NEW YORK STATE | Commission of Correction

Final Report of the New York State Commission of Correction:

In the Matter of the Death of

Patrick Miller, an incarcerated individual of the Onondaga County Justice Center

June 25, 2024

To: Sheriff Tobias Shelley
Onondaga County Sheriff's Office
407 S. State Street
Syracuse, New York 13202

Allen Riley
Chairman

Yolanda Canty
Commissioner

Elizabeth Gaynes
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 Patrick Miller, who died on April 5, 2023 , as a result of circumstances which occurred while an incarcerated individual in the custody of the Onondaga County Sheriff at the Onondaga County Justice Center, the Commission has determined that the following final report be issued.

FINDINGS:

1. Patrick Miller was a 43-year-old male who die on 4/5/23 due to intoxication from effects of N,N dimethylpentylone and fentanyl while in the custody of the Onondaga County Sheriff at the Onondaga County Justice Center (JC).

2. Miller was born in Syracuse, NY. Miller was survived by his daughter and two siblings. Miller reported having a 10th grade education and was unemployed. There was no further demographic or social history available to the Commission for Miller.

3. [redacted].

4. [redacted].

5. [redacted]

6. On 4/3/23 at 2:00 a.m., Miller was arrested by the Syracuse City Police Department on a bench warrant for previous charges of Criminal Possession of a Controlled Substance 7th Degree and Petit Larceny. Miller was transported to Upstate University Health System by the arresting officers after he was found unresponsive in the back of the officer's patrol car. [redacted] Miller [redacted] transported to the Onondaga JC.

7. On 4/3/23 at 2:52 a.m., Miller was admitted to the Onondaga County JC by Deputy F.M. for the previous charges of Criminal Possession of a Controlled Substance 7th Degree and Petit Larceny. Deputy C.D. performed a pat search on Miller with no contraband found. Miller scored a “3” on the Suicide Prevention Screening Guidelines for answering “yes” to having a history of drug or alcohol abuse, having a history of counseling or mental health evaluation/treatment, and for detainee apparently being under the influence of drugs.

8. [redacted]

9. On 4/3/23 at 5:16 a.m., Deputy J.E. documented in the POD 2A logbook that Miller was received from booking. Miller was assigned to cell # 10. Deputy J.E. documented in the POD 2A logbook that Frequent Checks (FC-every 15 minutes) were cells # 5 through # 11.

10. On 4/3/23 at 9:30 a.m., Miller was scheduled for a virtual arraignment. Miller refused to go to the arraignment.

11. On 4/3/23 at 9:38 a.m., Deputy J.R. documented in the POD 2A logbook that Miller was informed multiple times about his arraignment and Miller refused to wake up and participate in court. Miller reported multiple times, “I’m not going”.

12. [redacted]

13. [redacted]

14. [redacted]

[redacted]

15. [redacted]

16. [redacted]

17. [redacted]

18. [redacted]

19. On 4/4/23 at 9:30 a.m., Miller had a forced order to appear in court for his arraignment. When the Deputy opened Miller's cell door, Miller refused to go to court.

20. [redacted]

21. On 4/4/23 at 5:00 p.m., Miller was scheduled in court for his arraignment. Miller refused to go to the arraignment.

22. On 4/4/23 at 5:09 p.m., Deputy J.J. documented in the POD 2A logbook that Miller received a visit from his lawyer.

23. [redacted]

24. On 4/4/23 at 11:10 p.m., Deputy M.V. documented in the POD 2A logbook relieving Deputy J.J. of POD 2A and accepting 32 Incarcerated Individuals (II) with active supervision in effect.

25. On 4/4/23 at 11:15 p.m., Deputy M.V. documented in the POD 2A logbook that a full count of the unit was completed with a flashlight.

26. On 4/4/23 at 11:34 p.m., Deputy M.V. documented in the POD 2A logbook that a tour of the entire unit was completed with a flashlight.

27. On 4/4/23 at 11:45 p.m., Deputy M.V. documented in the POD 2A logbook that a full count of the unit was completed with a flashlight.

28. On 4/5/23 at 12:00 a.m., Deputy M.V. documented in the POD 2A logbook that a tour of the entire unit was completed with a flashlight.

29. On 4/5/23 at 12:15 a.m., Deputy M.V. documented in the POD 2A logbook that a full count of the unit was completed with a flashlight.

