation, Williams began throwing closed fisted punches at another II. Williams received a keep separate for fighting.

30. [redacted]

31. [redacted]

32. [redacted]

33. On 9/14/22, Williams received a keep separate for throwing a block trashcan full of water on another II.

34. [redacted]

35. [redacted]

36. [redacted] At 2:30 p.m., Williams tied multiple articles of clothing and sheets around his cell bars to keep the cell door from opening. Williams was asked to take the articles down and he stated, "absolutely not." Medical was notified that Williams had tied his cell shut and a facility Sheriff's Emergency Response Team (SERT) was going in to remove Williams. At 3:54 p.m., Williams was refusing orders to move as well as to kneel and to submit his hands for handcuffing. As a result, SERT entered the cell to restrain and move Williams to another cell. Williams was suspected of being under the influence of unknow illegal drugs. [redacted]

[redacted]

37. [redacted]

38. [redacted]

39. [redacted] During an interview with Commission staff, LCSW-R [redacted] stated that when initially evaluating an IIs suicide severity, she utilizes the Columbia Suicide Severity Rating Scale [redacted]

40. [redacted]

41. [redacted]

42. [redacted]

43. [redacted]

44. [redacted]

45. On 10/6/22 at 7:15 a.m., Williams flushed multiple sheets down the toilet that caused the toilet to back up.

46. [redacted]

47. [redacted]

48. On 10/23/22 at 10:55 a.m., Williams struck another II with a closed fist punch. With this inmate misbehavior report combined with all the previous ones that Williams had received through this incarceration, he was to remain locked-in through 7/20/2023.

49. On 10/26/22, two IIs requested keep separate orders from Williams. Williams received the two keep separate orders.

50. [redacted]

51. [redacted]

52. On 11/15/22, Williams was scheduled to appear in court. Williams refused to go.

53. [redacted]

54. [redacted]

55. [redacted]

56. On 11/21/22, Williams had three phone calls. At 4:57 p.m., one call with the phone number associated with his mother. At 5:13 p.m., one call with the phone number associated with his sister. Finally, at 6:33 p.m., one call with the phone number associated with his mother.

57. Between 11/1/22 and 11/22/22, Williams had a total of 35 phone calls including 20 with the phone number associated with his mother and five with the phone number associated with his sister.

58. [redacted]

59. [redacted]

[redacted] At 3:40 p.m., documentation in the facility shift logbook indicated that Williams returned to B-Block, and LCSW-R [redacted] left the housing unit.

60. On 11/22/22 at 4:59 p.m., Williams had a phone call with the phone number associated with his mother.

61. [redacted]

62. On 11/23/22 at 3:00 p.m., documentation in the facility housing logbook indicated that Williams' cell was opened for his HALT act time out. At 5:44 p.m., documentation in the facility shift logbook indicated that Williams requested to return to his cell.

63. On 11/24/22 at 4:06 p.m., documentation in the facility housing logbook indicated that Williams declined his time out. Correction Officer (CO) S.H. documented that Williams' door was popped open and Williams slammed it shut. CO S.H. asked Williams if he wanted out and Williams stated that he was good. CO S.H. asked Williams if he was okay because the color in his face didn't look normal. Williams replied that he was fine. During an interview with Commission staff, CO S.H. stated that Williams' typical behavior was to be standing at his door ready to come out and this was not Williams' typical behavior. CO S.H. reported his observations about Williams to CO J.W. CO J.W. was the other officer assigned to the housing unit for the shift.

64. On 11/24/22 at 4:30 p.m., documentation in the facility housing logbook indicated that Williams declined his dinner meal. During an interview with Commission staff, CO S.H. stated that this was very atypical of Williams. Williams would regularly ask for additional meals and took trays from other IIs if they refused them. During an interview with Commission staff, CO J.W. stated that he attempted to make conversation with Williams after also observing Williams' out of character behavior. CO J.W. stated that when Williams declined his meal, Williams stated that he wasn't hungry, he was just tired, and he wanted to see his kids and the neighboring II could have the meal.

65. On 11/24/22 between 4:30 p.m. and 7:02 p.m., there was no documentation regarding Williams in the facility housing logbook. CO S.H. conducted supervisory tours at 4:41 p.m., 5:10 p.m., 5:38 p.m., 6:06 p.m., 6:35 p.m. and 7:02 p.m. During an interview with Commission staff, CO S.H. stated that on these supervisory tours, he stopped in front of Williams' cell, and made visual contact with Williams. CO S.H. waited for Williams to respond, which he did with a head nod.

