



**Commission of  
Correction**

**Final Report of the  
New York State Commission of Correction:**

**In the Matter of the Death of**

**Giles Gerhart,  
an incarcerated individual of the  
Onondaga County Justice Center**

**March 26, 2025**

**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 Giles Gerhart, who died on September 6, 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. Giles Gerhart was a 39-year-old male who died on 9/6/23 due to an acute drug toxicity while in the custody of the Onondaga County Sheriff at the Onondaga County Justice Center (JC). The Medical Review Board has found there were failures by corrections staff to perform supervision in accordance with Minimum Standard requirements and a neglectful failure by medical staff to perform required assessments. The Medical Review Board opines that had Gerhart been properly assessed by medical and supervised by corrections staff during his incarceration, his death may have been prevented.
2. Gerhart was born in Ithaca, NY. Gerhart received his GED and was unemployed. A review of the records [REDACTED] Gerhart had one brother, 2 sisters, and one child.
3. [REDACTED]
4. [REDACTED]
5. [REDACTED]
6. On 9/4/23 at 3:58 p.m., Gerhart was arrested by the Syracuse Police Department on a bench warrant for previous charges of Criminal Possession of a Controlled Substance 7<sup>th</sup> Degree, Criminal Trespassing 2<sup>nd</sup> Degree, Strangulation 2<sup>nd</sup> Degree, and Assault 3<sup>rd</sup> Degree.
7. On 9/4/23 at 4:31 p.m., Gerhart was admitted to the Onondaga County Justice Center by Deputy J.H. for the charges of Criminal Possession of a Controlled Substance 7<sup>th</sup> Degree, Criminal Trespassing 2<sup>nd</sup> Degree, Strangulation 2<sup>nd</sup> Degree, and Assault 3<sup>rd</sup> Degree. Gerhart scored a "1" on the Suicide Prevention Screening for answering "yes" to [REDACTED] Deputy D.H. completed an emergency medical and mental health referral for Gerhart.

8.

[REDACTED]

During an interview with Commission staff, RN [REDACTED] reported that the general practice for an incarcerated individual (II) that reports having a history of substance use on admission to the facility is to have that II seen by the Medication Assisted Treatment (MAT) provider on the day following the admission, unless the following day is during the weekend.

[REDACTED] there was no documentation available to the Commission to indicate that Gerhart was scheduled to see the MAT provider prior to his death. Although within the requirements of 9 NYCRR §7011.5(a), for having an assessment for a substance use disorder, which states: *Without unnecessary delay, but no later than seventy-two (72) hours following a referral, an incarcerated individual shall receive a medical screening to determine if the individual suffers from a substance use disorder for which medication assisted treatment exists;* the Medical Review Board has found that Gerhart should have been scheduled for a medical screening for MAT services as required by the standard and the facility's procedures.

9.

[REDACTED]

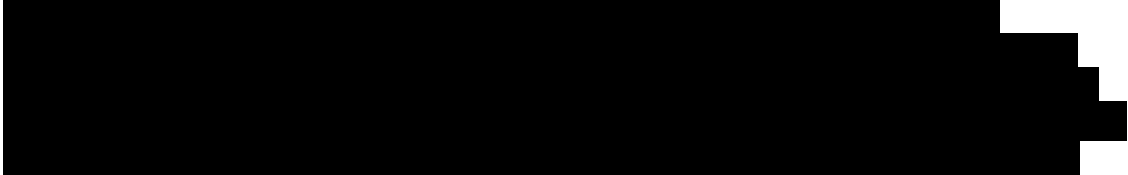
10.

[REDACTED]

11.



12. On 9/4/23 at 6:43 p.m., Deputy T.M. documented in the Pod 2A logbook that Gerhart was received on the unit from booking for general population. Gerhart was assigned to cell # 27.
13. On 9/4/23 at 7:00 p.m., Deputy T.M. documented in the Pod 2A logbook that a tour of the entire unit was completed. A review of the Pod 2A logbook by Commission staff found that Deputy T.M. did not complete another tour of the Pod until 7:54 p.m. A review of the facility's BCIS Datalogger Report for Pod 2A by Commission staff found that there was no documentation on the report that a tour was completed between 6:57 p.m. and 7:50 p.m.
14. On 9/4/23 at 9:31 p.m., Deputy T.M. documented in the Pod 2A logbook that a tour of the entire unit was completed. A review of the facility's BCIS Datalogger Report for Pod 2A by Commission staff found that there was documentation to support that Deputy T.M. completed tours of the unit between 9:31 p.m. through 10:28 p.m., however a review of the Pod 2A logbook by Commission staff found that Deputy T.M. did not document completing another tour of the Pod until 10:28 p.m. This is a violation of 9 NYCRR §7003.3(j)(4) 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: when general supervision is conducted, the date and time each supervisory visit is performed pursuant to the requirements of section 7003.2(b) of this Part and the signature of facility staff conducting the supervisory visit.*
15. On 9/4/23 between the hours of 7:00 p.m. through 11:00 p.m., a review of the Pod 2A logbook by Commission staff found there were no specific logbook entries made for Gerhart.
16. On 9/4/23 at 11:00 p.m., Deputy V.Z. documented in the Pod 2A logbook assuming the duties of the unit with a head count of 45 incarcerated individuals (II).
17. On 9/5/23 at 2:20 a.m., Deputy V.Z. documented in the Pod 2A logbook that a tour of the entire unit was completed. A review of the Pod 2A logbook and video of the housing area by Commission staff found that Deputy V.Z. did not complete another tour of the Pod until 3:02 a.m. As general supervision per 9 NYCRR §7003.2(a)(2) requires that supervisory visits be conducted in 30-minute intervals, the Commission has found that the required round was conducted late.

