NEW YORK STATE COMMISSION OF CORRECTION

In the Matter of the Death	:	FINAL REPORT OF THE
	:	NEW YORK STATE COMMISSION
of Aaron Shehu, an inmate of	:	OF CORRECTION
the Yates County Jail	:	
	:	

TO: Sheriff Ronald Spike
Yates County Sheriff's Office
227 Main Street
Penn Yan, NY 14527

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 Aaron Shehu who died on November 27, 2010 while an inmate in the custody of the Yates County Sheriff at the Yates County Jail, the Commission has determined that the following final report be issued.

FINDINGS:

1. Aaron Shehu was a 17 year old biracial male who died from suicidal hanging on 11/27/10 at 12:07 a.m. while in the custody of the Yates County Sheriff's Office. Shehu was discovered suspended from a sheet by a correction officer conducting rounds. CPR was initiated and Shehu was transported to Soldiers and Sailors Memorial Hospital Emergency Department. There were several suicide notes found in his cell. Had Aaron Shehu received adequate and appropriate mental health evaluation, treatment and case management from Soldiers and Sailors Memorial Hospital, John Kelly Behavioral Health Services, both hospital and jail-based, his suicide may have been prevented.

2. On 5/17/10, Shehu's instant offense and first arrest occurred when he was 16 years old. He arrested by the New York State Police and charged with Grand Larceny 4th, two counts, and Criminal Mischief 4th, two counts. ON 9/7/10, Shehu was arraigned on an indictment by the Yates County District Attorney charging him with Criminal Mischief 2nd, Grand Larceny 3rd, Grand Larceny 4th (3 counts), Criminal Possession Stolen Property 4th, and Operator Leaves Scene of Property Damage Accident (2 counts). According to Yates County Jail administration, Shehu also had a detainer for a Petit Larceny offense in Tompkins County.

3. [redacted]

4. [redacted]

[redacted]

5. [redacted]

[redacted]

6. [redacted]

7. [redacted]

8.

9. [redacted]

10. [redacted]

[redacted]

11. [redacted]

12. [redacted]

[redacted]

13. [redacted]

14. [redacted]

[redacted]

15. According to Freedom Village documentation, it is a private faith program for at-risk youth. Shehu resided in Freedom Village, in Lakemont, NY, starting on 1/27/10. Freedom Village offers services for parents of children who have personal challenges and difficulties. It describes its program as not a clinical psychological institution and they do not medicate their students and typically deal with young people who have displayed behavioral difficulties. Shehu's family applied for admission of Shehu to Freedom Village and it was explained that Shehu was presenting his family with serious challenges. Shehu's immature and irrational behavior had been too much from the other avenues that they pursued and they were looking for additional help. Shehu was portrayed as a low-functioning young man whose intelligence scores marked him as being borderline mentally retarded. It was made clear that, among his other behavioral problems, Shehu had been suicidal. His parents thought he often acted out for attention and that he was not genuinely suicidal. Freedom Village documentation indicated Shehu was not a good candidate for their program because of his mental health issues but was eventually admitted to the program.

16. While at Freedom Village, Shehu was spoken to on several occasions, as he often left notes of a morbid tone, referencing his desire to die or referring to his loneliness. On one occasion, Shehu was found trying to put something around his neck and threatening to hurt himself. Shehu's father met with Shehu and the Freedom Village administrative staff to discuss the situation and determine the proper course of action. After counseling with Shehu and speaking to his father, it was determined that Shehu would be given one more chance on the most tenuous grounds. A few weeks later, Shehu was again threatening to hurt himself. At this point, it became clear Shehu was unwilling or unable to control his behavior and he was a threat to himself. His parents were immediately contacted and Shehu was dismissed into their custody so that they could consider the best course of action for Shehu. The administration of Freedom Village concluded that Shehu was a very low-functioning, impulsive young man who felt very hopeless and their program was unable to help him. They reported that Shehu's issues proved to be more serious than what Freedom Village was designed to handle and was returned to the custody of his parents who had the full knowledge of these issues.

17. [redacted]

[redacted]

18. [redacted]

[redacted]

19. [redacted]

[redacted]

20. [redacted]

21. On 5/17/10, Shehu was arrested by New York State Police Officer M. for two counts of Grand Larceny 4th (felony) and two counts of Criminal Mischief 4th (misdemeanor). Shehu had allegedly stolen two vehicles to return to Freedom Village and threatened to hurt a fellow peer who reported Shehu's suicidal gesture and got Shehu removed from the program as a result. Shehu was committed to the custody of the Yates County Sheriff's Department by Judge J.S. with bail set at $10,000 cash/$20,000 bond. Yates County Jail Officer P.W. stated that the State Police Officer that transported Shehu to the jail stated he was very concerned about Shehu's safety and recommended that he be placed on constant observation after he was booked into the jail.

22. On 5/18/10 at 12:24 a.m., Shehu was booked into the Yates County Jail by Officer P.W. who completed a suicide screen. Shehu scored a five giving affirmative answers to "Arresting or Transporting officer believes that detainee may be a suicide risk, if yes, notify supervision." The comment written was "NYSP said they would put him on a watch." A positive response was elicited for "Detainee's family member or significant other (spouse, parent, close friend, lover) has attempted or committed suicide." Comment listed was grandfather in February 2008. The third question answered in the affirmative was, "Detainee has previous suicide attempt." The general comment was written "tried two weeks ago and took pills. The last question with a positive response was incited is, "This is detainee's first incarceration in lockup/jail." Officer P.W.'s impression of Shehu was very honest and calm. Constant supervision was instituted and Shehu was referred to mental health. [redacted]

23. The Yates County Jail employs an RN who is dually employed by Soldiers and Sailors Hospital half time for mental health services and Yates County for which she does medical-related nursing activities for the inmates. Commission investigators were unable to delineate her lines of authority and accountability in any particular case at Yates County Jail. [redacted]

The mental assessment form asks to be specific on the exact sphere

of orientation, [redacted]

24. [redacted]

25. [redacted]

26. In correspondence from the Yates County Probation Department dated 5/19/10 to Judge J.S. regarding Shehu, T.H. indicated Shehu did not qualify for a pre-trial release program. His mother, N.S., had expressed concern that he would abscond. N.S. reported that Shehu had similar charges in Tompkins County and had tried to run away in the past two months. It was indicated that Shehu had mental health issues and had been discharged from a "psych ward" for suicidal threats. On 5/19/10, Public Defender E.B. visited Shehu in Yates County Jail. On 6/7/10, Judge J.S. ordered a CPL §730.20 exam for Shehu regarding his fitness to proceed.

27. [redacted]

28. On 6/13/10, at 8:25 a.m., a suicide screen was completed by Officer C.B. who scored Shehu with an eight. The questions that were answered in the affirmative were "detainee lacks support of family or friends in the community;" "Detainee's family member or significant other (spouse, parent, close friend, lover) has attempted or committed Suicide." Comment for question listed as grandfather two years ago. The question "Detainee has history of counseling or mental health evaluation/treatment (note current psychotropic medications and name of most recent treatment agency." Notation listed was, saw Dr. D. a month ago. The fourth question answered in the affirmative was "Detainee has previous suicide attempt." Comment listed is "month ago." The question "Attempt occurred within the last month. If yes, notify supervisor." Shehu answered the question "Detainee is expressing feelings of hopelessness, If yes, notify supervisor" in the affirmative. Officer C.B.'s comment to this question was "nothing to look forward to." The next two questions which were answered with a "yes" were "This is detainee's first incarceration in lock up/jail" and "Detainee shows signs of depression." Officer C.B. documented that Shehu was "calm" and wrote "but does not wish to harm himself." Shehu was continued on constant supervision.

29. [redacted]

[redacted] The controls on RN M.S.'s authority, autonomy, supervision and accountability at Yates County Jail are unacceptably vague and unstructured.

30. [redacted]

[redacted] It was possible to secure Shehu's mental health records as pursuant to New York State Correction Law, section 601(d) which states:

> Any medical or psychiatric records in the possession of a health care provider shall be summarized in detail and forwarded by such health care provider to the medical director of the receiving local correctional facility upon the request of such a sheriff or medical director. Requests for such information shall be made when the information is necessary for timely and effective medical evaluation or treatment.

31. According to Yates County Jail visiting logs on 6/15/10, Shehu had a visit with his grandparents, E. and M.B. [redacted] Also a letter containing a list of people who would be attending his funeral was found in the cell at this time. On 7/5/10 at 11:35 p.m., Officer G.H. stated he was concerned about Shehu. Shehu had stated that his life was over and he would kill himself and no one would stop him this time. On 7/5/10 at 11:52 p.m., Officer P.W. and Officer G.H.

completed Shehu's suicide prevention screen. Shehu scored a nine. Shehu gave affirmative answers for "Detainee lacks support of family or friends in the community." Notation written was "they came once." The question: "Detainee has experienced a significant loss within the last six months (e.g., loss of job, loss of relationship, death of close family members) had a comment written as "family hates me." Other questions answered in the positive were: "Detainee is very worried about major problems other than legal situation; Detainee has history of counseling or mental health evaluation/treatment; Detainee has previous suicide attempt; Detainee is expressing feelings of hopelessness." In regards to the question, "Detainee is thinking about killing himself," the comment listed was "I will kill myself no matter what." The questions concerning Shehu's appearance of "Detainee shows signs of depression (e.g., crying, emotional flatness)" and "Detainee appears overly anxious, panicked, afraid or angry," were responded to in the affirmative. Officer P.W. wrote comments of "depressed" and "angry" to those questions. Shehu refused to answer the three questions of "Detainee's family member or significant other (spouse, parent, close friend, lover) has attempted or committed suicide," "Detainee has history of drug or alcohol abuse," and "Detainee expresses extreme embarrassment, shame, or feelings of humiliation." Officer P.W. documented her impression of Shehu as "he is very angry, says this is the end of life. It is a black hole, he will die no matter what. We can't stop him he promises." On 7/5/10, the officers instituted constant supervision with Shehu. Shehu also stated that he would be evaluated before July 15, 2010 by two physicians. He then stated he wasn't going back to a mental hospital no matter what. Officer G.H. had placed Shehu in cell #M39. Shehu then stated, "You can take everything if you want to, but I'm still going to kill myself and you can't stop me." Shehu was observed by Officer G.H. biting his wrist. Officer G.H. called for Officers D., P.W., and A.L. to respond. Officer G.H. stated to Shehu that if he did not stop biting his wrist he would place him in restraints, at which time Shehu stopped and became quiet. Shehu was transported to Soldiers and Sailors Hospital at approximately 12:55 a.m. on 7/6/10 by Officers L.S. and D.S.

