NEW YORK STATE COMMISSION OF CORRECTION

In the Matter of the Death of Frederick Haag, an inmate of the Tioga County Jail	FINAL REPORT OF THE NEW YORK STATE COMMISSION OF CORRECTION

TO: Sheriff Gary Howard
Tioga County Sheriff's Office
103 Corporate Drive
Owego, NY 13827

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 Frederick Haag who died on October 24, 2011 while an inmate in the custody of the Tioga County Sheriff at the Tioga County Jail, the Commission has determined that the following final report be issued.

FINDINGS:

1. Frederick Haag died on 10/24/11 at approximately 6:38 a.m. from suicidal hanging while in the custody of the Tioga County Sheriff at the Tioga County Jail. Haag's suicide was complicated by inadequate medical and mental health care as provided by Correctional Medical Care, Inc. (CMC, Inc.) at the Tioga County Jail.

2. Haag was born on 7/7/70 in Brooklyn, New York. He was an unemployed truck driver at the time of his arrest. Haag was divorced and had a son. Haag reportedly had a high school diploma. Haag's criminal history commenced with the instant offense.

3. On 6/22/11 in the Town of Richford, Haag was arrested and charged with Menacing 2nd and Strangulation 2nd related to an incident that began in Ithaca and ended in Johnson City. Haag allegedly picked up his ex/estranged girlfriend in his truck at a marina parking lot in Ithaca in the morning hours of 6/22/11. Haag then drove to Richford and pulled over, where the two argued and Haag choked her with his hands around her neck until her vision turned black, she reportedly saw "white spots," and could not breathe. Haag claimed that they both took a nap in the truck. When his ex-girlfriend awoke, Haag was in a rage and swinging around a pipe, hitting the steering wheel and "shifter." Haag began to drive and the argument continued as they drove through Whitney Point and eventually into Johnson City. Haag reportedly became increasingly violent and attempted to hit his ex-girlfriend in the head with the pipe. She then jumped from the moving truck, scraping her knee and elbow. Haag jumped out of the truck, grabbed her by the arm and restrained her until a passerby stepped in to get him away from her.

4. Haag was arrested by the New York State Police in Endwell without incident and issued an appearance ticket for Menacing 2nd, returnable in the Village of Johnson City Court on 6/29/11. Haag was arraigned at the Town of Richford Court for Strangulation 2nd and remanded to the Tioga County Jail in lieu of $20,000

cash/$40,000 secured bond. A Stay Away Order of Protection was issued and Haag was advised of same in court.

5. On 7/16/11, Haag allegedly violated the Order of Protection by e-mailing his ex/estranged girlfriend multiple times. She was in fear for her life and wanted Haag arrested. Haag was arrested and remanded to the Tioga County Jail without bail.

6. Haag was a generally physically healthy 41 year old. [redacted]

7. Tioga County Jail's medical and mental health services are contracted with Correctional Medical Care, Inc., a national contract correctional health care provider with corporate offices in Blue Bell, PA. CMC, Inc. is a business corporation holding itself out as a medical care provider.

8. [redacted] An admission assessment was not completed. RN M.G. stated to Commission staff that she completes her assessment with the medical history and documents on the back of the history form if there are any problem(s). This is a violation of §7010.2(b)(1) Health Services which states, "Each prisoner shall be examined by a physician licensed to practice in the State of New York or by medical personnel legally authorized to perform such examination at the time of admission or as soon thereafter as possible, but no later than 14 days after admission."

9. [redacted] This represents inadequate medical evaluation and treatment by CMC, Inc. CMC, Inc.'s medical care of Haag does not meet the community standard of care.

10. [redacted] This is a violation of §7003.3(h), as interpreted by Commission Chairman's Memorandum 17-99, which states in part: "The chief administrative officer and/or

the facility physician shall determine whether a prisoner requires additional supervision based on the prisoner's condition, illness or injury, and the chief administrative officer shall order such supervision if warranted. "More frequent supervisory visits" pertains to the interval between supervisory visits. The Medical Review Board has investigated several inmate suicides in which a determination for additional supervision was made pursuant to §7003.3(h). In these cases, the supervisory visit interval was shortened from 30 minutes to 15, 10, or even 5 minutes for inmates subject to suicide prevention precautions. As it is a well established fact that inmates can hang themselves with fatal results in less than 5 minutes, such shortened supervisory visit intervals were plainly inadequate and therefore a violation of §7003.3(h). Supervisory intervals of 5 to 15 minutes are not adequate as a suicide prevention precaution. Therefore, if the objective is to prevent suicide, only constant observation is effective. *See SCOC Chairman's Memorandum 99-17.*

11. [redacted]

12. [redacted]

[redacted]

13. [redacted]

14. [redacted]

15. [redacted]

16. [redacted] M.S. failed to complete a competent mental health assessment, diagnosis, and treatment plan and did not take appropriate action with a referral to an upper level clinician such as a psychiatrist.

17. [redacted] Despite Haag being visibly upset and exhibiting signs and symptoms of acute depression, he was not referred to a psychiatrist for intervention or a

medication evaluation which represents grossly inadequate mental health care by CMC, Inc.

18 [redacted]

M.S. was grossly negligent in the care provided to Haag in his current hopeless and helpless state of obvious clinical depression.

19. [redacted]

20. [redacted]

21. [redacted]

22. [redacted] This clearly remarkable mood swing is profoundly suspect and should have been recognized as such by CMC, Inc. clinicians.

