Commission of Correction

Final Report of the New York State Commission of Correction:

In the Matter of the Death of

Jeremy Joseph (DIN 19A2119), an incarcerated individual of the Coxsackie Correctional Facility

December 20, 2023

To: Honorable Daniel F. Martuscello, III
Commissioner
NYS Department of Corrections
And Community Supervision
The Harriman State Campus
1220 Washington Avenue
Albany, New York 12226

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 Jeremy Joseph who died on April 7, 2021, while an incarcerated individual in the custody of the NYS Department of Corrections and Community Supervision at the Coxsackie Correctional Facility, the Commission has determined that the following final report be issued.

FINDINGS:

1. Jeremy Joseph was a 40-year-old male who died on 4/7/21 due to a suicidal hanging while in the custody of the New York State Department of Corrections and Community Supervision (NYS DOCCS) at the Coxsackie Correctional Facility (CF). The Medical Review Board has found that there were quality care issues with Joseph's mental health care during his incarceration including missed appointments, continuity of diagnosis and treatment and failures to properly notify providers of medication refusals. It was also reported that Joseph owed a significant amount of debt to other incarcerated individuals however, it is unknown how much this influenced the terminal event.

2. In the instant offense, in Washington County in December 2018, Joseph unlawfully entered four dwellings and stole property including currency, jewelry, a pistol safe, two handguns and a Springfield armory XD9. Joseph was convicted of Burglary in the 2nd and 3rd Degrees and sentenced to seven years and eight months to nine years in state prison.

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4. On 6/6/19, Joseph was received at the Downstate CF.

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7. The delay in proper psychiatric follow up was identified by OMH during their mortality review and was addressed with a review by the Unit Chief at Clinton CF.

8. From 7/19/19 until 8/5/19, Joseph was transferred from Clinton CF to Coxsackie CF for a court appearance .

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A review of the mental health record revealed that the completion of the core history was later than the 45 days required per CBO policy. This issue was identified addressed by OMH during their incident review.

13. From 9/12/19 until 9/24/19, Joseph was transferred from Clinton CF to Coxsackie CF for a court appearance.

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20. . These issues were identified and addressed by OMH during their incident review.

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.This issue was identified by OMH in their incident review and was addressed by the Unit Chief.

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27. The Medical Review Board has found, as was also identified by the OMH CBO incident review, that there was pattern of both missed primary clinician sessions and missed scheduled psychiatric provider appointments for Joseph.

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30. On 11/9/20, a DOCCS transfer was submitted for Joseph to be separated from inmates and on 11/16/20, Joseph was placed in Involuntary Protective Custody (IPC). There was no further information available regarding this placement.

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33. The Medical Review Board finds that there was failure to properly maintain continuity of Joseph's psychiatric diagnosis and prescribed medication regimen.

34. On 12/8/20, Joseph was transferred to Coxsackie CF.

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42. As per NYS DOCCS Health Service Policy 1.16 Administering Medications II.H. if an inmate refuses the prescribed medication for three consecutive days, as documented on the MAR, the prescriber will be notified and the inmate will be scheduled for the next provider call out. Form 3195 "refusal of Medical Examination and/or Treatment" will be signed at that mandatory encounter.

During an interview with Commission staff, Dr. stated that he recalled at that time,

the social worker or unit chief would have been notified of refusals and not the provider as the providers were not at the facility.

43. . The Medical Review Board finds that there was a failure of medical staff to notify the mental health staff that Joseph had been refusing his medications. This issue was identified and addressed with the Unit Chief and the Deputy of Health Services on 8/12/21 to ensure that refusals are documented by nursing and submitted to mental health.

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45. During that time, there were three instances where the medication was refused for three consecutive days, however there was no referral made to mental health. This was a violation of NYS DOCCS Health Service Policy 1.16 Administering Medications.

46. On 4/7/21, Joseph made a final call to his mother. Joseph again asked his mother for money and issued an ultimatum stating that he would inflict violence on himself if he could not get financial help from her.

47. On 4/7/21 at 9:40 pm., CO M.R. was performing a supervisory tour on B2 block. On arrival to cell 8, CO M.R. did not see Joseph in the cell. CO M.R. retrieved the cell key and with CO V., they entered the cell and observed a rope hanging from the back cell window. The cell lights were turned on and Joseph was found lying on his stomach with a rope tied to bottom window latch of the cell window and the other end around Joseph's neck. Joseph was under the bunk with clothing over his head. A medical response was called and cardiopulmonary resuscitation (CPR) was initiated. Emergency Medical Services (EMS) was activated and the Automated External Defibrillator (AED) was applied at 9:42 p.m. RN [redacted] arrived [redacted] At approximately 10:03 p.m., Coxsackie EMS arrived on the unit [redacted]

48. There were notes located in Joseph's cell. One was a paper with four names and one cell number and dollar amounts that totaled $1,050. There was a handwritten note from Joseph that stated please give to a sergeant asap with no date on the note. Joseph was requesting protective custody. Joseph stated that he had not been coming out of his cell to go to chow as he feared being jumped. Joseph stated that he had "mean enmissy here." Joseph stated that had not been eating or taking his morning medications because of this. Joseph stated that he feared that he might hurt someone or himself if he did not get in protective custody. Another paper stated, "you need to communicate with the people you owe." There was a note written by Joseph to his family apologizing for his actions.

49. [redacted]. This was a violation of NYS DOCCS Health Service Policy 1.16 Administering Medications. [redacted] Dr. [redacted] stated that he would request medication lists and notes prior to the video conference and there was usually a therapist present that could get the records if needed.

ACTIONS REQUIRED:

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

The Medical Review Board requests that in addition to the completed incident review the following actions required:

1. That the Forensic Services Division shall conduct a quality assurance review with clinical staff at Clinton CF to assure the information in the Termination Transfer Progress note is accurate with correct diagnosis and medications.

2. That the Forensic Services Division shall conduct a quality assurance review with the clinical staff at Coxsackie CF to determine when Joseph's diagnosis was changed and by who.

3. That the Forensic Services Division conduct a review of the documented missed clinical and psychiatric appointments to identify causes and assure adequate levels of staffing and services are available to meet patient's needs.

A report of the findings any corrective actions taken shall be forwarded to the Board upon completion.

In a response dated 11/17/23 to the Commission's preliminary report, OMH indicated that the cited findings were reviewed and addressed with corrective actions as part of OMH's Special Investigation Report.

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

The Deputy Commissioner shall conduct a review regarding compliance with NYS DOCCS Health Service Policy 1.16 Administering Medications and the documented instances of Josephs medication refusals not being timely referred to the provider.

A report of the findings any corrective actions taken shall be forwarded to the Board upon completion.

In a response dated 10/17/23 the DOCCS Deputy Commissioner indicated that the requested review was completed.

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 20h day of December, 2023.

Allen Riley
Chairman
Commission of Correction

AR:DC:vc
2021-M-0049
December 20, 2023

cc: Dr. Carol Moores, Chief Medical Officer
James Donahue, Associate Commissioner of Mental Health
Superintendent Raymond Shanley, Coxsackie 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, Advocacy Letter Coordinator, CNYPC