32. [redacted]

[redacted]

33. [redacted] RN M.S. identified her position as a crisis counselor employed by John Kelly Mental Health Services, who provide psychiatric services to the Soldiers and Sailors Hospital. [redacted] In the course of the Commission's investigation, it was reported by security staff that Shehu was teased and made fun of by other minors incarcerated in the facility. Various security staff interviewed by the Commission reported they were aware of this, gave the inmates orders to stop, and also moved Shehu to separate housing areas. According to the Yates County Jail daily activities log and phone log, the security staff moved Shehu fifteen times before his demise. [redacted]

[redacted] RN M.S. stated she found with Shehu's age and incarceration there were only four forensic psychiatric hospitals in New York available to him. She noted that CNYPC in Marcy, NY and Kirby Forensic in Wards Island didn't accept patients younger than 17. Mid-Hudson PC and Rochester PC do not accept off-shift admissions. [redacted]

34. [redacted]

[redacted] At 11:05 a.m., Shehu was discharged back to the jail with correctional officers. [redacted] This is a violation of accepted New York State Hospital Code procedure according to the NYS Department of Health/Hospital and Primary Care Services/EMS where only NYS licensed physicians and physicians assistants may discharge patients from hospital emergency departments. This is also a violation of NYS Education Law Sub-article 3, Professional Misconduct, Section 6509(2) of a person (specifically a Social Worker, A.T.) practicing outside her scope of practice. Additionally, the Commission was informed by the NYS Department of Health that Soldiers and Sailors

Hospital's Emergency Department may be in violation of EMTALA (Emergency Medical Transfer and Labor Act), a federal law, as a clear assumption can be made that a psychiatric transfer for in-patient hospitalization for Shehu had been initiated, and was thereafter improperly aborted.

35. Shehu was placed on constant supervision when he came back to the correctional facility. According to the security constant supervision log on 7/6/10 at 2:49 p.m., Shehu was taken to see RN M.S. and taken off constant supervision at 2:55 p.m. by the nurse. [redacted] RN M.S.'s unilateral action to discontinue constant supervision on a patient who's plan of treatment only hours earlier had been inpatient psychiatric hospitalization without consultation or supporting documentation represents flagrantly incompetent care rising to a level of professional misconduct.

36. [redacted]

37. [redacted] Yates County Court documentation indicates that Shehu was found fit to proceed. On 7/16/10, Public Defender E.B. saw Shehu at the Yates County Jail. On 7/19/10, Shehu's parents X. and N.S. visited him at the correctional

facility. On 7/27/10, P. and J.S. saw Shehu for approximately 40 minutes. On 8/3/10, Shehu had a visit with his grandparents E. and M.B. [redacted] On 8/19/10, Public Defender E.B. saw Shehu at the Yates County Jail. [redacted]

38. On 9/5/10, Officer G.H. was approached by another minor inmate who stated he was worried that either inmate T.R. or Shehu had a weapon and would use it on him. Officer G.H. reported the incident to Officer D.R. Officer D.R. went to the block where the minors were located and asked if anyone had a weapon to give it to her. Shehu went to the trash can and pulled out a pen and then handed it to Officer D.R., asking her if this was a weapon. It was a pen with the ink cartridge removed and a piece of metal inserted in its place. Shehu reported he had found it in his cell when cleaning and was planning to use it to cut his arms with it when he was released. The metal was found to be a piece of metal from an eye glass frame.

39. [redacted]

40. On 9/28/10, Officer A.M. was given a letter written by Shehu and addressed to another inmate incarcerated in the Yates County Jail. Officer A.M. brought the letter to Sgt. B. who instructed him to bring it down to RN M.S. Officer A.M. stated he went to the medical unit on the same day and gave Shehu's letter directly to RN M.S. Shehu's letter indicated that he was sad about the possibility of being sent upstate or to a detention center. He also indicated that he had nothing to look forward to and lost his family and would be homeless. In the letter, Shehu stated "I'm pulling the plug or I'm hang(ing) everything up." He also indicated he was upset with his mother.

41. [redacted]

[redacted]

42. [redacted]

43. On 10/27/10 at 9:05 a.m., according to the Yates County Jail visitors' log, R.H., Psychologist, evaluated Shehu for a CPL section 330.20 evaluation. Public Defender E.B. stated he planned to utilize this evidence for Shehu's defense that he was not responsible for his criminal actions by reason of mental disease or defect. On 10/26/10, Shehu's grandparents visited him.

44. [redacted]

45. On 11/18/10 at 8:50 p.m., Officers O. and B. responded to E-block. Upon entering the block, Shehu was complaining about chest pain. Sgt. G. responded to E-Block to speak to Shehu. Sgt. G. stated Shehu was in pain, anxious, and sweating. Sgt. G. made a decision to call an ambulance for Shehu. [redacted] At approximately 11:30 p.m., Shehu was discharged back to Yates County Jail with a prescription for Pepcid 20 mg po qd. [redacted]

[redacted]

46. [redacted]

47. [redacted]

48. [redacted]

[redacted]

49. On 11/26/10 at 11:30 p.m., Officer D.C., who was assigned as the A-post rover, started her administrative rounds which included E-Post where the minors including Shehu were housed. Officer D.C. stated that at 11:30 p.m., she stopped and asked the four inmates housed on E-Post how they were all doing. Officer D.C. stated she directly looked at Shehu and he said "doing good." Officer D.C. stated Shehu was sitting on the bunk. In reviewing the security videotape and security log book, Shehu was adequately supervised at 30 minute intervals. The two juvenile inmates on either side of Shehu's cell were seen throwing out knotted sheets in front of Shehu's cell then dragging them back to their cells, only to throw them back out again. This behavior ceased when the officers were noted making their administrative rounds. There was no audio on the tape. On 11/27/10 at 12:07 a.m., Officer M.M. was completing his supervisory round and discovered Shehu was suspended by a sheet from his cell gate. He used his radio for "Officer Assistance" on E-Block. Officers D.S., G.H., and S.K. responded immediately to Shehu's cell. Sgt. N.F. radioed to the control room which Officer P.F. was assigned to directing her to call 911 and get the cut-down tool. Officer D.C. ran to get the cut down tool from the control room. Officer P.F. who was assigned this post informed her, "the fire key wasn't where it is supposed to be." The fire key unlocks the box where the tool is secured. Officer D.C. radioed that information to Sgt. N.F. and the other officers. Officer D.S. who responded to the emergency call stated he immediately climbed to the top of Shehu's cell to untie the ligature from Shehu's neck. Officer D.S. stated that he was successfully able to untie the ligature from Shehu's neck as it was loose. Due to Officer D.S.'s expedited response, the emergency knife would not have been used even if it arrived at Shehu's cell. The inability of Officer P.F. to locate the fire box key was not a factor in Shehu's emergency care or death. However, Officer P.F. should have insured that the fire key was secured before assuming responsibility for "fire key" while relieving the evening officer. This is a violation of 9 NYCRR 7003.9 Key Control (b) which states:

> All keys used in a local correctional facility shall be maintained in a safe and secure area.

50. Officer D.S., along with Officers S.K., G.H. and Sgt. N.F., tried to open Shehu's cell gate but it would only open approximately six inches due to the sheet tied to the bars. Sgt. N.F. and Officer S.K. picked up Shehu's body. Officer D.S. was able to untie the

knot and removed the ligature. Officer S.K. stated that he assessed Shehu with no pulse or respirations and started CPR immediately. Sgt. N.F. retrieved the AED which was applied by Officer D.S. The AED reported "no shock advised, continue CPR." Officer S.K. continued CPR until the Penn Yan Volunteer Ambulance arrived.

51. [redacted] Suicide notes were left for his mother, father, and several friends.

52. In conducting this investigation, The Commission requested the policies and procedures addressing the jail-based mental health services provided by John Kelly Mental Services and Soldiers and Sailors Memorial Hospital. After a review, there is no articulated policy or procedure to release an inmate from constant supervision at the Yates County Jail. Additionally, the Soldiers and Sailors Memorial Hospital does not address in their contract with Yates County the expected number of psychiatrist (M.D.) hours at the jail. The supervision of the registered nurse for mental health services is stated as written in the contract as "Clinical supervision for behavior health services will be provided by Soldiers and Sailors Memorial Hospital staff." However, Dr. C.L., according to the security visitor log, was only present at the Yates County Jail three times from 5/18/10 to 8/20/10 and no visits were recorded from 10/9/10 to 10/30/10. One clinical encounter was for the completion of a CPL section 730.20 exam for Shehu. The registered nurse for mental health services functions with only nominal supervision, and without appreciable accountability or limitation on authority or autonomy. There is no independent record review of inmates' mental health care for quality improvement or assurance that the mental health care provided at the correctional facility to the inmates by the mental health clinical staff meets the community standard.

RECOMMENDATIONS:

TO THE NYS DEPARTMENT OF HEALTH, DIVISION OF CERTIFICATION AND SURVEILLANCE:

The Division should conduct an investigation into the quality of care afforded Aaron Shehu by the Soldiers and Sailors Memorial Hospital [redacted] The investigation

should include the hospital's compliance with the EMTALA (Emergency Medical Transfer and Labor Act), a federal law, [redacted] Additionally, the Division should investigate Soldiers and Sailors Memorial Hospital Emergency Department's unauthorized discharge of Aaron Shehu back to the Yates County Correctional Facility without documentation of an order made by a licensed physician or licensed physician's assistant. The Board respectfully requests that the Division advise it of its findings and subsequent action.

