NEW YORK STATE | Commission of Correction

Final Report of the New York State Commission of Correction:

In the Matter of the Death of

Michael Wisdom (18A0166) an incarcerated individual of the Downstate Correctional Facility

June 25, 2024

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

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 Michael Wisdom, who died on October 17, 2021, while an incarcerated individual in the custody of the NYS Department of Corrections and Community Supervision at the Downstate Correctional Facility, the Commission has determined that the following final report be issued.

FINDINGS:

1. Michael Wisdom was a 45-year-old male who died on 10/17/21 due to a suicidal hanging while in the custody of the New York State Department of Corrections and Community Supervision (NYS DOCCS) at Downstate Correctional Facility[1] (CF).

2. [redacted] In the instant offense, between August and December of 2012, Wisdom picked up a package from the United Parcel Service that contained more than one kilo of cocaine. Wisdom also provided an address to a co-defendant for cocaine to be mailed to. During this timeframe, Wisdom possessed cocaine in excess of eight ounces which he conspired to sell in concert with several co-defendants. In June 2017, Wisdom was convicted of Conspiracy 2nd Degree and Criminal Possession Controlled Substance 1st and 3rd Degrees and was sentenced to 10 to 15 years in NYS DOCCS.

3. [redacted]

4. On 1/11/18, Wisdom was received at Downstate CF. In March 2018, Wisdom transferred to Clinton CF.

5. [redacted].

6. On 1/21/21, Wisdom transferred to Green Haven CF. [redacted]

7. [redacted]

8. [redacted]

9. [redacted]

10. [redacted].

11. [redacted].

12. [redacted]

13. [redacted]

14. [redacted]

15. On 4/23/21, Wisdom was admitted to the Special Housing Unit (SHU). Wisdom had received a Tier III infraction for Interference, Direct Order, and Movement Violation for refusing to leave the RCTP. [redacted]

16. [redacted]

17. [redacted]. There was no indication in the records provided to the Commission that the medical provider was notified of the medication refusals. This is a violation of NYS DOCCS Health Services Policy Manual Administering Medications 1.16.II.H. *If an inmate refuses the prescribed medication for three consecutive days, as documented on the Medication Administration Record (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.*

18. [redacted]

19. [redacted]

20. [redacted]

21. [redacted] There was no indication in the records provided to the Commission that any medical provider was notified of the medication

refusals. This is a violation of NYS DOCCS Health Services Policy Manual Administering Medications 1.16.II.H.

22. [redacted]

23. [redacted]. This issue was identified and addressed in the Office of Mental Health Special Investigation by a review of Policy #1.3 Mental Health Referrals with the appropriate staff.

24. [redacted] There was no indication in the records provided that any medical provider was notified of the medication refusals. This is a violation of NYS DOCCS Health Services Policy Manual Administering Medications 1.16.II.H.

25. On 7/23/21, Wisdom transferred to Coxsackie CF. Wisdom stated that he had lost 36 pounds in five months which Wisdom stated was unintentional weight loss. There was no weight documented on the transfer. There was also no documentation of the medications that Wisdom was prescribed. The forms completed on indraft indicated that Wisdom's medical medications were self-carry and that a list was attached, however, the Medical Review Board notes that this was inconsistent with nurse administered medication order placed on 4/9/21. There were no vital signs documented on the assessment. This is a violation of NYS DOCCS Health Services Policy Manual Health Appraisal I.B.1.a. *The Registered Nurse will: Complete Form 3297 "Incoming Draft Medical Screening*. [redacted]. The suicide prevention screening guidelines-SHU/KEEPLOCK (KL) Admission form was completed by security staff and Wisdom reported a history of wanting to hurt himself and an immediate phone referral was made to Mental Health Registered Nurse (RN) [redacted] Wisdom was serving SHU sanctions until 8/6/21.

26. [redacted]

27. [redacted].

28. [redacted]

29. [redacted]

30. [redacted]

31. [redacted]

32. [redacted] Sgt. H. was aware of the request for protective custody.

