

NEW YORK STATE COMMISSION OF CORRECTION

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In the Matter of the Death : FINAL REPORT OF THE  
: NEW YORK STATE COMMISSION  
of Justin McCue, an inmate of : OF CORRECTION  
the Dutchess County Jail :  
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TO: Sheriff Adrian Anderson  
Dutchess County Sheriff's Office  
150 N. Hamilton Street  
Poughkeepsie, NY 12601

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 Justin McCue who died on September 23, 2010 while an inmate in the custody of the Dutchess County Sheriff at the Dutchess County Jail, the Commission has determined that the following final report be issued.

FINDINGS:

1. Justin McCue was a 26 year old male who died on 9/23/10 from a suicidal hanging while in the custody of the Dutchess County Sheriff at the Dutchess County Jail. [REDACTED]
2. Justin McCue was born in 1983 in Tarrytown, NY and was raised in Dobbs Ferry, NY. His parents divorced in 2000. McCue lived with his mother in Cape Cod, MA and Bangor, ME until his arrest in 2003. McCue had a GED he received while in the Westchester County Jail. He had no employment history. [REDACTED] He had a child with a girlfriend in 2003.
3. [REDACTED]
4. [REDACTED]
5. Justin McCue was admitted into the Dutchess County Jail on 11/16/09 for Criminal Possession of Stolen Property and parole violation charges. He was screened for suicide risk at admission and scored a "0" on the screening form. [REDACTED]

[REDACTED]

6.

[REDACTED]

7.

[REDACTED]

8.

On 12/14/09, an officer who had issued McCue a razor for shaving in the morning noticed that the razor appeared altered when it was returned. Upon further inspection, it was discovered that one of the blades was missing and had been replaced with foil. Officers secured McCue and searched him for the missing razor. The razor was found and secured by the officers. McCue had made statements that he was going to use the razor to cut himself. Officers began to escort McCue down to medical to be assessed when they observed blood saturating his right sock. McCue had apparently used the razor to cut his right foot.

9.

[REDACTED]

10.

[REDACTED]

[REDACTED]

11.

[REDACTED]

12.

[REDACTED]

13.

[REDACTED]

Although not contributory to the terminal event, McCue's removal from constant supervision represented inadequate mental health care. [REDACTED]

[REDACTED] social worker D.W. should have continued the constant supervision order or have consulted with the psychiatrist prior to removing McCue. Additionally, the use of "contracts for safety" as a means to assess a patient's risk of harm is not recommended in the correctional setting due to the inability of clinicians to establish long-term therapeutic relationships.

14.

[REDACTED]

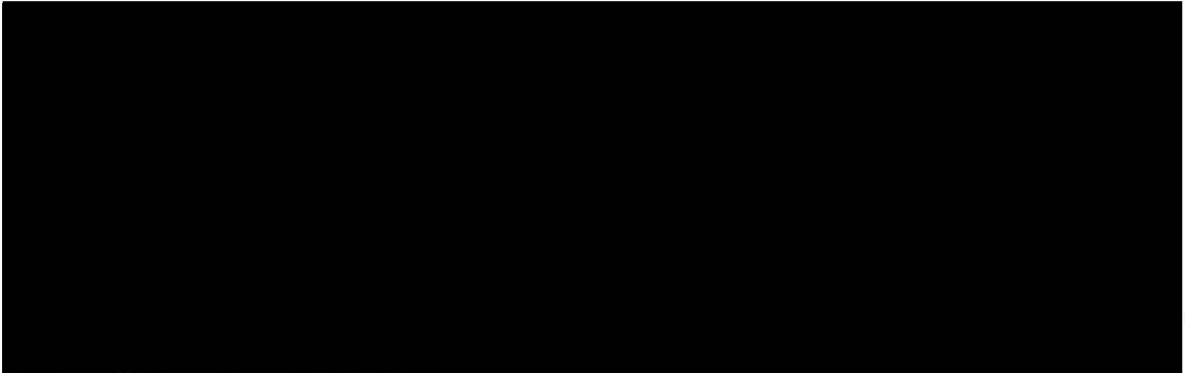
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[REDACTED]