TO THE SOLDIERS AND SAILORS MEMORIAL HOSPITAL, JOHN KELLY BEHAVIORAL HEALTH SERVICES:

1. The Behavioral Health Services should revise its local mental health services agreement in the area of the frequency of board-certified psychiatrists completing actual patient encounters, examinations, and development of treatment plans for serious, treatment-resistant, persistently mentally ill patients at the Yates County Jail in accordance with Mental Hygiene Law §41.16. Additionally, attention should be given to the supervision, accountability, autonomy, mental health evaluations, and medical record documentation of the registered nurse (M.S.) employed at the Yates County Jail.

2. The Behavioral Health Services should revise its local mental health services agreement with special attention focused on the failure of the registered nurse to conduct a comprehensive mental health exam and risk assessment upon the discontinuance of constant supervision without a psychiatric evaluation or appropriate documentation. The Behavioral Health Services should submit the revision of its local service plan agreed upon with the Yates County Jail to the Office of Mental Health, Division of Forensic Services and the State Commission of Correction Medical Review Board by 12/31/11.

3. The Behavioral Health Services should conduct a quality improvement review of a sample of not less than twenty patient records containing documentation by Dr. C.L. of patient encounters at the Yates County Jail. This shall be completed with attention to psychiatric diagnoses and prescribing of appropriate psychotropic medications. The results of this study should be forwarded to the Office of Mental Health, Division of Forensic Services and the State Commission of Correction Medical Review Board by 12/31/11.

4. The Behavioral Health Services shall develop Forensic Mental Health Services policies and procedures which shall include core procedures for psychiatric evaluations, prioritization of clinician services, obtaining past histories of psychiatric treatment as outpatient and/or psychiatric hospitalization, admissions to state psychiatric hospitals, release of inmates placed on constant supervision, and

documentation requirements. The results of this policy development should be forwarded to the Office of Mental Health, Division of Forensic Services and the State Commission of Correction Medical Review Board by 12/31/11.

TO THE COMMISSION ON QUALITY OF CARE AND ADVOCACY FOR PERSONS WITH DISABILITIES:

1. The Commission should conduct an investigation into the whole history of the mental health evaluation and treatment of Aaron Shehu [redacted]

2. The Commission should conduct an inquiry into the out-patient mental health treatment given Aaron Shehu [redacted] The Commission should review S.G.'s, LCSW, [redacted] Additionally, the Commission should conduct an inquiry into the Tompkins County Mental Services' processing and triage of SPOA referrals.

3. The Commission should conduct an inquiry into the care, placement, delivery of services, and treatment of Aaron Shehu by OMRDD through the Broome County DDSO.

TO THE NYS EDUCATION DEPARTMENT, OFFICE OF THE PROFESSIONS:

1. That the Office of the Professions conduct an investigation into the professional conduct of A.T., Licensed Clinical Social Worker for malpractice, gross incompetence, gross negligence, and practicing outside the scope of LCSW [redacted]

2. That the Office of the Professions conduct an investigation into the professional conduct of M.S., Registered Nurse, for malpractice, gross incompetence, gross negligence, and failing to execute a physician's order in her nursing care with Aaron Shehu at the Yates County Correctional Facility.

TO THE SHERIFF OF YATES COUNTY:

That the Sheriff direct the Yates County Jail security staff to comply with 9 NYCRR §7003.9 entitled Key Control.

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 30th day of September, 2011.

Phyllis Harrison-Ross, M.D.
Commissioner

PHR:mj
10-M-158
6/11

cc: Mary Ellen Hennessy, Director, Division of Certification & Surveillance, NYS Department of Health
Dr. Jose Acevedo, President & CEO, Soldiers and Sailors Memorial Hospital
Roger Bearden, Chief Operating Officer, NYS Commission on Quality of Care & Advocacy for Persons with Disabilities

STATE OF NEW YORK • EXECUTIVE DEPARTMENT
STATE COMMISSION OF CORRECTION
80 WOLF ROAD, 4TH FLOOR
ALBANY, NY 12205-2670
(518) 485-2346
FAX (518) 485-2467

CHAIRMAN
Thomas A. Beilein

COMMISSIONER
Phyllis Harrison-Ross, M.D.

September 30, 2011

Sheriff Ronald Spike
Yates County Sheriff's Office
227 Main Street
Penn Yan, NY 14527

RE: Aaron Shehu 29079
DOD: 11/27/10
FAC: Yates CJ
MRB#: 10-M-158

Dear Sheriff Spike:

Attached please find the final report in the matter of the death of the above captioned individual. This report has been approved by the Medical Review Board and the Commission of Correction. Please be advised that this report will become available to the public pursuant to New York's Freedom of Information Law on October 7, 2011.

You should be aware that some of the medical and/or mental health information contained herein may be prohibited by law from secondary dissemination. Therefore, you should check with your county attorney or other legal advisor prior to releasing any information contained in this report or its attachments, if any.

If you have any questions, please do not hesitate to contact our office at (518) 485-2463.

Sincerely,

Phyllis Harrison-Ross, M.D.
Commissioner & Chairwoman
Medical Review Board

Attachment

cc: Mary Ellen Hennessy, Director, Division of Certification & Surveillance, NYS Department of Health
Dr. Jose Acevedo, President & CEO, Soldiers and Sailors Memorial Hospital
Roger Bearden, Chief Operating Officer, NYS Commission on Quality of Care & Advocacy for Persons with Disabilities

ANDREW M. CUOMO
GOVERNOR

STATE OF NEW YORK
COMMISSION ON QUALITY OF CARE AND ADVOCACY
FOR PERSONS WITH DISABILITIES
401 STATE STREET
SCHENECTADY, NEW YORK 12305-2397
1-800-624-4143 (Voice/TTY/Spanish)
www.cqc.ny.gov

ROGER BEARDEN
CHAIR
BRUCE BLOWER
PATRICIA OKONIEWSKI
MEMBERS

July 26, 2011

Phyllis Harrison-Ross
Commissioner & Chair
Medical Review Board
State Commission of Correction
80 Wolf Road, 4th floor
Albany, NY 12205-2670

RE: Aaron Shehu 29079
DOD: 11/27/10

Dear Commissioner Harrison-Ross:

We are in receipt of your referral and Preliminary Report regarding the death of Aaron Shehu, an inmate of the Yates County Jail. As you are aware, the Commission on Quality of Care and Advocacy has new responsibilities effective July 1, 2011 under the SHU Exclusion Law. We have prioritized our work to focus primarily on NYS Correctional Facilities and these responsibilities. As such, we are unable to conduct an investigation into Mr Shehu's mental health treatment at this time.

If you wish to discuss this matter further please call myself or Megan O'Connor-Hebert at 388-2884.

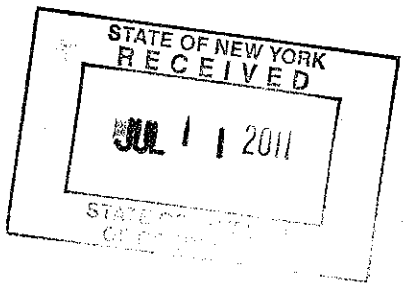
Sincerely,

Roger Bearden, Chair

NEW YORK
state department of
HEALTH

Nirav R. Shah, M.D., M.P.H.
Commissioner

Sue Kelly
Executive Deputy Commissioner



July 6, 2011

Phyllis Harrison-Ross, MD
State of New York - Executive Department
State Commission of Correction
80 Wolf Road - 4th Floor
Albany, NY 12205

Re: Soldiers And Sailors Memorial Hospital
Of Yates County, Inc.
Complaint #NY00103357

Dear Dr. Harrison-Ross:

The New York State Department of Health has received your complaint registered on July 6, 2011 against the above named facility.

All facilities must adhere to the Codes, Rules and Regulations of the State of New York and care rendered to patients is measured against these Codes to determine that an appropriate level of care has been rendered.

Professional staff in the regional office of the New York State Department of Health will consider the issues identified in your complaint, however, only those issues that are within the regulatory jurisdiction of the Department will undergo further review. The Department report of findings to you will indicate whether or not the facility fulfilled the requirements of the State Hospital Code based upon the concerns you raised. Please be advised that there are confidentiality statutes in place that relate to the release of certain types of information such as facility quality assurance actions, facility incident reports, and patient's personal identifiers.

If you have any additional information to share with the Department, you may contact the Western Regional Office (Rochester Area) directly at (585) 423-8053.

Sincerely,

Peter Farr
Health Program Administrator II
Division of Certification and Surveillance

Office of the
YATES COUNTY SHERIFF
RONALD G. SPIKE

Public Safety Building • 227 Main Street,
Penn Yan, New York 14527-1720
Telephone: 315-536-4438

Web site: www.yatescountysheriff.org
Email: sheriff@yatescounty.org

JOHN C. GLEASON
Undersheriff

HOWARD R. DAVIS, JR.
Chief Deputy

PHONES: (315) area code

Emergency	**911**
Fax	536-5191
Administration	536-5172
Animal Control	694-6077
Civil Division	536-5174
Court Security	536-5107
Criminal Division	536-5176
Dispatcher	536-4439
Jail Division	536-5175
Juvenile Division	536-5177
Marine Division	536-5526
P.S. Comm. Div.	531-3214
Records Division	536-5178
Tip Hotline	536-5558

July 22, 2011

Phyllis Harrison-Ross, M.D.
Commissioner & Chair Medical Review Board
NYS Commission of Correction
80 Wolf Road, 4th Floor
Albany, NY 12205-2670

RE: **Aaron Shehu 29079** DOD: November 27, 2010
FAC: Yates County Jail MRB#:10-M-158

Dear Dr. Ross:

Thank you for sending me the 30 page "Preliminary Report" of the NYS Commission of Correction in its death investigation of Aaron Shehu, an inmate at our jail. I appreciate the opportunity being afforded by the MRB for my review, comments or recommendations.