23. [redacted]

24. [redacted]

25. [redacted] The patient's moods were swinging, a clear danger signal that went unrecognized by CMC, Inc. clinicians. An appropriate level of care was not afforded this inmate during periods of hopelessness, helplessness, and paranoia. [redacted]

26. On 10/24/11, Haag was discovered hanging in his cell by CO M.H. at approximately 6:13 a.m. during supervisory rounds at the Tioga County Jail. Haag had used a sheet as a ligature which he had attached to the vent above the toilet in his cell. When discovered, Haag was facing out of his cell. He was last noted sleeping in his bed by CO M.H. on her previous round at approximately 6:01 a.m.

27. CO M.H. activated her duress alarm at which time Sgt. T.A. and CO S.B. responded. Sgt. T.A. and CO S.B. entered Haag's cell and checked for a pulse. The sergeant had picked up the cut-down tool on his way into the unit. Sgt. T.A. exited Haag's cell to "gather his thoughts." According to record, Sgt. T.A. believed he had a "dead man" and took a few moments to determine his next course of action.

28. Sgt. T.A. and CO S.B. held Haag up while Sgt. T.A. used the cut-down tool to cut Haag down. Haag was placed on the floor where CPR was initiated by Sgt. T.A. while CO S.B. attached the AED. EMS was notified and arrived in approximately ten minutes. [redacted]

29. On 10/24/11 entries are noted in error commencing at 6:01 a.m. and have been corrected in an inappropriate manner. This is a violation of §7003.3(1) which states, "Alterations made by facility staff to any entries contained within such ledger shall be (1) accomplished by facility staff drawing a single line through the entry to be changed which does not prevent the original entry from being read; and (2) dated and signed by the staff member making the alteration with the reason(s) noted why the record was altered.

30. Evidence submitted to the Medical Review Board revealed that clinician M.S. engaged in the practice of psychology or psychiatric social work without a license to do so, a crime in New York State.

RECOMMENDATIONS:

TO THE OFFICE OF THE TIOGA COUNTY SHERIFF:

1. The Office of the Sheriff shall undertake an inquiry to determine whether, based upon the grossly and flagrantly improper and inadequate care delivered in this case, CMC, Inc. is fit to provide medical and mental health care at the Tioga County Jail or should be terminated for cause.

2. The Office of the Sheriff shall immediately comply with §7003.3(h) which states, "The chief administrative officer and/or the facility physician shall determine whether a prisoner requires additional supervision based on the prisoner's condition, illness or injury, and the chief administrative officer shall order such supervision if warranted." This supervision requirement is delineated and clarified in the Commission's Chairman's Memorandum 17-99, enclosed.

3. The Office of the Sheriff shall immediately comply with §7003.3(1), "Alterations made by facility staff to any entries contained within such ledger shall be (1) accomplished by facility staff drawing a single line through the entry to be changed which does not prevent the original entry from being read; and (2) dated and signed by the facility staff member making the alteration with the reason(s) noted.

4. The Office of the Sheriff shall immediately require its health services contractor, CMC, Inc., to comply with §7010.2(b)(1), Health Services which states, "Each prisoner shall be examined by a physician licensed to practice in the State of New York or by medical personnel legally authorized to perform such examination at the time of admission or as soon thereafter as possible, but no later than 14 days after admission."

5. The Office of the Sheriff shall recruit and hire a contract monitor qualified by training and experiencing to assure that an appropriate level of care is provided by Correctional Medical Care, Inc. and that all aspects of the contract are in compliance.

6. The Office of the Sheriff shall comply with Chairman's Memorandum No. 4-98 dated April 1, 1998 regarding the need for family and friends to report knowledge of inmates threatening self harm or suicide.

TO THE PRESIDENT OF CORRECTIONAL MEDICAL CARE, INC.:

1. Correctional Medical Care, Inc. shall immediately comply with §7010.2(b)(1), Health Services which states, "Each prisoner shall be examined by a physician licensed to practice in the State of New York or by medical personnel legally authorized to perform such examination at the time of admission or as soon thereafter as possible, but no later than 14 days after admission."

2. Correctional Medical Care, Inc. shall conduct an investigation into the performance of RN M.G. [redacted] Correctional Medical Care, Inc. shall take appropriate administrative action related to RN M.G.'s omission of appropriate documentation.

3. Correctional Medical Care, Inc. shall conduct an investigation into the practices of M.S. [redacted] Correctional Medical Care, Inc. shall take appropriate administrative action related to M.S.'s lack of appropriate referral of Haag to the next level of care.

4. Correctional Medical Care, Inc. shall immediately direct M.S. to make appropriate referrals of mental health patients to the psychiatrist for intervention and psychiatric medication management.

TO THE NEW YORK STATE EDUCATION DEPARTMENT, OFFICE OF THE PROFESSIONS:

1. The Office of the Professions should conduct an investigation into the hiring practices of Correctional Medical Care, Inc. who has allowed M.S. to provide mental health practitioner services/counseling at the Tioga County Jail. (M.S. currently holds a Master's degree in Forensic Psychology and as such is unable to become a practitioner.)

2. The Office of the Professions should conduct an investigation into the practitioner services/counseling being provided by M.S. as Director of Mental Health at the Tioga County Jail and under the employ of Correctional Medical Care, Inc. M.S. is providing services without appropriate licensure and beyond what is permitted by her level of education.

TO THE OFFICE OF THE TIOGA COUNTY DISTRICT ATTORNEY:

That the Office of the District Attorney conduct a criminal investigation into the professional activities of Facility Mental Health Director M.S. for engaging in the practice of psychology or psychiatric social work without a license to do so, a crime in New York State, and that the Office take such action as may be warranted including referral to the Tioga County Grand Jury.

WITNESS, HONORABLE PHYLLIS HARRISON-ROSS, M.D., 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 this 18th day of December, 2012.

Phyllis Harrison-Ross, M.D.
Commissioner

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