30. On 4/5/23 at 12:33 a.m., Deputy M.V. documented in the POD 2A logbook that a tour of the entire unit was completed with a flashlight. Per a review of the video recording of Pod 2A by Commission staff, Deputy E.S. (Confirmed by Administrative staff) was the deputy that completed the 15-minute tour of Pod 2A during that time. Per a review of the video recording of Pod 2A by Commission staff, Deputy E.S. was observed briskly walking past cell # 10 as he quickly shined the flashlight in the cell and continued to walk briskly past cell # 10. Although a supervisory visit was completed, the Commission has found that the performance of the observation did not meet the requirements of 9 NYCRR §7003.3 (c) which states:
At a minimum, general supervision shall be maintained in all facility housing areas when all prisoners are secured in their individual housing units.
and is further defined in 9 NYCRR §7003.2(a)(1) which states:
Supervisory visit shall mean: a personal visual observation of each individual prisoner by facility staff responsible for the care and custody of such prisoner to monitor their presence and proper conduct.
After a review of the Pod 2A logbook by Commission staff, Deputy E.S. did not documented completing the tour. This is a violation of 9 NYCRR §7003.3(j)(2) which states:
All written records pertaining to facility housing supervision required pursuant to this section shall be recorded in ink in a bound ledger of consecutively numbered pages which shall be maintained in each housing area. Such records shall include, but not be limited to the following information: the name (s) of facility staff conducting the supervision.

31. On 4/5/23 at 12:36 a.m., Deputy M.V. documented in the POD 2A logbook that Lieutenant (Lt.) C. was on the unit for a visit.

32. On 4/5/23 at 12:49 a.m., Deputy M.V. documented in the POD 2A logbook that Lt. C. exited POD 2A.

33. On 4/5/23 at 12:49 a.m., Deputy M.V. documented in the POD 2A logbook that a full count of the unit was completed with a flashlight used for observation. Per a review of the video recording of Pod 2A by Commission staff, Deputy M.V. was observed at the bottom of the Pod 2A staircase shining a flashlight towards cell # 10 that housed Miller, that was approximately 12 feet away from Miller's cell door. The Commission finds that proper observation of an incarcerated individual in a cell cannot be completed at that distance and is a violation of 9 NYCRR §7003.3 (c).

34. Deputy M.V. stated in a Voluntary Affidavit from the Onondaga County Sheriff's Office, "I was doing frequent checks on cell # 10 because he was determined to be in need of frequent checks by medical. This means I check cell # 10 every fifteen minutes by shining my light in and laying eyes on the inmate. Miller was lying on his right side with his right arm under his chin in a fist and appeared to be sleeping when I checked on him each time".

35. On 4/5/23 at 12:51 a.m., Deputy M.V. documented in the POD 2A logbook that RN S.S. was on the unit for detox.

36. On 4/5/23 at approximately 1:00 a.m., Deputy M.V. and RN [redacted] approached cell # 10 that housed Miller. Deputy M.V. knocked on Miller's cell door and asked him if he wanted detox. Miller did not respond and Deputy M.V. and RN [redacted]. entered Miller's cell. [redacted] Deputy M.V. stated in a Voluntary Affidavit from the Onondaga County Sheriff's Office, "Nurse [redacted] felt for a pulse and asked me to call a medical emergency with an ambulance. Nurse [redacted]. immediately started CPR while Miller was still on the bunk. Staff arrived when I called a medical emergency and Sergeant D. arrived and placed the Automated External Defibrillator (AED) on Miller along with administering rescue breaths with an air bag. Shortly after, Deputy F. and Deputy D. relieved Nurse [redacted] of CPR duties. They relocated Miller to the floor and continued CPR.

37. [redacted]

[redacted]

38. [redacted]

ACTIONS REQUIRED:

TO THE ONONDAGA COUNTY SHERIFF OFFICE:

The Sheriff shall conduct an inquiry into the conduct of the deputies who were responsible for Miller's supervision in view of the fact that supervisory tours prior to Miller's discovery were not conducted per minimum standard requirements. Administrative action should be taken if found to be in violation of facility policy and procedures.

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

In a response dated 6/24/24 to the Commission's preliminary report, Onondaga County Sheriff Office indicated that an internal investigation regarding the findings has been initiated.

WITNESS, HONORABLE YOLANDA CANTY, 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 25th day of June 2024.

Yolanda Canty
Commissioner
Commission of Correction

YC:BB:vc
2023-M-0037
June 25, 2024