



**Commission of  
Correction**

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

**In the Matter of the Death of**

**Nickalas Connor,  
an incarcerated individual of the  
Washington County Jail**

**September 24, 2025**

**To: Sheriff Jeffrey Murphy  
Washington County Sheriff's Office  
399 Broadway  
Fort Edward, New York 12828**

**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 Nickalas Connor, who died on March 21, 2024 , as a result of circumstances which occurred while an incarcerated individual in the custody of the Washington County Sheriff at the Washington County Jail, the Commission has determined that the following final report be issued.

FINDINGS:

1. Nickalas Connor was a 33-year-old male who died on 3/21/24 due to a suicidal hanging while in the custody of Washington County Sheriff at the Washington County Jail. The Medical Review Board has found that there were deficiencies and a lack of a comprehensive management plan in the mental health care provided to Connor prior to his terminal event.
  
2. [REDACTED]  
[REDACTED] In October 2023, Connor was arrested and charged with Predatory Sexual Assault Against a Child: Specified Offense Against a Child less than age 13, Rape 1<sup>st</sup> Degree: Actor is 18 years or more/Victim is under 13 years of age, Criminal Sexual Act 1<sup>st</sup> Degree: Actor is 18 years or more/Victim is under 13 years of age, Course of Sexual Conduct against a Child 1<sup>st</sup> Degree: Actor is 18 years or more/Victim is under 13 years of age and Aggravated Cruelty to Animals. These charges were all abated by his death.
  
3. [REDACTED]  
[REDACTED]
  
4. [REDACTED]  
[REDACTED]  
[REDACTED]
  
5. On 10/12/2023 at 9:12 p.m., Connor was received at the Washington County Jail. Correction Officer (CO) G.M. noted on the initial screening form that Connor was currently taking blood pressure medications, had drank alcohol as recently as the day prior and had been previously incarcerated in Washington County and Warren County Jails. Connor denied having a history of mental illness or a potential for self-harm or suicidal ideation. CO G.M. noted that medical and mental health referrals were made. CO G.M. documented on the suicide prevention screening that Connor had made statements to the transporting officers during the arrest process that indicated a possible suicide risk. During an interview with Commission staff, CO G.M. stated that Connor had made self-harm statements to the transporting officers, however the specifics were not provided to him. CO G.M. documented that Connor’s mother had died within the last six months, Connor had a history of alcohol abuse and expressed hopelessness. CO G.M. noted that Connor stated that he would withdraw from alcohol. CO G.M. documented on the suicide prevention screening that a supervisor was notified, and that constant

supervision was instituted. There was no indication of a referral to medical or mental health on this form. Connor was assigned to cell E-174.

6. [REDACTED]

7. [REDACTED] The Medical Review Board questions what were the security and or classification risks that necessitated the physician to have to conduct the medical assessment cell side and why were these reasons not documented in the medical record. [REDACTED]

8. [REDACTED]

9. [REDACTED]

10. On 10/13/23 at 1:08 p.m., Connor was moved from the E-174 cell to C Pod linear due to being removed from constant supervision.

11. [REDACTED]

12. [REDACTED]

13. [REDACTED]

14. [REDACTED]

15. On 10/15/23 at 10:57 a.m., Connor was moved from Pod C linear to Pod B 1 cell.

16. [REDACTED]

17. [REDACTED]

18. [REDACTED]

19. [REDACTED]

20. [REDACTED]

[REDACTED]

21. [REDACTED]

22. [REDACTED]

23. [REDACTED]

24. On 10/19/23 at 10:22 a.m., Connor was moved from Pod B 1 cell to Pod B 10 cell due to reorganization.

25. [REDACTED]

26. [REDACTED]

27. [REDACTED]

28. [REDACTED]

The Medical Review Board finds that this was a failure to maintain a patient record in violation of 9 NYCRR

§7010.2(j) which states:

*Adequate health service and medical records shall be maintained which shall include but shall not necessarily be limited to such data as: date, name(s) of inmate(s) concerned, diagnosis of complaint, medication and/or treatment prescribed. A record shall also be maintained of medication prescribed by the physician and dispensed to a prisoner by a staff person.*

29. [REDACTED]

30. On 11/25/23 at 11:30 a.m., Connor was escorted to medical after Connor allegedly had hot water thrown on him by another incarcerated individual. [REDACTED]

31. [REDACTED]

32. [REDACTED]

33. [REDACTED]

34. [REDACTED]

35. [REDACTED]

[REDACTED]

36. [REDACTED]

37. [REDACTED]

38. [REDACTED]

39. [REDACTED]

40. [REDACTED]

41. [REDACTED]

42. [REDACTED]

- [REDACTED]
43. [REDACTED]  
[REDACTED]  
[REDACTED] The Medical Review Board notes that there was no documented diagnosis associated with the change in therapy for Connor. Additionally, there was no documented evaluation of Connor's reported psychosis symptoms.
44. [REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]
45. [REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]
46. [REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]
47. [REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]
48. [REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]
49. [REDACTED]  
[REDACTED]  
[REDACTED]

[REDACTED]

50. [REDACTED]

51. [REDACTED]

52. [REDACTED]

53. On 3/16/24, CO J.S. documented in the shift log entry summary that Connor requested to speak to behavioral health. CO J.S. also documented that the unit needed additional behavioral health services request forms. Per a voluntary statement to the Washington County Sheriff's office, CO J.S. stated that he had had several encounters with Connor as he checked in on Connor's physical and mental well-being. CO J.S. further indicated that Connor stated that he was hearing voices and that he was, "going crazy." CO J.S. stated that he understood the importance of documenting this encounter and encouraged Connor to speak with behavioral health. There was no documentation to indicate if any of these observations and information was provided to mental health staff.