1. Greetings: This paragraph needs to be edited from indicating that custody was by the *Nassau County Sheriff etc.* and in fact at the time he was in the custody of the Yates County Sheriff at the Yates County Jail.
2. Findings:
   a. Items #1 through #34 no comment.
   b. Item #35. Given the revelations I now know as revealed in #34.... I comment that to the YCSO staff credit he was placed on constant supervision when returned to the jail although taken off later by RN.
   c. #36 through #48 no comment; and for #49 – see attached.
   d. #50 through #52 no comment.
   e. Misc. "To the" various entities – no comment
   f. Misc end of report – "To the Sheriff" – direct the YC Jail staff comply with 9 NYCRR 7003.9 – Key Control – see attached related to #49.

I again thank you for affording us the opportunity to have a confidential review of this preliminary report. Although we deeply regret the actions of Mr. Shehu in ending his life I am even more proud after reading this and becoming privy to information not previously known of the way the Yates County Sheriff's Corrections staff interacted and followed professional custodial procedures and beyond in looking out for his welfare and security while in our custody. The #49 "key" issues has relevancy in your report, but not as a contributing factor in his self initiated death or in our response to it. My comments in the attachment speak for themselves.

Sincerely,

Ronald G. Spike
Sheriff of Yates County

STATE OF NEW YORK
RECEIVED
JUL 25 2011
STATE COMMISSION
OF CORRECTION

ACCREDITED AGENCY

ATTACHMENT
LETTER TO NYS SCOC MRB#10-M-158 – AARON SHEHU

#49

When the MRB states: "Officer P.F. was assigned to directing her to call 911 and get the cut-down tool. Officer D.C. ran to get the cut down tool from the control room. Office P.F. who was assigned this post informed her, "the fire key wasn't where it is supposed to be." ....."Officer P.F. should have insured that the fire key was secured before assuming responsibility for the "fire key" while relieving the evening officer."

Section 9 NYCRR 7003.9 Key Control (b) states "All keys used in a local correctional facility shall be maintained in a safe and secure area."

1. It is the policy and practice of the Yates County Jail to keep the "key to the fire box" inside the safest and securest room/post in the facility [redacted]
2. >Indeed the Officer assigned to the post is required to insure that this key was secured.
3. Officer P.F. stated, [at approx 12:05AM] *"I opened 10A gate and went to get the fire key so I could get the override keys and the fire key was missing. Sgt. Freeland radioed for the knife to be sent down to E-Block and for me to call 911 for an ambulance. I radioed the Sergeant that the knife was missing. I called 911 to send an ambulance to the jail and told them we needed a knife because the fire key was missing. I then looked around over by the firebox and I found the key on the floor underneath the firebox. I took out the knife and the over-ride keys out but the knife was no longer needed."* [Officers' had already released him from the ligature around his neck].
4. >The fact is that Yates County 911 Dispatch's Computer Aided Dispatch records indicate a call from the jail control room post at 12:06:57AM requesting an ambulance. The Penn Yan Ambulance Corp located one block away was activated. They radioed enroute at 12:08:21AM and arrived at the jail at 12:08:55AM. Officer notes that she let the Ambulance into the jail garage at 12:09AM and EMT's on scene in the jail block at 12:10AM.
5. [redacted]
6. >There is no logic as to why the key would be underneath the firebox. I have personally been in the jail control room hundreds of times and the key is always [redacted] according to policy, not near the fire box. [redacted] The firebox key is the ONLY exception. [redacted] For the key to be underneath the fire box is illogical, but nevertheless the officer's statement is what it is as to where it was located.
7. >As the times indicate only a moment existed from the call for the knife to it not being necessary as officers' attending to Shehu quickly lifted him and manually took the ligature off his neck area. Even if the knife was taken to his cell block immediately it still would not have been used as it was not needed.

8. **<u>Major point</u>: "Key Control" -The inability of Officer P.F. for whatever reason to obtain the cut-down knife according to policy when alerted was not a factor in the removal of the ligature from Shehu, and not a factor in his first aid or his death. This is an important point that should be included in the report of the MRB. Thank you.**

9. Subsequent to this please know that for future insurance and accountability we are implementing a "<u>Control Shift Change Verifications</u>" form (see attached) to be completed whenever a shift change occurs at the Control Room post. It shall also state *"By completing and signing this form, you are verifying that all monitors, alarms, control panels and lockers are accounted for and are in working order. Log any discrepancies below and notify shift supervisor/OIC immediately."* This will insure that best practices are verified before the shift by the Control Room operator and insure key control.

CONTROL ROOM SHIFT CHANGE VERIFICATIONS

ON-COMING SHIFT: "A"_____ "B"_____ "C"_____ DATE: ___ / ___ / ___

GARAGE ALARM: _____

FIRE CONRTOL PANEL: _____

INMATE TELEPHONES: _____

ROOF ALARM: _____

PERIMETER FENCE ALARM: _____

KEY LOCKER: _____

COURTHOUSE FIRE ALARM: _____

FIRE KEYS: _____

SYSTEM CONTROL AND

ALARM PANEL _____

VIDEO MONITORS:

UNIT #1 _____

UNIT #2 _____

UNIT #3 _____

UNIT #4 _____

BY COMPLETING AND SIGNING THIS FORM, YOU ARE VERIFYING THAT ALL MONITORS, ALARMS, CONTROL PANELS AND LOCKERS ARE ACCOUNTED FOR AND ARE IN WORKING ORDER. LOG ANY DISCREPANCIES BELOW AND NOTIFY SHIFT SUPERVISOR / O.I.C. IMMEDIATELY.

_____

_____

_____

_____

_____

_____

_____

_____

OFF-GOING SHIFT:

_____ _____ DATE: ___ / ___ / ___ TIME: _____ AM PM

OFFICER SIGNATURE

ON-COMING SHIFT:

_____ _____ DATE: ___ / ___ / ___ TIME: _____ AM PM

SHIFT OFFICER SIGNATURE

SHIFT SUPERVISOR/ O.I.C.:

_____ _____ DATE: ___ / ___ / ___ TIME: _____ AM PM

SHIFT OFFICER SIGNATURE

FINAL APPROVAL BY CHIEF ADMINISTRATIVE OFFICER: _____

Soldiers & Sailors Memorial Hospital
418 North Main Street • Penn Yan, New York 14527 • (315) 531-2000

December 29, 2011

Phyllis Harrison-Ross, M.D.
Commissioner and Chairperson
Medical Review Board
State Commission of Correction
80 Wolf Road, 4th Floor
Albany, New York 12205

Dear Dr. Harrison-Ross:

Pursuant to the Commission's request pertaining to the recommendations on page twenty eight (28) in the final report, in the matter of the death of Aaron Shehu issued September 30, 2011, Soldiers and Sailors Memorial Hospital offers the following response regarding activities related to the recommendations.

On August 18, 2011 the New York State Department of Health (DOH) as authorized by the Department of Health and Human Services, Centers for Medicare and Medicaid Services conducted a complaint survey. The complaint alleged a violation of 42CFR 489.24, Responsibilities of Medicare Participating Hospitals in Emergency Cases and/or the related provisions of 42 CFR 489.20. On December 9, 2011, Jose Acevedo, M.D., President and CEO received notification from the Centers for Medicare and Medicaid Services confirming that as a result of the August 18, 2011 DOH survey, Soldiers and Sailors Memorial Hospital was "found in compliance with requirements regarding the emergency care obligations of Medicare facilities".

Soldiers and Sailors Memorial Hospital and the County of Yates, acting through its duly appointed Community Services Board represented by the Deputy Director of Community Services, have been in close communication and actively working together on the 2012 outpatient mental health services agreement. The mutually developed agreement has been submitted to the county for review.

The nurse who was contracted to provide services to the Yates County Jail at the time of the case voluntarily resigned to pursue other employment. Subsequently, the Yates County Jail hired a new registered nurse who is employed by the jail and accountable to the Jail Administrator and the Medical Director of the Yates County Jail Services. Soldiers and Sailors Memorial Hospital's John D. Kelly Behavioral Health continues to provide psychiatric consultation at the request of the Yates County Jail Services Medical Director.

Soldiers and Sailors Memorial Hospital's John D. Kelly Behavioral Health Services representatives, the Deputy Director of Community Services and the Jail Administrator met on September 9, October 27 and December 27, 2011 and will continue to meet on a quarterly basis to maintain collaborative relationships between the agencies. In the matter of the medical record review and development of policies and procedures, considering that the medical records and the policies and procedures are the property of the Yates County Jail, Soldiers and Sailors Memorial Hospital representatives offered to the Yates County Jail administrators names of professional experts who are qualified to conduct independent review of cases as an option to address the recommendation in the Commissions report.

Sincerely,

Eileen Gage, MA RN
Vice President / CNO

EG/lm

cc: Jose Acevedo, M.D., President & CEO

ABRAMS FENSTERMAN

Abrams, Fensterman, Fensterman, Eisman, Greenberg, Formato & Einiger, LLP

Attorneys at Law
www.abramslaw.com

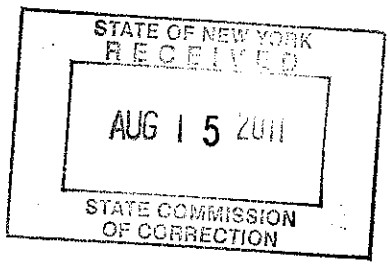
630 Third Avenue - 5th Floor
New York, New York 10017
Phone: 212-279-9200
Fax: 212-279-0600

500 Linden Oaks - Suite 110
Rochester, New York 14625
Phone: 585-218-9999
Fax: 585-218-0562
FAX NOT FOR LEGAL SERVICE

1111 Marcus Avenue - Suite 107
Lake Success, New York 11042
Phone: 516-328-2300
Fax: 516-328-6638

August 12, 2011

VIA FEDERAL EXPRESS



Phyllis Harrison-Ross, M.D.
Commissioner & Chair
Medical Review Board
State Commission of Correction
80 Wolf Road, 4th Floor
Albany, New York 12205-2346

RE: Aaron Shehu 29079
DOD: 11/27/10
FAC: Yates CJ
MRB#: 10-M-158
Response to June 24, 2011 Preliminary Report

Dear Dr. Harrison-Ross:

Enclosed please find the Response of Soldiers and Sailors Memorial Hospital to the June 24, 2011 Preliminary Report of the New York State Commission of Correction regarding the above-referenced matter. We respectfully request that the Commission of Correction Medical Review Board consider the Response and amend the preliminary report accordingly.