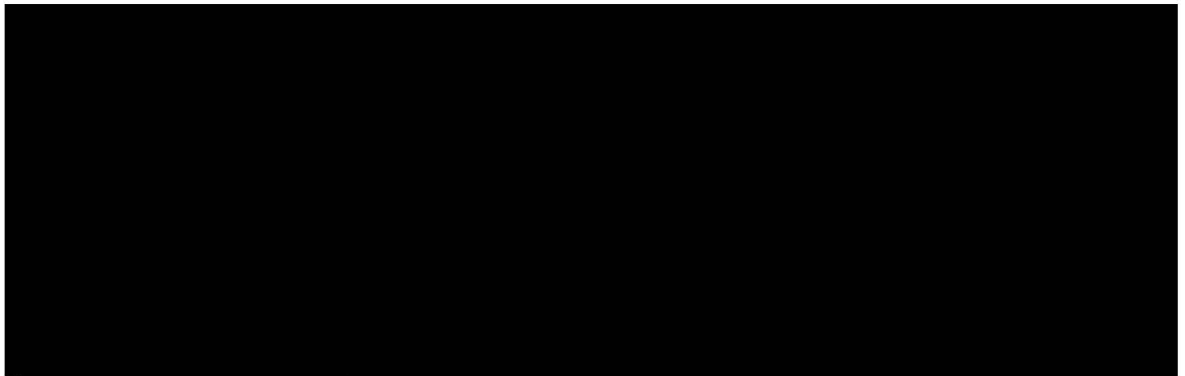
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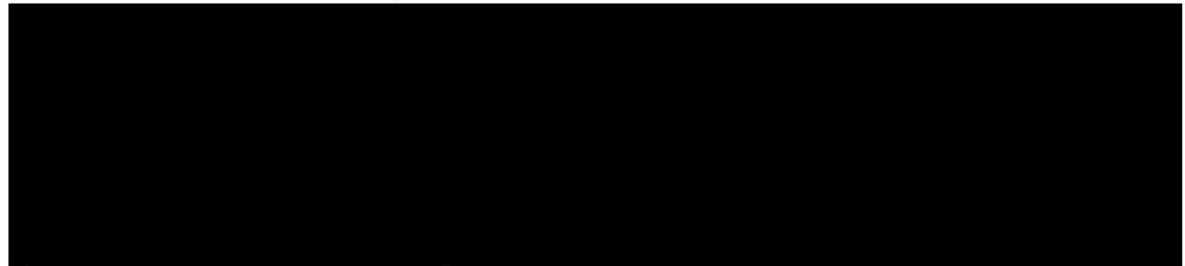
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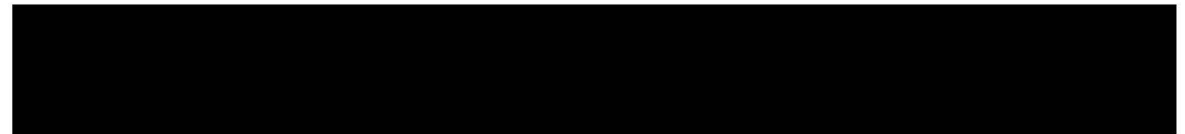
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21.



22.



This represented improper and inadequate mental health care and treatment. There was no valid basis to discontinue McCue from mental health services.


23. McCue's remaining course of incarceration was unremarkable. He had no incidents or disciplinary problems. On 6/1/10, he was moved into protective custody per his request after being threatened by another

inmate. [REDACTED]