33. [redacted] During this appointment, security staff interviewed Wisdom for protective custody.

34. [redacted]

[redacted]. This issue was identified in the OMH incident review and the Coxsackie CF Unit Chief conducted a clinical review with the involved staff.

35. [redacted]

36. [redacted]

37. [redacted].

38. [redacted]

39. [redacted]

[redacted]

40. [redacted]

41. [redacted]

42. [redacted]

43. On 9/29/21 at 9:00 p.m., Wisdom arrived at the Sullivan CF [redacted]

44. [redacted]

45. [redacted]

46. [redacted]

47. [redacted].

48. [redacted]

49. [redacted]

50. [redacted]

51. [redacted]

52. [redacted]. The Medical Review Board opines that Wisdom received an inadequate and inaccurate psychiatric diagnosis. The Board opines that Wisdom, had presented for months with symptoms of depression, anxiety and psychosis that were unrecognized or dismissed by the psychiatric providers and inadequately managed.

53. [redacted]

[redacted]

54. On 10/12/21, Wisdom was transferred to Downstate CF reception from Sullivan CF intransit to Coxsackie CF. [redacted]

55. On 10/15/21, Sgt. D.B. completed an immediate mental health referral that noted that Wisdom believed that he was being released to his family and refused to go to draft or to eat. Wisdom's speech was rambling and very low. The referral was an immediate referral but was not received by mental health until 11/9/21. This issue was identified in the Office of Mental Health Special Investigation and was addressed through DOCCS administration. It was determined that the DOCCS staff that completed the referral form placed it in a mailbox which delayed the receipt of the referral and that was not the protocol for immediate referrals. DOCCCS administration noted that they would address the issue with the appropriate DOCCS staff member.

56. On 10/17/21 at approximately 6:00 a.m., Corrections Officer (CO) J.C. was conducting rounds and found Wisdom hanging from his cell window with a state sheet tied around his neck. A medical response was activated. CO N.B. arrived and assisted in cutting Wisdom down. At 6:05 a.m., the automated external defibrillator (AED) was applied with no shock advised and cardiopulmonary resuscitation (CPR) was initiated. Emergency medical services was activated and at approximately 6:15 a.m., RN [redacted] arrived [redacted]

57. A note was found in Wisdom's cell that read "they put my family in a room to be killed they won't let us live!!! Someone help!!". There were three other letters to his family in his cell.

ACTIONS REQUIRED:

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

The Acting Commissioner shall direct a review of the requests for Protective Custody completed for Wisdom to assure that the requests were investigated and addressed per policy.

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

1. The Deputy Commissioner shall convene a quality assurance review with Green Haven CF medical staff regarding compliance with NYS DOCCS Health Services Policy 1.16.

2. The Deputy Commissioner shall convene a quality assurance review with Coxsackie CF medical staff regarding compliance with NYS DOCCS Health Services Policy 1.19 Health Appraisals.

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

In a response dated 5/1/2024 to the Commission's preliminary report, NYS DOCCS indicated that the requested reviews were completed with corrective action(s) taken.

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

1. The Forensic Services Division shall conduct a quality assurance review with the attending psychiatric providers for Wisdom with a focus on his diagnoses and treatment plan given his presentation of symptoms.

2. The Forensic Services Division shall conduct a quality assurance review with Green Haven CF to determine who removed Wisdom from services on 2/9/21 and what documentation was completed.

3. The Forensic Services Division shall conduct a quality assurance review with Green Haven CF staff to determine if a referral was received on 1/21/21 and if Wisdom was seen.

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

In a response dated 5/6/2024, the Division of Forensic Services indicated that the requested reviews were completed with corrective action(s) taken. Regarding a mental health referral from 1/21/21 it was unable to be established if the referral was ever received.

[1] Downstate CF closed as of March 10, 2022

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:DC:vc
2021-M-0140
June 25, 2024

cc: Dr. Carol Moores, Chief Medical Officer
James Donahue, Associate Commissioner of Mental Health
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