Thank you for allowing us additional time to research this important matter and prepare the Response for submission.

If you have any question or require additional information, please do not hesitate to contact me.

Very truly yours,

Richard T. Yarmel

Enclosure
cc: Jose Acevedo, M.D.

SOLDIERS AND SAILORS MEMORIAL HOSPITAL RESPONSE TO NEW YORK STATE COMMISSION OF CORRECTION MEDICAL REVIEW BOARD JUNE 24, 2011 PRELIMINARY REPORT [MRB#: 10-M-158] AUGUST 12, 2011

Preliminary Statement

Soldiers and Sailors Memorial Hospital ("SSMH") submits this Response to the June 24, 2011 Preliminary Report issued by the New York State Commission of Correction, Medical Review Board (the "Preliminary Report"), in order to clarify the facts and assumptions contained in the Preliminary Report. As will be demonstrated in this Response, although some of the errors contained in the Preliminary Report are minor in nature, others are of critical importance as they led to incorrect assumptions and findings which in turn resulted in unsupported conclusions and unnecessary recommendations. In fact, the following potentially devastating conclusions contained in the Preliminary Report were based on factual errors: that Aaron Shehu's suicide at the Yates County Jail ("Jail") in November 2010 "may have been prevented" had he "received adequate and appropriate mental health evaluation, treatment and case management from" SSMH; that violations of State and federal law occurred; that the professional conduct of social worker AT constituted "malpractice, gross incompetence, gross negligence, and practicing outside the scope of LCSW"; and that the professional conduct of Jail registered nurse MS ("Jail nurse MS") constituted "malpractice, gross incompetence, gross negligence, and failing to execute a physician's order." SSMH strongly believes that when the facts and incorrect assumptions surrounding the care and treatment provided to Aaron Shehu are corrected, the Medical Review Board will significantly revise its findings and recommendations.

I. Errors of Fact in Preliminary Report[1]

Greetings: "Whereas" paragraph incorrectly refers to "Nassau County Sheriff at the Nassau County Correctional Center."

1. SSMH was never responsible for providing "case management" services to the Jail. **[Attachment 1.]**

2. States Shehu was arrested on 5/17/10. Finding #21 states he was arrested on 5/18/10

4. Shehu was not "born on 9/25/94." He was born on 7/29/93.

19. "SPOA" is an abbreviation for Single Point of Access.

23. [redacted]

[1] References are to sections and Finding numbers in the Preliminary Report.

[redacted]

24. & 29. Jail policy does not require that Jail nurse MS contact the psychiatrist before a decision is made to remove an inmate from constant supervision status. **[Attachment 2.]** The Jail's Suicide Prevention Policy contains the Jail's "written plan for suicide prevention." The Procedure section of this Policy permits corrections officers to assess during the "receiving screening" an "inmate's potential for suicide" and, if the corrections officer determined that the inmate is at risk, "the nurse or a crisis worker" will be notified and "housing that affords suicide watch for the inmate will be arranged." Procedure 1.d. provides as follows:

> "Inmates who are assessed as being at risk for suicide at a later time by health service or correctional staff, will be relocated to a housing area that affords suicide watch." [Emphasis added.]

Correction officers and "health service staff" such as Jail nurse MS are, therefore, specifically authorized to initiate suicide watch.

Procedure 1.e. specifically authorizes a "mental health professional" (such as Jail nurse MS) other than a psychiatrist to evaluate inmates who are at risk for suicide. We note that Jail nurse MS is clearly a "mental health professional" given her extensive mental health training and experience and the fact she was originally hired to provide professional mental health services to Yates County under the 1/1/10-12/31/10 Contract between SSMH and Yates County. **[Attachment 3.]** Procedure 3.b. provides for assessment by a "Yates County Mental Health Professional" (i.e., Jail nurse MS) who is specifically authorized to order the level of suicide precautions. Finally, Procedure 4.d. provides as follows:

> "It is possible that an inmate who has been on constant watch could next be placed on less frequent checks and fin[ally] returned to checks when regular rounds are being made."

This procedure indicates that corrections officers or health service staff, such as Jail nurse MS, are authorized to discontinue the continuous or constant watch precaution and instead place the inmate on less frequent checks or regular rounds checks. There is no requirement in the Jail Suicide Prevention Policy that Jail nurse MS contact Dr. CL, psychiatrist, before such a determination is made. [redacted]

32. [redacted]

34. [redacted]

34. [redacted]

34. [redacted]

[redacted]

35. [redacted]

35. & 48. There is no Jail policy requiring that the FLH Admission Assessment Forms be completed at the Jail.

II. Errors in Assumptions in the Preliminary Report

A. Finding 52 of the Preliminary Report provides that "the policies and procedures addressing the jail-based mental health services provided by John Kelly Mental Services and Soldiers and Sailors Memorial Hospital" were reviewed and "there are no articulated policy or procedure to release an inmate from constant supervision at the Yates County Jail." The Preliminary Report Finding 52 further provides "There is no independent record review of inmates' mental health care for quality improvement or assurance that the mental health care provided at the correctional facility to the inmates by the mental health clinical staff meets the community standard." It is indicated throughout the Preliminary Report that the policies and procedures of SSMH are applicable to the Jail and that SSMH is responsible for creating and implementing Jail policies and procedures. This is an incorrect assumption. The Jail is not a clinic of SSMH or the John D. Kelly Clinic. The John D. Kelly Clinic does not have a satellite location at the Jail and forensic patients are not treated at the John D. Kelly Clinic. The services provided in the Jail are governed by the policies and procedures of the Jail and the statutes and regulations governing the Jail; not by the policies and procedures of SSMH, or regulations and statutes governing SSMH or its clinics which have been approved by the New York State Health Department. Any issues concerning Jail policies and procedures and forms, or quality reviews, need to be resolved by the Jail, not by SSMH. SSMH does not dictate the policies and procedures of and quality reviews performed at the Jail.

B. Dr. CL serves as a consultant to the Jail on an as needed basis. Dr. CL is not the attending physician for the inmates of the Jail.

C. The 1/1/10 – 12/31/10 Contract between Yates County and SSMH in place at the time of the 7/6/10 SSMH Emergency Department ("SSMH ED") visit provided for "Outpatient Mental Health Services." **[Attachment 3.]** There was no requirement in the Contract which was in effect [redacted] for any services to be provided by SSMH at the Jail. In fact, the Contract does not mention the Jail or forensic services.

D. In August 2010, the Contract was amended to require SSMH to provide "behavioral health services and medical care services" to the Jail. **[Attachment 1.]** The August 2010 Amendment provides "Clinical supervision for behavioral health services will be provided by Soldiers and Sailors hospital staff; supervision for medical care services will be provided by the physician at the Yates County Jail." This amendment, which was in effect from August 2010 through the date of Aaron Shehu's death in November 2010, only required SSMH "staff" to provide supervision of behavioral health services at the Jail. It did not require a physician to provide supervision of behavior health services in the Jail. This is in stark contrast to the requirement in the August 2010 amendment to the Contract which clearly states that medical care services be supervised by the physician at the Jail.

III. 7/6/10 SSMH ED Visit

[redacted]

AT received her MSW from SUNY Buffalo. She also worked as a hospital psychiatric technician for five years where she provided crisis intervention services to suicidal and

[2] Registered nurse/crisis counselor MS is referred to as "Lynn" in the "Emergency and Outpatient Department Continuation Sheet" contained in Attachment 6.

homicidal individuals; performed group, individual and family therapy; and participated in treatment team planning. She then served as a hospital primary therapist where she documented assessment data obtained from patient interviews, observation and other sources; assisted in the formulation of treatment plans; engaged in therapeutic relationships; and collaborated and communicated with primary care providers and multidisciplinary team members regarding patient care issues.

[redacted]

[redacted]

Once at the Jail, Aaron Shehu remained on constant supervision for almost four hours. He was then removed from constant supervision in accordance with Jail policy [redacted]

Jail nurse MS is extraordinarily qualified for her position at the Jail. MS earned a bachelors degree in social work from SUNY Brockport and has been a Registered Nurse for over 30 years. Jail nurse MS obtained her registered nursing degree from Willard Psychiatric Center School of Nursing and she has spent the majority of her career working with mentally ill inmates at Wayne Behavioral Health Network and Finger Lake Visiting Nurse, providing mental health evaluations, individual and supportive therapy and case management services. Jail nurse MS participated in developing and implementing a grant for provision of MICA services to inmates, she interfaced with the Public Defender's Office and other agencies to provide inmates with service linkage upon release, she supervised case managers in treatment planning for the continuation of mental health services upon inmate release and, in collaboration with a psychiatrist, she implemented a medication clinic for inmates to provide medication, symptom

management, and monitoring and assessment of medication effectiveness. Additionally, in 2003 Jail nurse MS completed the NYS Office of Mental Health/**NYS Commission of Correction**/Ulster County Department of Mental Health's "train the trainer" program for "Suicide Prevention Crisis Intervention in County Jails and Police Lockups." **[Attachment 8.]** She was, therefore, qualified to train corrections officers in suicide prevention and crisis intervention. Moreover, in 2005 she completed a NYS Office of Mental Health/**NYS Commission of Correction**/Ulster County Department of Mental Health's suicide prevention and crisis intervention "train the trainer" refresher program. **[Attachment 8.]** Furthermore, in 2009 she completed the **NYS Commission of Corrections** "Suicide Risk Assessment Training for Criminal Justice Mental Health Providers." **[Attachment 9.]** Finally, her resources in the Jail include the following: The Practical Art of Suicide Assessment, Shawn Christopher Shea, A Guide for Mental Health Professionals and Substance Abuse Counselors (2002) and How to Indentify Suicidal People, Thomas W. White, PhD., A Systematic Approach to Risk Assessment (1999).