24. Justin McCue was housed in Housing Unit 4 cell 19 on 9/23/10. At 7:06 a.m., a breakfast meal tray was delivered to McCue's cell. At 7:20 a.m., the meal tray was picked up from his cell by the housing unit officer.
25. Officer M.K. was assigned Housing 4 for the 8:00 a.m. to 4:00 p.m. tour. Officer M.K. conducted a tour of the unit during shift change at 7:56 a.m. (note 7:50 a.m. on video camera recording of unit), and did not notice any unusual activity.
26. At 7:51 a.m. on the unit video recording, a towel can be seen being put over McCue's cell door window.
27. At 8:17 a.m. on the unit video recording, Officer M.K. conducted a supervisory round of the unit and passed by cell 19. Officer M.K. is observed to knock on the cell door but does not stop and order McCue to remove the towel from the window.
28. At 8:22:45 a.m., Officer M.K. returned to cell 19 to see if McCue wanted to attend recreation. Officer M.K. observed the towel up over the window and knocked on the cell door. There was no response from McCue so Officer M.K. requested to have the cell door opened.
29. At 8:23:10, McCue's cell door is opened and McCue is found hanging from a sheet affixed to the light fixture in the ceiling of the cell. Officer M.K. called for a medical emergency on his radio to have staff respond to the scene. Officer C.S. arrived immediately and entered the cell with Officer M.K. Officer M.K. held McCue up while Officer C.S. cut the ligature away with his cut down knife. McCue was cut down and placed on his bunk. Officer C.S. began to check for vital signs.
30. By 8:24 a.m., Sgts. A.P., M.A., and B.S. entered the scene. Sgt. A.P. assisted Officer C.S. getting McCue on the floor and his shirt cut off. McCue was not breathing and had no pulse. Sgt. A.P. began chest compressions and Sgt. B.S. called for the AED and bag valve mask. Officers M.M. and C.G. responded and assisted with CPR.

31. [REDACTED]

32. [REDACTED]

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33. The Dutchess County Jail administration along with their contract medical and mental health provider, Correctional Medical Care Inc., conducted an in-house mortality review regarding McCue's suicide and identified some areas for system improvement. It was recommended that a clinician maintain in contact with the patient even if they are refusing medication so that they may intervene at times of risk. If a pattern of refusal of care is noted, social workers will reach out, with the patient's permission, to family members or friends to try and establish a means of support around therapy. Patients will be required to sign a release. Lastly, every inmate who has been returned from being treated at Mid-Hudson PC or Central New York Psychiatric Center will be seen at regular intervals for risk assessment even if they are not on any medications. While these recommendations address the failure to maintain mental health services for an uncooperative patient, the Board found them to be insufficient.
34. Mental Health Services are currently provided at the Dutchess County Jail by a staff of part-time social workers and part time psychiatrists by contract through Correctional Medical Care Inc. Due to the size of the jail (292 beds) and the complexity of most jail mental health cases, the services of a full time social worker is warranted to manage cases and coordinate patient care.

RECOMMENDATIONS:

TO THE OFFICE OF THE DUTCHESS COUNTY SHERIFF:

1. The Office of the Sheriff shall conduct an investigation into the actions of Officer M.K. who failed to order McCue to remove a towel covering the cell door window or investigate why it was up during a supervisory tour of the housing area. Administrative action should be taken if the conduct is found to be in violation of Department policy and procedures.
2. The Office of the Sheriff, along with its contract medical and mental health provider, Correctional Medical Care Inc., shall improve procedures dealing with patients who refuse contact and/or medications. After two refusals, clinical staff shall go to the housing area and directly engage the patient. The reasons for and circumstances of refusal shall be determined and documented. The clinical staff shall remain engaged with the patient in this manner. The patient shall not be terminated from services.
3. The Office of the Sheriff, with its contract medical and mental health provider, Correctional Medical Care Inc., shall establish a full time social worker position to better coordinate and manage mental health care at the facility.

4. The practice of using contracts for safety at the Dutchess County Jail shall be discontinued immediately. Contracts for safety are not recognized as part of a generally accepted correctional mental health treatment practice nor are they considered standard community practice. Such contracts are unreliable in the extreme as a guarantor of inmate/patient safety, particularly in the correctional setting.

WITNESS, HONORABLE PHYLLIS HARRISON-ROSS, M.D., 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 this 17<sup>th</sup> day of April, 2012.

  
Phyllis Harrison-Ross, M.D.  
Commissioner

PHR:mj  
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