NEW YORK STATE COMMISSION OF CORRECTION

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| In the Matter of the Death<br><br>of Richard Vandemark, an inmate<br>of the Ulster CJ | :<br>:<br>:<br>:<br>: | FINAL REPORT OF THE<br>NEW YORK STATE COMMISSION<br>OF CORRECTION |

TO: Sheriff Paul Van Blarcum
Ulster County Sheriff's Office
380 Boulevard
Kingston, NY 12401

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 Richard Vandemark who died on April 8, 2009 while an inmate in the custody of the Ulster County Sheriff's Office, the Commission has determined that the following final report be issued.

FINDINGS:

1. Richard E. Vandemark III was a 21 year old white male who died on 4/8/09 from suicidal hanging at the Ulster County Correctional Facility while in the custody of the Sheriff of Ulster County. Inadequate supervision and the failure to provide a timely mental health assessment are factors implicated in Vandemark's death.

2. [redacted]

3. [redacted]

4. Vandemark was arrested on 4/7/09 by the Ulster County Sheriff's Office and charged with Assault 2nd, Criminal Possession of a Weapon 3rd, Menacing 2nd and Trespass. He was arraigned and remanded to the Ulster County Correctional Facility at approximately 6:30 a.m. in lieu of $5,000 cash/$10,000 bond.

5. On admission to the facility, Vandemark was screened by Officer T.R., scoring a "7" on the Suicide Prevention Screening Guidelines. Vandemark answered affirmatively to:

**#2 Detainee lacks support of family or friends in the community:** stating none in area.

**#3 Detainee has experienced a significant loss within the last six months (e.g., loss of job, loss of relationship, death of close family member):** stating lost girlfriend.
**#4 Detainee is very worried about major problems other than legal situation (e.g., serious financial or family problems, a medical condition or fear of losing a job):** stating financial.
**#5 Detainee's family member or significant other (spouse, parent, close friend, lover) has attempted or committed suicide:** stating sister attempted.
**#7 Detainee has history of counseling or mental health evaluation/treatment:** reporting Ulster County Mental Health.
**#11 Detainee is expressing feelings of hopelessness (nothing to look forward to):** stating "nothing." This question is a shaded area on the screening form designed for automatic notification to the supervisor and the institution of constant supervision. Suicide Prevention and Crisis Intervention Training emphasizes that hopelessness and helplessness are said to be the best short-term indicators of suicide risk.
**#13 Detainee shows signs of depression (e.g., crying, emotional flatness):** documented by the officer as crying. Vandemark's admission screening indicated a clear and imminent risk for suicide attempt.

6. In the Officer's Comment section, Officer T.R. documented, "states no thoughts of suicide at this time." Officer T.R. reported that "at no time did (he) get any indication that Vandemark intended to cause harm to himself." Officer T.R. stated that Vandemark did not appear to be under the influence of alcohol or drugs but was in need of medical attention.

7. The referral section was marked by Officer T.R. for referrals to Medical/Mental Health as non-emergencies.

8. The Suicide Screening Guidelines "Action" section states in part that if any shaded box is checked, as was box #11, to notify a supervisor and institute a constant watch. Sgt. A.T., the intake supervisor, was notified and signed the Suicide Screening Guidelines. Vandemark was not assigned constant supervision in accordance with the guidelines but rather active supervision. Active supervision is not an adequate substitution for constant supervision.

9. Upon interview, Sgt. A.T. described Vandemark as "beat up and bleeding" with his hand wrapped up due to a laceration inflicted from the knife used during the alleged assault. Sgt. A.T. questioned Vandemark as to whether he had received any medical attention before coming into the facility. Vandemark reported he had not. Sgt. A.T. stated that constant supervision was not instituted because Vandemark was being sent out to the hospital and all inmates are "basically under constant supervision" in the booking area. He added that since Vandemark had been referred by booking to medical and mental health, he would be seen upon return to the jail.

10. It was determined during the course of the investigation that a common practice in the jail exists whereby inmates that screen at high risk and/or have a scored shaded area on the suicide prevention screening guidelines during booking are not always assigned constant supervision by officers or their supervisors, instead referred to medical. Registered nurses would then be responsible to make a decision regarding such constant supervision. This practice is not in accordance with either the written suicide prevention screening guidelines or the relevant training. Such training requires that an inmate scoring high and/or having a scored

shaded area on the screening guideline should automatically be assigned constant supervision until the inmate can be examined by an appropriately licensed mental health professional.