66. On 11/24/22 at approximately 7:30 p.m., documentation in the facility housing logbook

indicated that while conducting a supervisory tour, CO S.H. saw Williams in his cell lying face down on his bunk. After CO S.H. completed his supervisory tour, he walked back to Williams' cell and observed blood on the walls. With no response from Williams, CO S.H. called the medical emergency. Security staff arrived and attempted to open Williams' cell door, but it had been tied closed with clothing between the bed and the door. After multiple attempts, Williams' cell door was opened. Williams was found unresponsive with what appeared to be clothing and a sheet tied around his neck. The facility cut down tool was utilized, and the ligature was removed from around Williams' neck by CO A.J. Williams was turned over and had blood-soaked fabric around his left wrist. CPR was initiated by CO A.J. An AED was placed but no shock was advised. At 7:34 p.m., EMS was activated. During an interview with Commission staff, CO S.H. stated that when he looked at Williams after completing the supervisory tour, he noticed that Williams' back did not raise and he did not respond to his name when called. Williams was in an awkward position with his head in the back right corner of his cell. During an interview with Commission staff, Corporal D.M. stated that Williams had looped a sheet from the front leg post of the bunk through the cell door slot and affixed it to the slot rest on the outside of the cell door. During an interview with Commission staff, CO J.W. stated that while rescue attempts were being made by other officers, he searched the cell. CO J.W. stated that he observed blood on the walls and floor and a spork with a staple at the end wrapped with what appeared to be a torn-up t-shirt located in the middle of the cell floor. A handwritten suicide note was taped to Williams' cell door that read "hahaha STUPiD my plan was TO Die I FUCKING WiN hahahaha ha See you SOON TOXIC VIRUS STATUS (devil picture) DiCK #goT you Too".

67. At 7:45 p.m., Auburn City Ambulance arrived [redacted]

68. [redacted]

69. During an interview with Commission staff, Corporal D.M. stated that there were two other II's housed in the same housing unit as Williams at the time of the terminal event. In the facility's interview of these two II's, neither indicated that Williams had said anything about self-harm. During an interview with Commission staff, II [redacted] stated that Williams asked him a few days prior to the incident if he had a razor blade and Williams indicated that he was going to harm himself. II [redacted] stated that he attempted to talk Williams out of this idea as he had his kids to live for. II [redacted] stated that Williams believed that there was someone out to kill him and that this was the only option. II [redacted] did not inform anyone of Williams' intentions.

70. [redacted]

ACTIONS REQUIRED**:**

TO THE DIRECTOR OF CAYUGA COUNTY MENTAL HEALTH AND THE CAYUGA COUNTY JAIL PHYSICIAN:

1. The Director shall conduct a comprehensive quality assurance review of the mental health and psychiatric care provided to Williams to include:

    a. Why Williams was not properly assessed for psychiatric treatment after multiple requests for medications.
    b. Why Williams was not properly assessed for psychiatric treatment after being placed on a constant watch.
    c. Why Williams' previous medical records from Cayuga County Community Mental Health were not utilized for a continuation of care.
    d. Why Williams' medical records from New York State Office of Mental Health were not requested to be utilized for continuation of care.
    e. Why there was no clinical diagnosis or documented mental status exam for Williams despite multiple encounters with the clinician.

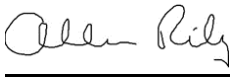
2. The Director and Jail Physician shall conduct a review and revision of the referral process for a psychiatric care at the Cayuga CJ to assure that individuals with known psychiatric histories and who have mental illness complaints are appropriately triaged for a psychiatric provider's review with supporting documentation included in the patient's record. Policies and procedures based on said review shall also be developed and implemented to assure proper provision and continuity of care.

A report of the findings and any corrective actions taken shall be provided to Commission upon completion.

In a response dated 9/13/2023 to the Commission's preliminary report, the Cayuga County Sheriff, Jail Administration, Jail Physician, and Director of Community Services provided a

comprehensive review and corrective action plan regarding mental health services at the Cayuga CJ. The county has submitted plans for the following: establishing a rotation of three psychiatric nurse practitioners to provide psychiatric serves, replacing the existing social worker with a new fulltime and part time social worker along with an assigned social worker supervisor, providing a mental health support staff to process referrals, schedule appointments and coordinate follow-ups, establishing weekly meetings with jail administration for transitioning new mental health staff, implementing a new mental health referral process, and the development of an electronic medical record for both mental health and medical staff. The Commission will continue to monitor the implementation of the service delivery improvements at subsequent health services evaluations and site visits.

WITNESS, HONORABLE ALLEN RILEY, Chairman, 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, 2023.



Allen Riley
Chairman
Commission of Correction

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