



**Commission of
Correction**

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

In the Matter of the Death of

**Matthew Zagorski,
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 Matthew Zagorski, who died on January 20, 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. Matthew Zagorski was a 37-year-old male who died on 1/20/24 due to a suicidal hanging while in the custody of the 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 Zagorski's mental health care prior to his terminal event.
2. [REDACTED] In November 2022, Zagorski was arrested and charged with Burglary 2nd Degree: Illegal Entry of a Dwelling, Grand Larceny 4th Degree: Value of Property Greater than \$1000, Criminal Contempt 1st Degree: Violate an Order of Protection-Physical Contact, Endangering the Welfare of a Child, Criminal Mischief 4th Degree, Harassment 2nd Degree: Physical Contact and was released on bail. In December 2023, Zagorski was arrested and charged with Burglary 2nd Degree: Illegally Entry of a Dwelling, Grand Larceny 3rd Degree: Property Value Exceeds \$3000, Criminal Possession of Stolen Property 4th Degree: Possession of a Credit Card, Grand Larceny 4th Degree: Credit Card, Bail Jumping 2nd Degree, Criminal Contempt 1st Degree: Violate Order of Protection-Physical Contact, Act in a Manner Injurious to a Child less than 17, Criminal Mischief 4th Degree and Forgery 3rd Degree. These charges were all abated by his death.
3. [REDACTED]
4. [REDACTED]
5. On 12/18/23 at 8:39 p.m., Zagorski was received at the Washington County Jail. Corrections Officer (CO) S.D. noted on the Initial Risk Assessment that Zagorski had a history of incarceration in Washington and Saratoga County Jails and had prior charges of burglary with four total arrests. CO S.D. noted that Zagorski's appearance and behavior were normal, that Zagorski did not appear to be under the influence of drugs or alcohol and summarized the Initial Risk Assessment as "INMATE APPEARS OK." No medical or mental health referrals were made.
6. [REDACTED]

[REDACTED]

7.

[REDACTED]

The Medical Review Board questions the efficacy of prescribing a mild anxiolytic for a patient describing psychosis symptoms and why an immediate referral to psychiatry was not made.

8.

[REDACTED]

The Medical Review Board finds that there was no diagnosis documented for Zagorski and no immediate referral to psychiatry despite endorsing obvious psychosis symptoms.

9.

[REDACTED]

The Medical Review Board opines that Zagorski was presenting with active signs of psychosis and should have been scheduled for a psychiatric evaluation as soon as possible and not rescheduled for another week out.

10.

[REDACTED]

11.

[REDACTED]

12.

[REDACTED]

13.

[REDACTED]

[REDACTED]

14.

[REDACTED]

The Medical Review Board finds that there was no clearly documented diagnosis of Zagorski by the provider nor was there a clear mental health management treatment plan. Additionally, the Board opines that there was an unacceptable delay in obtaining a psychiatric assessment of Zagorski who was presenting with signs of active psychosis.

15.

[REDACTED]

16.

[REDACTED]

17.

[REDACTED]

- [REDACTED]
18. [REDACTED] The Medical Review Board opines that abrupt changes to Zagorski's medication should not have occurred without allowing sufficient time to achieve efficacy or attempting to titrate the dosage.
19. [REDACTED]
20. On 1/20/24 at 6:53 a.m., CO J.S. documented in the shift log summary that breakfast meals were distributed to the incarcerated population and that all appeared ok.
21. On 1/20/24 at 11:25 a.m., CO M.F. documented in the shift log summary that lunch meals were distributed, and 13 incarcerated individuals appeared ok.
22. On 1/20/24 at 3:47 p.m., CO M.F. documented in the shift log summary that CO C.F. was briefed, and 13 incarcerated males appeared ok.
23. On 1/20/24 at 3:50 p.m., CO C.F. documented in the shift log summary that she had been briefed from CO M.F. with nothing notable to report from the previous shift. CO C.F. documented in the shift log summary that all 13 incarcerated individuals appeared ok. At 4:14 p.m., CO C.F. completed a supervisory tour of Bravo pod and documented in the shift log summary that all 13 incarcerated individuals appeared ok. At 4:30 p.m., CO C.F. documented in the shift log summary that the lock-in period was over and that 13 incarcerated individuals appeared ok.
24. On 1/20/24 at 4:15 p.m., CO C.F. documented in the shift log summary that the security tour was completed and 13 incarcerated individuals appeared ok.
25. On 1/20/24 at 4:30 p.m., CO C.F. documented in the shift log summary that lock-in had ended and that the recreation yard was inspected and unlocked. CO C.F. documented that 13 incarcerated individuals appeared ok. In a written statement provided to Washington County Sheriff's Office investigators, CO C.F. stated that she believed when she conducted a supervisory tour, cell B-18 cell, occupied by Zagorski, had a sheet that was suspended and covering the doorway. There was no indication as to how long the sheet was up during CO C.F.'s supervisory rounds after assuming the B Pod post. Supervisory visit is defined in 9 NYCRR §7003.2(a)(1)(2) as:

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 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 the safety, security and good order of the facility.

