NEW YORK STATE | Commission of Correction

Final Report of the New York State Commission of Correction:

In the Matter of the Death of

David LaBarr, an incarcerated individual of the Ontario County Jail

September 25, 2024

To: Sheriff David J. Cirencione
Ontario County Sheriff's Office
74 Ontario Street
Canandaigua, New York 14424

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 David LaBarr, who died on March 6, 2023 , as a result of circumstances which occurred while an incarcerated individual in the custody of the Ontario County Sheriff at the Ontario County Jail, the Commission has determined that the following final report be issued.

FINDINGS:

1. David LaBarr was a 66-year-old male who died on 3/6/23 from a suicidal hanging while in the custody of the Ontario County Sheriff at the Ontario County Jail (CJ). LaBarr had used pairs of ear bud cords affixed to a grab bar to asphyxiate himself. The Medical Review Board has found that although LaBarr was adequately followed by mental health services, there was a failure to properly conduct housing area supervision tours by officers as required by Minimum Standards given that LaBarr was discovered hours after he had hung himself in his cell.

2. [redacted] On 12/3/22, in the instant offense, LaBarr was arrested and charged with Assault 1st Degree; Intent to Cause Serious Injury with a Weapon, a class B Felony. LaBarr was unsentenced which resulted in this charge being abated by his death.

3. [redacted]

4. On 12/3/22 at 2:20 a.m., LaBarr was booked into the Ontario CJ after being arrested by the Canandaigua Police Department for Assault 1st Degree: Intent to Cause Serious Injury with Weapon. [redacted]

[redacted].

5. [redacted].

6. [redacted]

7. [redacted]

8. [redacted]

9. [redacted].

10. [redacted]

11. [redacted]

[redacted]

12. [redacted].

13. [redacted].

14. [redacted]

15. [redacted]

16. [redacted]ing

[redacted]

17. [redacted]

18. [redacted]

19. [redacted]

20. [redacted]. During an interview with Commission staff, CO T.C. stated that it seemed to benefit LaBarr to vent and on this particular day, LaBarr would not contract for safety, so CO T.C. contacted LCSW [redacted]. CO T.T. stated that he maintained constant observation of LaBarr until LCSW [redacted]. arrived. [redacted]

[redacted]

21. [redacted].

22. [redacted]

23. [redacted]

24. [redacted]

During an interview with Commission Staff, CO P.R. stated that LaBarr was upset about a power of attorney form. CO P.R. reported that he informed his supervisor and mental health. [redacted].

25. [redacted]

26. [redacted]

27. [redacted].

28. [redacted].

29. [redacted].

30. A review of the housing unit logbooks from 3/4/23 at 12:15 a.m. through 3/6/23 at 5:31 a.m., included documentation of LaBarr completing mundane daily incarcerated individual tasks.

31. On 3/5/23, CO M.C. was noted in the logbook as assuming control of the housing area at 3:38 p.m. At 11:13 p.m., CO M.C. made a final logbook entry. From 10:19 p.m. through 10:53 p.m., per the logbook entries, CO C.S. relieved CO M.C. and assumed control over the housing unit.

32. On 3/5/23 at 11:18 p.m., CO D.O. assumed control over the housing unit. At 11:44 p.m., CO D.O. documented a headcount of 24 individuals with his first documented housing area supervisory tour. During an interview with Commission staff, CO D.O. stated that he could not recall the exact time that he had last seen LaBarr awake but for two or three supervisory watch tours after the 11:00 p.m. standing head count, LaBarr was observed awake on his bunk. This was not atypical as LaBarr never went right to bed. CO D.O. stated that LaBarr requested a razor during the standing head count for the morning, but nothing seemed off with him. CO D.O. stated that he did not recall seeing any ear buds in LaBarr's cell at head count. CO D.O. documented beginning housing area watch tours at 12:14 a.m., 12:45 a.m., 1:20 a.m. and 1:46 a.m. with all of the incarcerated individuals being documented as asleep. At 2:19 a.m. and 2:46 a.m., CO M.C. documented a housing area supervisory tour. At. 2:59 a.m., Sergeant S.L. documented completing a supervisory tour. During an interview with Commission staff, CO D.O. stated that he could not recall anything out of the ordinary that was discussed with Sergeant S.L. after he completed a full housing area watch tour. CO D.O. continued documenting supervisory watch tours that started at 3:15 a.m., 3:54 a.m., 4:27 a.m., 4:56 a.m. and 5:31 a.m.