54. On 3/18/24 at 10:50 a.m., Connor was moved from Pod B 10 cell to Pod B 18 cell due to reorganization.

55. [REDACTED]

56. On 3/18/24 at 10:36 p.m., CO W.B. documented in the shift log entry summary that Connor was locked in Pod B 18 cell due to Connor allegedly attempting to start a fight with another incarcerated individual.
57. On 3/19/24 at 11:47 a.m., Connor was again locked in his cell. CO A.S. documented in the shift log entry summary that Connor was allegedly attempting to start fights with everyone in Pod B. CO A.S. noted that Connor would be taken from Pod B to booking at the completion of the break CO A.S. was giving CO M.H.
58. On 3/19/24 at 12:05 p.m., Connor was escorted to booking.
59. On 3/19/24 at 12:18 p.m., Connor was assigned to move from Pod B 18 cell back to Pod B 10 cell due to reorganization.
60. On 3/19/24 at 12:22 p.m., Connor was escorted back to Pod B. CO M.H. noted that Connor was not locked in.
61. On 3/20/24 at 11:54 a.m., CO J.S. documented that Connor was housed and secured in B-10 cell at the beginning of his shift. CO J.S. documented that all appeared ok.
62. On 3/21/24 at 6:45 a.m., CO J.S. completed a supervisory tour of B pod and noted that all 13 incarcerated individuals were ok. At 6:57 a.m., CO J.S. documented that a breakfast meal tray was delivered to Connor in cell B-10.
63. On 3/21/24 at 7:15 a.m., while conducting a security round, CO J.S. found Connor unresponsive to verbal commands. CO J.S. called via the radio a "code purple." CO J.S. requested that the cell door to be opened by the control room and entered the cell. In B10 cell, Connor was found with a bed sheet ligature tied around his neck which was attached to the bar of the cell window. CO J.S. attempted to remove the ligature but was unsuccessful due to the tension. CO A.B., CO C.D. CO D.C. and RN [REDACTED] responded with the automated external defibrillator (AED). CO C.D. lifted Connor and CO D.C. cut the ligature from the window bar. Facility staff then laid Connor on the floor of the cell and cut the remaining ligature from Connor's neck. [REDACTED]  
[REDACTED]  
[REDACTED] Fort Edward Rescue Squad EMS arrived and assumed care of Connor [REDACTED]  
[REDACTED]  
[REDACTED]

ACTIONS REQUIRED:

TO THE JAIL PHYSICIAN OF WASHINGTON COUNTY JAIL:

The Jail Physician shall conduct a comprehensive quality assurance review of the care provided to Connor regarding:

1. Why medical records were not maintained in compartment with 9 NYCRR §7010.2(j).
2. Why Connors initial health assessment needed to be completed only cell side.

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

*In a response dated 9/9/25 to the Commission's preliminary report, Hudson Headwaters Health Network (HHHN)<sup>1</sup>, the former designated service provider for the Washington CJ, indicated that the requested reviews were completed. HHHN indicated their review revealed that the medical records were not maintained in accordance with minimum standard requirements. Additionally, HHHN indicated that they did not have a verified reason as to why Connor's health assessment was completed cell side.*

TO THE DIRECTOR OF EDEN CARE BEHAVIORAL HEALTH:

The Medical Review Board shall a quality assurance review of Connor's mental health care be completed with a focus on:

1. Why was there no clearly documented diagnosis of Connor.
2. Why were there incomplete records of remote clinical encounters.
3. Why was there no documented evaluation of suicide risk or review of self-harm statements made prior to removing Connor from constant supervision on 10/13/23.

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

*In a response dated 7/8/25 to the Commission's preliminary report, the Eden Center for Integrative Care<sup>1</sup> indicated that the requested reviews were completed. Eden Center administration indicated that a revision to processes for delivering services was completed including: enhanced documentation standards, comprehensive treatment planning, timely psychiatric referrals and follow-up, medication treatment coordination, and quality assurance review. The implemented revisions will be verified at a later scheduled health services evaluation by the Commission.*

TO THE CHAIR OF THE WASHINGTON 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.

*In a response dated 9/8/25 to the Commission's preliminary report, the Washington County Attorney indicated they conducted the requested review and informed the Commission that the designated provider for health services at the jail has been contracted to the Eden Center for Integrative Care.*

<sup>1</sup>Hudson Headwaters Health Network contract to provide services for the Washington CJ ended as of 12/31/2024.

<sup>2</sup>As of 1/1/25, the Eden Center is now the single designated services provider for the Washington CJ

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 24<sup>th</sup> day of September 2025.



Yolanda Canty  
Commissioner  
Commission of Correction  
YC:AL:vc  
2024-M-0047  
September 24, 2025