As Zagorski was not seen by CO C.F. due to having a sheet covering his cell door, a personal observation of Zagorski was not completed and thus supervisory visits were not completed in compliance with 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.

During the investigation, the Commission was informed that CO C.F. was no longer employed by the Washington County Jail.

26. On 1/20/24 at 4:38 p.m., CO C.F. heard incarcerated individuals calling out “he’s hung, he’s hanging himself,” and responded to B-18 cell. CO C.F. found two incarcerated individuals holding Zagorski upright to reduce tension. Zagorski was found hanging from a rolled-up sheet tied over the top bunk of the cell. The sheet was attached to a large trash liner bag of water inside a laundry net bag being used as a counterweight. CO C.F. returned to her post and called a code “purple,” a suicide/attempted suicide. Sergeant (Sgt.) M.M., RN [REDACTED], CO K.S., CO G.M., CO S.M., CO D.D. and CO M.B. responded. Sgt. M.M. directed security staff to replace the two incarcerated individuals supporting Zagorski’s weight and the incarcerated individuals exited the area. [REDACTED]

[REDACTED] At 4:42 p.m., Fort Edward Rescue Squad arrived and assumed care of Zagorski. [REDACTED]

27. A review of the Watch Tour Report documented that regular watch tours were started and completed as scheduled from 11:41 a.m. until Zagorski was found.
28. A review of the Watch Tour Report documented that an RN came to Bravo pod at 2:43 p.m. and left at 2:49 p.m. for a medication pass without incident.
29. During the investigation by the Commission, Washington County Jail provided that they have updated their policy to reflect a zero tolerance of sheets being hung on cells to

obstruct any view and now require a one for one exchange of trash receptacle liners.

ACTIONS REQUIRED:

TO THE OFFICE OF THE WASHINGTON COUNTY SHERIFF:

The Sheriff shall direct jail administration to review the corrective action(s) taken in this incident to assure that compliance with the requirements of 9 NYCRR §7003.3(c) is being maintained.

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

In a response dated 9/9/25 to the Commission's preliminary report, Washington County Jail Administration indicated that they updated policy and procedure to reflect that cell coverings are not permitted. The jail administration disputed the Commission's findings that the officer conducting supervision of the housing area where Zagorsky was housed was not in compliance with the requirements of 9 NYCRR §7003.3(c). The Commission's findings did not indicate that the officer was not present nor had failed to complete a supervisory round but rather reflected the information provided in a statement that indicated a sheet was covering the cell during a tour, thus indicating that "a personal observation of the individual" could not have been made.

TO THE MEDICAL DIRECTOR OF WASHINGTON COUNTY JAIL:

The Medical Director shall conduct a comprehensive quality assurance review of the care provided to Zagorski regarding:

1. Why medical records were not maintained in comportment with 9 NYCRR §7010.2(j).
2. Why an immediate referral was not made to psychiatry despite Zagorski presenting with active psychosis symptoms.

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

In a response dated 9/9/25 to the Commission's preliminary report Hudson Headwaters Health Network (HHHN)¹, the former designated service provider for the Washington County Jail, indicated that the requested reviews were completed. HHHN indicated their review revealed that the assessments and referrals for Zagorski met the standard of care. The Medical Review Board disagrees and remains affirmed in its opinion that Zagorski had hallmark signs and symptoms of acute psychosis at admission to the jail, and due to the significant risk that active psychosis can present in carceral settings, there was a need for an immediate referral to psychiatry.

TO THE DIRECTOR OF EDEN CARE BEHAVIORAL HEALTH:

The Director shall conduct a comprehensive quality assurance review of the care provided to Zagorski regarding:

1. Why there was a delay in obtaining a psychiatric evaluation of Zagorski despite

- presenting with signs of active psychosis.
2. Why there was no documented psychiatric diagnosis made for Zagorski.
 3. Why were Zagorski's medication regimens changed without sufficient to time establish therapeutic effect.
 4. Why there was no comprehensive documented treatment plan for Zagorski.

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

In a response dated 7/8/25 to the Commission's preliminary report, the Eden Center for Integrative Care² 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 that 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.

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

²As 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, 12th Floor, in the City of Albany, New York 12210 on this 24th day of September 2025.



Yolanda Canty
Commissioner
Commission of Correction

YC:AL:vc
2024-M-0015

September 24, 2025