11. [redacted]

12. [redacted]

13. Upon return to the Ulster County Correctional Facility at approximately 1:00 p.m. on 4/7/09, Vandemark was admitted to the facility's infirmary for observation and monitoring. Medical and mental health services at the Ulster County Correctional Facility are contracted with Correctional Medical Care, Inc., a business corporation holding itself out as a medical care provider.

14. [redacted] There is no indicating in the record that RN T.A. reviewed or otherwise noted Vandemark's completed suicide prevention guidelines screening report. During interview, Nurse T.A. could not recall if Vandemark's Suicide Screening Guideline was available to her when she admitted him to the infirmary. No constant supervision was initiated on Vandemark upon admission to the infirmary.

15. [redacted]

There is no indication in the record that Dr. B.G. reviewed or otherwise noted Vandemark's completed suicide prevention guidelines screening reports.

16. [redacted]

17. [redacted]

18. [redacted]

19. Shortly after this encounter, several nurses stated that they heard a loud confrontation between the day officer, B.H., and the inmate. During interview, Officer B.H. stated that he did not recall that confrontation. However, in a sworn statement to Ulster County Sheriff's Office Investigators, Officer B.H. reported that he told the inmate to get away from the window looking out at the nurse's station. He stated that the inmate had a question and he told him that he was interfering with the count. At approximately 9:30 a.m., Officer B.H. stated that he spoke to Vandemark informing him his room needed to be cleaned. Vandemark ate lunch at approximately 11:30 a.m.

20. At 12:18 p.m. on 4/8/09, Officer B.H. brought Vandemark cleaning supplies and ordered him to clean his room. He stated that Vandemark complied and cleaned his room. This practice is wholly inappropriate in an infirmary setting. Officer B.H. claimed that he always checks with a nurse before such practice is ordered. Nurses interviewed during the course of this investigation denied this but were aware of the practice. They claimed that they were unaware of Officer B.H. ordering Vandemark to clean his room on that day.

21. According to the supervisory log, at approximately 1:15 p.m., Officer B.H. gave Vandemark a warning to get out from under his covers. On the next round, he gave Vandemark a second order to get out from under his covers, then took away his TV privileges.

22. During the interview process, it became apparent that practices such as not allowing inmates bed rest, or use of bed covers in the infirmary are common. Officers stated that these practices are in accordance with policies in the other housing areas. The infirmary is not a regular housing area, therefore, should have policies and procedures of an infirmary commensurate with the conditions and needs of inmates admitted there, and such policies and procedures should be subject to the approval of the Medical Director.

23. At approximately 2:52 p.m. on 4/8/09, Vandemark's attorney visited. At approximately this same time, K.B., LMSW, requested to see Vandemark. The officer stated that Vandemark had an attorney visit and stated that K.B. told him she would come back. The attorney left at 3:07 p.m. Vandemark was never evaluated by mental health. During interview, K.B. was questioned as to why Vandemark was not seen earlier in the day in consideration of his high risk suicide screen and two mental health referrals. She stated that due to his complaint of anxiety attacks, she scheduled him to see the psychiatrist as he would probably need medication. The psychiatrist would be at the facility at 2:00 p.m. K.B. claimed that the psychiatrist "ran out of time" but she planned on seeing Vandemark that evening.

24. At approximately 3:55 p.m., Officer B.H. was relieved by Officer J.S. At 4:24 p.m., Vandemark was escorted to the booking area by Officer A. where he was served with an order of protection. The order directed him to stay away from the victims and family he was charged with assaulting in the instant offense. Officer A. stated that Vandemark inquired, "What does this mean? Am I not going to be able to see these people forever?" Officer A. stated that he explained the order and asked Vandemark if he needed to talk to someone, the nurse or social worker. Vandemark reportedly declined.

25. Vandemark was escorted back to the infirmary by Officer A. arriving at 4:37 p.m. according to the supervisory log. Officer A. stated that he informed Officer J.S. of Vandemark being served with an order of protection.

26. Vandemark was housed alone in a three-bed housing unit directly across from the nursing station. The housing unit door is a steel detention grade door with a full glass vision panel. Adjacent to the left side of the door is a screened panel required by the Commission for communication into the housing unit. This corner is not in the sight line of an officer looking into the area through the panel glass. Beds are located on the right and left wall. Supervisory rounds are conducted every 15 minutes in the infirmary.