33. As documented in his post tour statement, after the completion of the 5:31 a.m. supervisory watch tour, CO D.O. brought the breakfast food cart into the housing area. After the incarcerated individuals were let out of their cells to get breakfast, CO D.O. noticed that LaBarr had not come out as he usually had. During an interview with Commission staff, CO D.O. stated that he could recall that everyday LaBarr would come out last for breakfast. CO D.O. knocked on LaBarr's cell door without a response. LaBarr's door was keyed open and CO D.O. entered LaBarr's cell and asked if he wanted breakfast. At this time, CO D.O. discovered that LaBarr was not on his bunk but had placed sheets, blankets, and his shoes under a blanket on the bunk to make it look

like he was. LaBarr had also utilized his wheelchair, which was kept in his cell, to block the view of the officers conducting supervisory tours from outside his cell door. During an interview with Commission staff, CO D.O. stated that the placement of LaBarr's wheelchair was no different than any other night. CO D.O. indicated that he turned to his left and observed LaBarr in a lying position face down with multiple headphone cords tied around his neck that were also tied to the towel bar of his cell sink. During an interview with Commission staff, CO D.O. stated that LaBarr was behind the cell sink and the wheelchair with his feet tight to the cell wall and his chest on the floor with just his head being supported by the earbud cords. CO D.O. snapped the cords apart and laid LaBarr onto the cell floor. CO D.O. called a medical emergency via the facility radio. CO D.O. observed LaBarr to be purple in color with no pulse, cold to the touch and bloated. CO D.O. observed blood on the floor below LaBarr's face. At 5:35 a.m., security staff including Sergeant T.K. responded and Emergency Medical Services (EMS) was activated. Facility medical staff did not respond as they were not in the facility at that time. CO.D.O. discovered an envelope on LaBarr's desk with "Do not open until after my death" written on it.

34. At 6:00 a.m., Canandaigua Emergency Squad arrived [redacted]

35. [redacted]

36. Upon further review of the terminal event, seven of CO D.O.'s 11 supervisory watch tours exceeded the required 30-minute interval. During an interview with Commission staff, CO D.O. stated that he did not have a reason for the late watch tours. CO D.O. stated that he now uses timers on the facility computers to assure timely watch tours. For this violation, CO D.O. received an employee counseling by the facility. The Medical Review Board finds that there was a failure to complete supervisory watch tours in comportment with the requirements of 9 NYCRR §7003.2(a) Supervisory visit and 9 NYCRR §7003.2(b) General supervision, which state:

7003.2(a) Supervisory visit shall mean: (1) a personal visual observation of each individual prisoner by facility staff responsible for the care and custody of such prisoners to monitor their presence and proper conduct; and (2) a personal visual inspection of each occupied individual prisoner housing unit and the area immediately surrounding such housing unit by facility staff responsible for the care and custody of prisoners to ensure safety, security, and good working order of the facility.

7003.2(b) General supervision shall mean the availability to prisoners of the facility staff responsible for the care and custody of such prisoners which shall include supervisory visits conducted at 30-minute intervals.

37. CO D.O. also violated Ontario County Correctional Facility's standing operation procedure directive 4-15 Post Orders Pod 7, Cell Check Intervals: 2. checks not to exceed 30-minute intervals.

38. After this terminal event, Ontario CJ no longer allows incarcerated individuals with wheelchairs to keep the wheelchairs in their cell overnight.

ACTIONS REQUIRED:

TO THE OFFICE OF THE ONTARIO COUNTY SHERIFF:

1. The Sheriff shall take notice of the Medical Review Board's finding of the presence of postmortem changes as observed by the security staff as well as EMS and initiate an investigation into the conduct of the officers who were assigned with the supervision within the housing area. Administrative action should be taken if an individual was found to be in violation of department directives.

2. The Commission acknowledges the administrative action previously taken by the Sheriff's Office in this matter. The Commission requests that a review be conducted regarding other identified staff who failed to comport with the requirements of 9 NYCRR §7003.2(a) Supervisory visit and 9 NYCRR §7003.2(b) General supervision. Administrative action should be taken if an individual was found to be in violation of agency policy and procedures.

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

In a response dated 7/22/24 to the Commission's preliminary report, the Sheriff indicated that the requested reviews were completed.

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 September 2024.

Yolanda Canty
Commissioner
Commission of Correction

YC:MB:vc
2023-M-0025
September 25, 2024