18. 
19. On 9/5/23 at 3:39 a.m., Deputy V.Z. documented in the Pod 2A logbook that a tour of the entire unit was completed. At 4:07 Deputy V.Z. documented in the logbook that Sgt. M. was on the post for a visit. At 4:22 a.m., Deputy V.Z. documented in the Pod 2A logbook that Deputy M.C. was on the Pod for his 30-minute break. A review of the Pod 2A logbook by Commission staff found that there was not another completed tour of the Pod until 5:02 a.m. A review of the video recording of Pod 2A by Commission staff observed that Deputy M.C. sat down at the Deputy station and appeared to be sleeping until 5:01 a.m. The Commission found that there was no supervisory round completed between 3:39 a.m. and 5:02 a.m. This is a violation 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.*
20. On 9/5/23 at 5:02 a.m., Deputy C. documented in the Pod 2A logbook that a tour of the entire unit was completed with a flashlight.
21. On 9/5/23 at 5:29 a.m., Deputy V.Z. documented in the Pod 2A logbook that a tour of the entire unit was completed. A review of the facility's BCIS Datalogger Report for Pod 2A by Commission staff found that there was documentation to support that Deputy V.Z. did complete tours of the unit between 5:29 a.m. through 7:00 a.m., however a review of the Pod 2A logbook by Commission staff found that Deputy V.Z. did not document completing another tour of the Pod prior to him being relieved of his duty by Deputy M.S. at 7:00 a.m. This is a violation of 9 NYCRR §7003.3(j)(4).
22. On 9/4/23 between the hours of 11:00 p.m. through 9/5/23 at 7:00 a.m., a review of the unit logbook by Commission staff found that there were no specific logbook entries made for Gerhart.
23. On 9/5/23 at 7:00 a.m., Deputy M.S. documented in the Pod 2A logbook assuming the duties of the unit with a head count of 47 incarcerated individuals. A review by Commission staff of the logbook from 9/4/23 at 11:00 p.m. through 9/5/23 at 7:00 a.m. revealed that there were no specific occurrences that required a logbook entry for Gerhart.
24. On 9/5/23 at 7:26 a.m., Deputy M.S. documented in the Pod 2A logbook that a tour of the entire unit was completed. A review of the facility's BCIS Datalogger Report for Pod 2A by Commission staff found that there was documentation to support that Deputy M.S. did complete tours of the unit between 7:26 a.m. through 9:10 a.m., however a review of the Pod 2A logbook by Commission staff found that Deputy M.S. did not document completing another tour of the Pod until 9:10 a.m.
25. On 9/5/23 at 9:30 a.m., Gerhart was scheduled for arraignment in Syracuse City Criminal Court. Per the Onondaga County Sheriff's Office memorandum by Lieutenant (Lt.) A.B., Gerhart refused his court appearance.