27. At 4:38 p.m. on 4/8/09, Officer J.S. documented that chow was on the floor. He documented supervisory rounds every 15 minutes with the last several rounds recorded at 5:30 p.m., 5;45 p.m., and 6:00 p.m. At 6:05 p.m. he recorded, "Nurses in to change (patient #2's) diaper." Another round is recorded for 6:15 p.m.

28. At approximately 6:16 p.m., Vandemark was found by Officer J.S. hanging in the shower area suspended from the curtain rod by a bed sheet ligature. Officer J.S. radioed for help and lifted Vandemark up while responders L.T., RN, and S.H., LPN, removed the ligature. [redacted]

29. Commission staff reviewed video-tape of the infirmary housing area and the nursing station from 5;45 p.m. through 6:16 p.m. Vandemark was seen walking towards the shower area at 5:53 p.m. At 5:56 p.m., the tape reveals Officer J.S. and a nurse looking into the housing area through a closed door. Approximately 30 seconds later, Officer J.S. looked in again and walked to the nursing station located several feet away. At 5:58 p.m. and 5:59 p.m., he again looked into the room and walked back to the nurse's station. At 6:02 p.m., he again looked into the housing area and then walked away from the nursing station towards the other side of the infirmary. At 6:13 p.m., he returned to the housing area and tapped his proxy pen and again walked away. At 6:16 p.m., he returned and at this time entered the housing area. Officer J.S. was in violation of 9 NYCRR §7003.2(a)(1)(2) Security and supervision which states:

(1) A 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

(2) 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.

Good correctional practice dictates that in performing a count, the officer has one paramount responsibility, which is to observe and report the presence of living bodies or the absence of assigned inmates. To be sure that a live inmate is counted, the employee must see skin and breathing or other movement.

31. In a sworn statement to Ulster County Sheriff's Office investigators, Officer J.S. stated that prior to finding Vandemark hanging he performed his last round at 6:00 p.m. When asked if he saw him at that time, he stated, "Yes, I think Vandemark was at the bedside table writing." In viewing the housing area tape, Officer J.S. had not seen Vandemark for approximately one half hour. He had not attempted to communicate through the screened panel and had not gone into the housing area when he was unable to visually see Vandemark. In addition, Officer J.S. made false entries in the supervisory log book by indicating that rounds were made and a living, breathing body counted when that was not the case. Commission staff were unable to interview Officer J.S. as he is no longer employed at the correctional facility. Commission staff were informed by Ulster County Sheriff's Office Correctional Division that Officer J.S.'s resignation was not related to the Vandemark incident.

32. Vandemark left suicide notes to his parents and a friend.

RECOMMENDATIONS:

TO THE SHERIFF OF ULSTER COUNTY:

1. Conduct a review of Vandemark's admission screening at booking, specifically the process of administering the ADM 330 Suicide Prevention Screening Guidelines to determine whether officers are conducting the screening properly, initiating appropriate levels of supervision, and making necessary referrals to mental health.

2. Provide and document provision of regular Suicide Prevention and Crisis Intervention refresher training.

3. Direct contract health care provider Correctional Medical Care, Inc. to conduct a documented review of the mental health services referral process to include required review of suicide prevention screening documentation by medical and allied medical staff with appropriate action for suicide prevention precautions and timely evaluation of high risk inmates. This written review with documentation of action recommended and taken shall be submitted to the Medical Review Board by **February 19, 2010.**

4. Conduct an investigation into the conduct of the correction officer who was assigned to Vandemark's supervision on 4/8/09 during the 7:00 a.m.-3:00 p.m. shift.

5. Develop and implement, in conjunction with the Medical Director, written policies and procedures appropriate for infirmary housing. These policies and procedures should be commensurate with delivery of infirmary care defined as care provided to residential patients with a physical or mental illness, diagnosis, or health care need that requires daily medical supervision, medication and/or therapy, or assistance with activities of daily living at a level needing skilled nursing intervention. Such policies and procedures, counter-signed by the facility Medical Director, shall be forwarded to the Commission on or before **February 19, 2010.**

6. Conduct a review of inmate count and supervisory round methods and procedures, specifically in the infirmary housing areas. Policies and procedures should be revised or developed accordingly and forwarded to the Commission on or before **February 19, 2010.**

WITNESS, HONORABLE PHYLLIS HARRISON-ROSS, M.D., Commissioner, NYS Commission of Correction, 80 Wolf Road, 4th Floor, in the City of Albany, New York 12205 this 19th day of March, 2010.

Phyllis Harrison-Ross, M.D.
Commissioner

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