The Preliminary Report further provides that SSMH "may be in violation of EMTALA." We strongly disagree. EMTALA requires a medical screening to determine whether an emergency medical condition ("EMC") exists, and then provides for restrictions on transfer and discharge unless the patient is stabilized. [redacted] Under the "State Operations Manual, Appendix V – Interpretive Guidelines – Responsibilities of Medicare Participating Hospital in Emergency Cases" it is proper for the medical screening examination and treatment to stabilize the patient to be performed by non-physician practitioners. **[Attachment 10.]** Additionally, "Interpretive Guidelines-Responsibilities of Medicare Hospitals in Emergency Cases" ("Guidelines"), which is used by reviewers when evaluating whether EMTALA has been followed, provide that in psychiatric emergencies, an individual would be considered to have an EMC if he is expressing suicidal thoughts and it is determined that he is dangerous to himself. **[Attachment 11.]** Finally, the Guidelines provide that a patient with a psychiatric EMC would be considered stable for discharge "when he/she is no longer considered to be a threat to him/herself or to others." **[Attachment 11.]** [redacted]

[redacted]

IV. 11/26/10

[redacted]

[redacted]

[redacted]

V. Recommendations

A. NYS Department of Health

[redacted]

[redacted]

B. SSMH, John Kelly Behavioral Health Services

1. Mental Hygiene Law Section 41.16 requires the "local government unit" to develop "local services plans" related to services for the mentally disabled. SSMH will be pleased to be involved in the planning process with the "local government unit" in accordance with Mental Hygiene Law Section 41.16(c). As was fully explained above in Section II.A. of this Response, the Jail is not an SSMH clinic. SSMH cannot mandate that the Jail develop and implement policies and procedures. Any recommendation to develop such policies and procedures should be directed towards the Jail.

2. This recommendation should be directed towards the Jail which is responsible for Jail quality improvement reviews.

3. This recommendation should be directed towards the Jail which is responsible for developing Jail policies and procedures.

C. Commission Quality of Care

1. The evaluation and treatment of Aaron Shehu on 7/6/10 was appropriate. [redacted]

2. Not Applicable to SSMH.

3. Not Applicable to SSMH.

D. NYS Department of Education

1. AT The factual basis for this recommendation for the Office of Professions to investigate AT's professional conduct is fatally flawed. [redacted]

[redacted] There is no basis for a recommendation to be made to the Office of Professions to investigate AT's professional conduct.

2. MS The conclusion that Jail nurse MS "failed to execute a physician's order" is without a factual basis. [redacted]

There is no Jail policy which requires MS to consult with a physician before releasing an inmate from constant supervision. Jail nurse MS acted in accordance with Jail policy (or the lack thereof) during the entire course of Aaron Shehu's incarceration. She provided appropriate care and follow-up repeatedly and in accordance with her license, extensive training and Jail policy. There is no basis for a recommendation to be made to the Office of Professions to investigate Jail nurse MS's professional conduct.

E. Sheriff of Yates County

The only recommendation specifically directed towards the Jail relates to Key Control. It should be considered (i) whether the video camera should have enabled the correctional officers to see Aaron Shehu tie a sheet through the bars of his cell (particularly when the video camera was able to record the other inmates taunting Aaron Shehu with knotted sheets); (ii) whether policies should be in place to prevent the taunting which took place; and (iii) whether Aaron Shehu should have been moved to another area of the Jail.

VI. Expert Review and Opinion of J. Richard Ciccone, MD, DFAPA

Dr. Ciccone is a preeminent board certified forensic psychiatrist. **[Attachment 15.]** As a member of the Medical Review Board of the Commission on Quality of Care, Dr. Ciccone was responsible for the review of deaths in public and private psychiatric facilities. After an extensive review of this case, which included interviews and a tour of the Jail including the cell in which Aaron Shehu committed suicide, he issued a report (**Attachment 7**) which contained the following conclusions:

1. "In my opinion, Soldiers and Sailors Hospital provided appropriate psychiatric care of Mr. Shehu during his visit to the Emergency Department on July 6, 2010.

[redacted]

2. [redacted]

3. "In my opinion, the care provided by Soldiers and Sailors Hospital to Mr. Shehu in November 2010 was appropriate. [redacted]

4. "In my opinion, the care provided by Soldiers and Sailors Memorial Hospital was not the proximate cause of Mr. Shehu's death. [redacted]

[redacted]

It is our understanding that Aaron Shehu may have attempted to call his family during the evening of November 26, 2010 and his call was not accepted. It raises the issue of whether this stressor when combined with the unrelenting taunting by the two juvenile inmates on either side of his cell, all of which occurred well after Aaron Shehu was seen by Jail nurse MS and determined to be stable, ultimately led to his suicide.

Conclusion

No one questions that Aaron Shehu's death was a tragedy. However, the care provided in the SSMH ED on July 6, 2010 was appropriate and played no role in his suicide almost five months later. [redacted]

For all of the reasons provided in this Response, SSMH respectfully requests that the State Commission of Correction Medical Review Board significantly revise the findings, conclusions and recommendations contained in its Preliminary Report.

AMENDMENT TO THE 2010 CONTRACT WITH SOLDIERS AND SAILORS HOSPITAL for clarification of registered nursing services to the Yates County Jail.

This Amendment is to the January 1, 2010 to December 31, 2010 contract that exists among the Yates County Legislature, the Yates County Department of Community Services, and Soldiers and Sailors Hospital having its principle offices at 418 N. Main St., Penn Yan, NY 14527. The Yates County Office of the Sheriff is added as a party to this contract. The Hospital will provide behavioral health services and medical care services to the Yates County Jail as per the established job description as is the current practice and has been in years past. Clinical supervision for behavioral health services will be provided by Soldiers and Sailors hospital staff; supervision for medical care services will be provided by the physician at the Yates County Jail. The services are provided by a registered professional nurse. There is no fiscal change to the existing contract.

YATES COUNTY LEGISLATURE

H. Taylor Fitch, Chair — Date: 8/26/10

SOLDIERS AND SAILORS HOSPITAL

Frank Korich, Vice President and Site Administrator — Date: 8/23/10

YATES COUNTY COMMUNITY SERVICES

Director/Designee — Date: 8-20-10

YATES COUNTY OFFICE OF THE SHERIFF

Ronald Spike, Sheriff — Date: 8-20-10

YATES COUNTY SHERIFF'S OFFICE CORRECTIONS BUREAU MEDICAL POLICY AND PROCEDURE MANUAL	CODE: CB-09-02-51 NUMBER: SUPERCEDES NR: NEW
SUBJECT: SUICIDE PREVENTION	PAGE 1 OF 4 PAGES DISTRIBUTION: ALL AUTHORIZED MANUALS

REFERENCES: NYSSA 157

AUTHORITY: _____ DATE: _____
SHERIFF RONALD G. SPIKE

POLICY:

THE HEALTH SERVICES WILL FOLLOW THE FACILITY'S WRITTEN PLAN FOR SUICIDE PREVENTION.

THE PLAN WILL INCLUDE, AT A MINIMUM, THE FOLLOWING COMPONENTS:

1. IDENTIFICATION
2. TRAINING
3. ASSESSMENT
4. MONITORING
5. HOUSING
6. REFERRAL
7. COMMUNICATION
8. INTERVENTION
9. NOTIFICATION
10. REPORTING
11. REVIEW
12. CRITICAL INCIDENT DEBRIEFING

EVERY EFFORT WILL BE MADE TO PREVENT SUICIDAL GESTURES AND ATTEMPTS IN THE FACILITY THROUGH CONSTANT SURVEILLANCE AND VIGILANT MONITORING ON THE PART OF ALL HEALTH SERVICE STAFF AND CORRECTIONAL OFFICERS.

PROCEDURE:

1. IDENTIFICATION: (SEE ATTACHMENT)
   a. THE RECEIVING SCREENING IS THE FIRST OPPORTUNITY FOR ASSESSING EACH INMATE'S POTENTIAL FOR SUICIDE BY ASKING SPECIFIC QUESTIONS REGARDING CURRENT SUICIDAL IDEATIONS AND HISTORY OF PREVIOUS ATTEMPTS.
   b. IF THE INMATE IS ASSESSED AS BEING AT RISK FOR SUICIDE, THE RECEIVING OFFICER WILL NOTIFY THE NURSE OR A CRISIS WORKER AS SOON AS POSSIBLE AND ARRANGE FOR HOUSING THAT AFFORD SUICIDE WATCH FOR THE INMATE.
   c. THE NURSE WILL FOLLOW-UP TO ENSURE THAT APPROPRIATE HOUSING AND WATCH HAVE BEEN INITIATED.
   d. INMATES WHO ARE ASSESSED AS BEING AT RISK FOR SUICIDE AT A LATER TIME BY HEALTH SERVICE OR CORRECTIONAL STAFF, WILL BE RELOCATED TO A HOUSING AREA THAT AFFORDS SUICIDE WATCH.

e. ALL INMATES WHO ARE IDENTIFIED AS BEING AT RISK FOR SUICIDE WILL BE REFERRED TO THE PSYCHIATRIST OR MENTAL HEALTH PROFESSIONAL FOR EVALUATION AT THE SOONEST POSSIBLE TIME.