26. [REDACTED] During an interview with Commission staff, RN [REDACTED] reported that when performing a COWS assessment, she is able to count the incarcerated individuals respirations even if they refuse the assessment.
27. A review of the unit logbook by Commission staff found that between the hours of 7:00 a.m. through 3:00 p.m. on 9/5/23, there was one entry in the logbook that pertained to Gerhart. The logbook indicated that at 11:02 a.m., LPN [REDACTED] was on the unit for Gerhart's wound care.
28. On 9/5/23 at 3:00 p.m., Deputy T.M. documented in the Pod 2A logbook assuming the duties of the unit with a head count of 41 incarcerated individuals.
29. On 9/5/23 at 4:04 p.m., Deputy T.M. documented in the Pod 2A logbook that a tour of the entire unit was completed. A review of the facility's BCIS Datalogger Report for Pod 2A by Commission staff found that there was documentation to support that Deputy T.M. did complete tours of the unit between 4:04 p.m. through 4:53 p.m., however a review of the Pod 2A logbook by Commission staff found that Deputy T.M. did not document completing another tour of the Pod until 4:53 p.m.
30. On 9/5/23 at 6:02 p.m., Deputy T.M. documented in the Pod 2A logbook that a tour of the entire unit was completed. A review of the Pod 2A logbook and housing area video by Commission staff found that Deputy T.M. did not complete another tour of the Pod until 6:51 p.m. As active supervision per 9 NYCRR §7003.2(c)(2) requires that supervisory visits be conducted in 30-minute intervals, the Commission has found that required supervisor visit was conducted late.
31. On 9/5/2 at 5:50 p.m., Deputy T.M. documented in the Pod 2A logbook that Nurse C. was on the unit for detox.
32. On 9/5/23 a [REDACTED] [REDACTED] [REDACTED]. During an interview with Commission staff, Director of Nursing (DON) RN [REDACTED] reported that during a COWS assessment, the RN might do vital signs, ask the incarcerated individual what kind of detox symptoms they are having, ask them if they are having any thoughts of hurting themselves or anyone else, they are offered Gatorade to hydrate, and the incarcerated individual is asked if they want medication. [REDACTED] [REDACTED] [REDACTED]. A review of the COWS assessment by Commission staff, found that at the bottom of the COWS assessment, there are six "yes or no" questions that the nurse is to ask the incarcerated individual. The questions in summary ask if the incarcerated individual expresses thoughts of self-harm, if they had a negative phone call or visit, if they had a negative court outcome, if they expressed feelings that there was nothing to look forward to, and if they were offered an electrolyte drink. [REDACTED] [REDACTED] [REDACTED]



[REDACTED]

The Medical Review Board opines that the documented findings of post-mortem changes indicates that Gerhart was deceased for four or more hours when he was discovered unresponsive.

<sup>1</sup>Contract health services provider Wellpath discontinued services at the Justice Center on 8/31/24 and was replaced by CFG Inc.

ACTIONS REQUIRED:

TO THE OFFICE OF THE ONONDAGA COUNTY SHERIFF:

1. The Sheriff shall conduct an inquiry into the conduct of the deputies who were responsible for Gerhart's supervision in view of the fact that supervisory tours were not conducted per minimum standard requirements. Administrative action should be taken if found to be in violation of facility policy and procedures.
2. The Sheriff shall conduct an inquiry into the conduct of the deputies who were responsible for the omission of documentation of unit rounds in the unit logbook. Administrative action should be taken if found to be in violation of facility policy and procedures.
3. The Sheriff shall conduct an inquiry into the conduct of the deputies who were responsible for Gerhart's supervision in view of the fact that obvious post-mortem changes indicate that his death occurred at least four hours prior to his discovery. 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 1/7/25 to the Commission's preliminary report, the Onondaga County Sheriff indicated that the requested inquiries were completed with administrative action taken with cited staff.*

TO THE ONONDAGA COUNTY JAIL PHYSICIAN AND THE MEDICAL DIRECTOR FOR WELLPATH:

1. The Medical Director shall conduct a comprehensive quality assurance review regarding why Gerhart was not scheduled to see the MAT nurse prior to his death.
2. The Medical Director shall conduct an investigation into the conduct of RN [REDACTED] who falsified in Gerhart's medical record conducting a withdrawal assessment when video evidence

indicates the nurse never entered Gerhart's cell or interacted with Gerhart. Administrative action should be taken, including referral to the Office of Professional Discipline if found to be in violation of agency policy.

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

*In a response dated 2/3/25 to the Commission's preliminary report, Correct Care Solutions (Wellpath Inc.) indicated that the referenced video does not appear to demonstrate that RN [REDACTED] failed to assess Gerhart at the time recorded in the COWS assessment. Commission staff re-reviewed video evidence submitted of Gerhart's housing area. Between the hours of 4:00 p.m. and 8:00 p.m. on 9/5/23 a nurse is observed entering the unit two times but does not appear to engage in any observable assessment activity of Mr. Gerhart at his cell.*

TO THE DEPARTMENT OF EDUCATION, OFFICE OF PROFESSIONAL DISCIPLINE:

The Medical Review Board requests that an investigation be conducted into the professional misconduct of RN [REDACTED] for falsifying medical documentation indicating that she encountered Gerhart for a COWS assessment on 9/5/23 at 7:04 p.m.

TO THE CHAIR OF THE ONONDAGA COUNTY LEGISLATURE:

As the appointing authority for the delivery of jail incarcerated individual health services pursuant to Correction Law section 501, the County Legislature shall review the above findings and conduct an inquiry into the fitness of the formally designated provider.

WITNESS, HONORABLE YOLANDA CANTY, Commissioner, NYS Commission of Correction, Alfred E. Smith State Office Building, 80 South Swan Street, 12<sup>th</sup> Floor, in the City of Albany, New York 12210 on this 26<sup>th</sup> day of March 2025.



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Yolanda Canty  
Commissioner  
Commission of Correction

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2023-M-0092  
March 26, 2025