2. TRAINING:
   a. HEALTH SERVICE STAFF AND CORRECTIONAL STAFF WILL BE TRAINED IN ALL ASPECTS OF SUICIDE PREVENTION INCLUDING THE KNOWLEDGE THAT AN INMATE IS PARTICULARLY SUSCEPTIBLE TO BECOMING SUICIDAL UPON ADMISSION, AFTER ADJUDICATION, UPON RETURN FROM COURT, FOLLOWING BAD NEWS ABOUT A FAMILY MEMBER OR SIGNIFICANT OTHER, AFTER SUFFERING FROM SOME TYPE OF HUMILIATION OR REJECTION AND WHEN PREVIOUS DEPRESSION APPEARS TO BE RECEDING.
   b. ALL MEMBERS WILL BE TRAINED REGARDING RECOGNITION OF VERBAL OR BEHAVIORAL SIGNS OF SUICIDE IDEATION DURING THEIR ORIENTATION PROGRAM. ADDITIONAL TRAINING WILL BE PROVIDED ANNUALLY.
   c. THE FOLLOWING SIGNS AND SYMPTOMS OF SUICIDE IDEATION SHOULD BE REVIEWED AT ALL TRAINING:
      1) DESPAIR/HOPELESSNESS
      2) POOR SELF IMAGE/FEELINGS OF INADEQUACY
      3) GREAT CONCERN REGARDING, "WHAT WILL HAPPEN TO ME?"
      4) PAST HISTORY OF SUICIDE ATTEMPT.
      5) VERBALIZATION OF A SUICIDE PLAN
      6) EXTREME RESTLESSNESS EXHIBITED BY SUCH BEHAVIOR AS CONTINUOUS PACING
      7) LOSS OF INTEREST IN PERSONAL HYGIENE AND DAILY ACTIVITIES
      8) VISITATION REFUSALS THAT PREVIOUSLY WERE ACCEPTED
      9) DEPRESSED STATE INDICATED BY CRYING, WITHDRAWAL, INSOMNIA, LETHARGY, INDIFFERENCE TO SURROUNDINGS AND OTHER PEOPLE
      10) SUDDEN DRASTIC CHANGE IN EATING OR SLEEPING HABITS
      11) HALLUCINATIONS, DELUSIONS OR OTHER MANIFESTATIONS OF LOSS OF TOUGH WITH REALITY
      12) SUDDEN, MARKED IMPROVEMENT IN MOOD FOLLOWING PERIOD OF OBVIOUS DEPRESSION
      13) WITHDRAWALS, UNDER THE INFLUENCE OF DRUGS/ALCOHOL

3. ASSESSMENT AND REFERRAL
   a. IMMEDIATELY FOLLOWING RECOGNITION THAT AN INMATE IS AT IMMINENT RISK FOR SUICIDE, PLACEMENT IN A HOUSING AREA THAT AFFORDS THE CLOSEST MONITORING, e.g. CONSTANT SURVEILLANCE, IS APPROPRIATE UNTIL THE INMATE CAN BE FURTHER ASSESSED BY THE YATES COUNTY HEALTH STAFF.
   b. UPON ASSESSMENT BY YATES COUNTY MENTAL HEALTH PROFESSIONAL, THE LEVEL OF SUICIDE PRECAUTIONS WILL BE ORDERED

4. MONITORING:
   THE TYPES OF SUICIDE PREVENTION WATCHES ARE AS FOLLOWS:
   a. SUICIDE WATCH - THIS WATCH CONSISTS OF THE INMATE BEING IN CONSTANT OBSERVATION OF A CORRECTIONAL OFFICER. IT IS GENERALLY RESERVED FOR INMATES WHO ARE IMMINENTLY AT RISK FOR SUICIDE OR SELF-INJURIOUS BEHAVIOR. RECENT, POTENTIALLY LETHAL SUICIDE ATTEMPTS WOULD WARRANT A CONTINUOUS WATCH.

b. SUPERVISION RECOMMENDED BY MEDICAL OR MENTAL HEALTH STAFF CONSISTING OF 5 TO 10 MINUTE INTERVALS DOCUMENTED IN WRITING IN THE LOGBOOK.
c. ACTIVE SUPERVISION CONSISTING OF 15 MINUTE CHECKS EVEN WHILE THE REST OF THE POPULATION IS ON 30 MINUTE CHECKS.
d. IT IS POSSIBLE THAT AN INMATE WHO HAS BEEN ON CONSTANT WATCH COULD NEXT BE PLACED ON LESS FREQUENT CHECKS AND FINELY RETURNED TO CHECKS WHEN REGULAR ROUNDS ARE BEING MADE.

5. HOUSING:
   a. MEDICAL STAFF WILL FOLLOW THIS FACILITY'S PLAN FOR WHERE THE INMATES ARE ON SUICIDAL PRECAUTIONS ARE TO BE HOUSED.
   b. ONCE THE INMATE HAS BEEN IDENTIFIED AS BEING AT RISK FOR SUICIDE, HE/SHE SHOULD NOT BE HOUSED OR LEFT ALONE.
   c. ROOMS/CELLS THAT ARE USED FOR SUICIDE WATCH SHOULD BE MADE AS SUICIDE PROOF AS POSSIBLE.

6. REFERRALS:
   ALL INMATES IDENTIFIED AS BEING SUICIDAL WILL BE EVALUATED BY A MENTAL HEALTH PROFESSIONAL AT THE EARLIEST POSSIBLE TIME. IF MENTAL HEALTH PROFESSIONALS DETERMINE THAT THE INMATE NEEDS TO BE TRANSFERRED TO A FORENSIC FACILITY FOR FURTHER TREATMENT, ARRAIGNMENTS WILL BE MADE THROUGH THE JOHN B. KELLY BEHAVIORAL HEALTH CENTER, S & S MEMORIAL HOSPITAL, AND THE AVAILABLE FORENSIC UNIT.

7. COMMUNICATION:
   DAILY COMMUNICATION MUST BE MADE BETWEEN THE DESIGNATED SERVICE STAFF AND CORRECTIONAL STAFF REGARDING THE STATUS OF ANY INMATE WHO IS ON SUICIDE PRECAUTIONS.

8. INTERVENTION:
   ANYTIME AN ACTUAL SUICIDE ATTEMPT IS IDENTIFIED, IT IS TREATED AS A MEDICAL EMERGENCY, AND HEALTH SERVICE PROFESSIONALS WILL RESPOND IMMEDIATELY. IN THE EVENT OF A HANGING ATTEMPT, THE BODY IS SUPPORTED WHILE THE INMATE IS GENTLY BROUGHT TO THE GROUND/FLOOR. AS WITH ANY OTHER MEDICAL EMERGENCY, THE ABC'S ARE OF THE UTMOST IMPORTANCE. EVERY EFFORT MUST BE MADE TO STABILIZE AND/OR RESUSCITATE A PATIENT WHO HAS ATTEMPTED SUICIDE WHILE EMERGENCY MEDICAL SUPPORT IS SUMMONED FOR IMMEDIATE TRANSPORT IF NECESSARY.

9. NOTIFICATION:
   THE FACILITY MEDICAL PROFESSIONAL (DOCTOR) IS NOTIFIED IMMEDIATELY AFTER THE ATTEMPTED SUICIDE.

10. REPORTING:
    THE MEDICAL PROFESSIONAL (DOCTOR) WILL PARTICIPATE IN COMPLETING ALL REPORTING ACTIVITIES SURROUNDING ANY SUICIDE ATTEMPT OR COMPLETION AS REQUIRED BY THE FACILITY.

11. REVIEW:
AS DEFINED IN THE FACILITY'S SUICIDE PLAN, APPROPRIATE HEALTH SERVICE PROFESSIONALS ALONG WITH THE DOCTOR, WILL PARTICIPATE IN REVIEW OF SUICIDES OR ATTEMPTED SUICIDES AT THE REQUEST OF THE FACILITY'S LIEUTENANT.

12. CRITICAL INCIDENT DEBRIEFING:
THE HEALTH ADMINISTRATOR WILL ENSURE THAT A DEBRIEFING WITH MENTAL HEALTH PROFESSIONALS PRESENT IS MADE AVAILABLE TO ALL HEALTH SERVICE STAFF WHO HAVE BEEN AFFECTED BY A SUICIDE OR SUICIDE ATTEMPT.

13. WHEN SITUATIONS ARISE WHICH ARE NOT COVERED BY SPECIFIC POLICIES AND PROCEDURES, ALL CO STAFF SHALL EXERCISE THEIR BEST JUDGEMENT IN THE LIMITATIONS OF THEIR RESPONSIBILITY FOR THE SAFETY AND SECURITY OF THE FACILITY, THE STAFF, INMATES, PUBLIC AND IN THE BEST INTEREST OF THE DEPARTMENT.

cc: Eileen
Deb DeMott
Linda Rowe

OUTPATIENT MENTAL HEALTH SERVICES AGREEMENT

This AGREEMENT, made the 1st day of January, 2010, between the County of Yates, a municipal corporation of the State of New York, having its principal office in Penn Yan, New York (hereinafter referred to as the County), and the ~~Finger Lakes Regional Health System~~/Soldiers and Sailors Memorial Hospital, having its principal office at 418 North Main St. in Penn Yan, New York 14527 (hereinafter referred to as the Hospital).

WITNESSETH

WHEREAS, the County, acting through its duly appointed Community Services Board and the Hospital, which has been furnishing Outpatient Mental Health Services (clinic and continuing day treatment, crisis, and case management) desire to make a written AGREEMENT relating to their operations; and

WHEREAS, the Hospital employs or contracts with individual providers for professional mental health services and is willing and able to provide such services; and

WHEREAS, the parties desire to arrange for the continuous availability of outpatient mental health services to the Yates County community;

NOW, THEREFORE, in consideration of the mutual covenants hereinafter set forth, it is mutually agreed by and between the parties as follows:

I. SCOPE

A. Appointment - County hereby agrees to retain and appoint the Hospital as an independent contractor and Hospital accepts such appointment and agrees to provide professional and administrative services for the mental health clinic, the Continuing Day Treatment Program, including Supportive Skills Training, Activity Therapy, Verbal Therapy, Crisis Intervention, and Clinical Support, the Clinic Treatment Program including Case Management, Crisis Intervention, and Clinical Support, and psychiatric consultation services in the school districts of Penn Yan, Marcus Whitman, Dundee, and the Wayne-Finger Lakes BOCES.

B. Legal Compliance - The Hospital will provide Programs in compliance with applicable federal and state statutes, rules, regulations, agency directives, accreditation requirements, ethical and professional standards and currently accepted and approved methods and practices of the mental health profession. In particular, services shall be provided in accordance with all provisions of the New York regulations specified in the Official Compilations of Codes, Rules, and Regulations of the State of New York (14 NYCRR) including, but not limited to Part 587/588 - Operation of Outpatient Programs for the Mentally Ill, as such regulations currently exist and are amended from time to time. These regulations address the areas of:

1. Certification
2. Organization and Administration
3. Program
4. Staffing
5. Quality Assurance
6. Program Evaluation, including client and family satisfaction

Measures
7. Utilization Review
8. Admission and Discharge Criteria
9. Treatment Planning
10. Discharge Planning
11. Records and Documentation
12. Requirements related to physical premises
13. Client Rights

II. HOSPITAL OBLIGATIONS

A. The Hospital hereby commits to a maintenance of effort with respect to outpatient mental health services. This includes retaining an adequate number and variety of staff to meet all obligations associated with the operation of outpatient mental health services. The Hospital will maintain at least the year 2009 level of clinic and continuing day treatment services to consumers and families.

B. The Hospital agrees to work closely with the Community Services Board (CSB) and the Director of Community Services (DCS). This includes:

1. Participation in the County planning processes.

2. Programmatic expansion or changes of services as identified by the Community Services Board or Hospital in response to identified needs seen in the community, given the availability of the necessary financial and human resources.

3. Regular sharing of co-relevant information with the DCS and the CSB, including information related to quality assurance and program evaluations.

4. Monthly statistics and reports for Programs servicing Yates County residents must be maintained by the Hospital. These statistics and reports include, but are not limited to, a copy of the monthly LS 3. Additionally,

a) Total enrollment for each program
b) Length of waiting list for each program
c) Number of non-Yates County residents enrolled in each program
d) Any programmatic changes

C. The Hospital will notify the DCS of all scheduled site visits, all unannounced visits when these occur, and will share all reports and plans of correction related to site visits with the DCS.

III. COUNTY OBLIGATIONS

The County's DCS will communicate on a regular basis with Hospital staff regarding programmatic aspects of the outpatient mental health programs. This includes sharing appropriate information received from state and regional regulatory agencies.

The DCS will conduct regular site visits, attend site reviews by licensing authorities, and review all correspondence related to site reviews. During site visits, or upon request, the DCS will have access to pertinent documentation relating to the function of outpatient mental health services, including, but not limited to, the minutes of Special Review Committee meetings.

The allocation is contingent on ongoing state funding support to Yates County. All state fiscal policies are to be utilized in the expenditure of these funds. Soldiers and Sailors intends to render the following mental health services to mental health recipients:

- Clinic $151,784.00
- Case Management $ 40,136.00
- Service Dollars $ 13,616.00
- Crisis Outreach $ 16,216.00
- Advocacy. $ 15,400.00
- Continuing Treatment $ 3,936.00
- Transportation $ 14.912.00

IV. TERM

This AGREEMENT shall become effective January 1, 2010 through December 31, 2010.

V. MISCELLANEOUS

A. Indemnification: Each party covenants to indemnify and hold the other harmless against all losses, damages, expenses, liabilities, and any other costs arising out of or incurred in connection with the other party's breach or default in performance of this AGREEMENT or arising out of the negligence or other unlawful malfeasance or nonfeasance by the other party or the other party's servants, agents, or employees in connection with the fulfillment of duties under this AGREEMENT.

A copy of the Hospital's Certificate of Insurance, and documentation that the County has been named as co-insured is attached to this contract.

B. Required Access to Records: Hospital agrees that, subject to the legality and applicability of Section 952 of the Omnibus Reconciliation Act of 1980 and implementing regulations:

1) Until the expiration of four years after the furnishing of services pursuant to the AGREEMENT, Hospital shall make available, upon written request, to an authorized federal official or representative, this AGREEMENT and books, documents, records of Hospital that are necessary to certify the nature and extent of costs incurred with respect to any services furnished for which payments may be made under the Medicare or Medicaid programs.

2) If the Hospital carries out any of the duties of this AGREEMENT through a subcontractor, having a value or cost of $10,000. or more over a twelve month period, with a related organization, such subcontract shall contain a clause to the effect that until the expiration of four years after the furnishing of such services pursuant to such subcontract, the related organization shall make available upon written request, to an authorized federal official or representative, this AGREEMENT and books, documents, records of Hospital that are necessary

to certify the nature and extent of costs incurred with respect to any services furnished for which payments may be made under the Medicare or Medicaid programs.

C. MISCELLANEOUS PROVISIONS:

1) If any provision of this AGREEMENT shall be or become invalid under any provision of federal, state, or local law, such invalidity shall not affect the validity or enforceability of any other provision hereof.

2) This AGREEMENT, including Appendix A, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Business Associate Agreement, sets forth the entire agreement between the parties with respect to the subject matter hereof, and no amendment, change, or modification shall be effective unless in writing and signed by the parties hereto.

3) Neither party may assign this AGREEMENT without the express written consent of the other.

4) The waiver of a breach of provision of this AGREEMENT by either party shall not operate or be construed as a waiver of any subsequent breach.

5) Unless otherwise specified, notices or consents required to be given by either party to the other under this AGREEMENT shall be in writing and personally delivered or sent by registered or certified mail, return receipt requested, to the undersigned representatives of the recipient at its address first stated above, or as changed pursuant to a notice served as prescribed by this paragraph. Such notices shall be deemed to be effective on the date when they are mailed or personally delivered.

6) Neither party is authorized to act as agent for the other or to incur any liability or dispose of any assets in the name of or on behalf of the other unless provided in this AGREEMENT or specifically authorized in writing by the party which would be responsible for this obligation.

7) This AGREEMENT may be terminated by either party, without cause, provided that thirty (30) days writtern notice be given to the other party.

IN WITNESS THEREOF, this AGREEMENT has been signed by the duly authorized officers of the respective parties.

FOR SOLDIERS AND SAILORS MEMORIAL HOSPITAL OF YATES COUNTY
418 North Main Street
Penn Yan, N.Y. 14527

By: F. Kenik Date 11/25/09
Administrator

FOR YATES COUNTY
417 Liberty Street
Penn Yan, N.Y. 14527

By: _____ Date 4/13/10
Chairman, Yates County Legislature

(SOLDIERS AND SAILORS AGREEMENT CONTINUED)

By: _____ Date 10-26-09
Director/Designee, Community Services

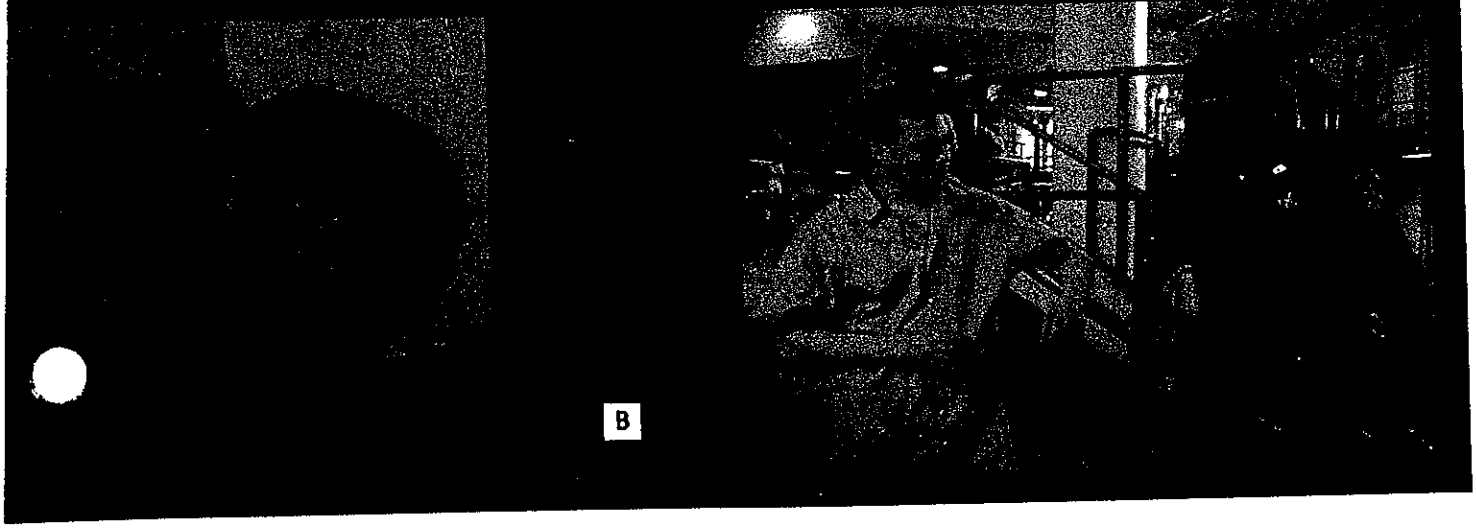
ide Prevention
risis Intervention
in County Jails
nd Police Lockups

BASIC PROGRAM TRAINER'S MANUAL

...York State
...Mental Health

...York State
...rtment of Correction

...County
...Mental Health



Suicide Prevention and Crisis Intervention in County Jails and Police Lockups

BASIC PROGRAM TRAINER'S MANUAL

NOVEMBER 2003

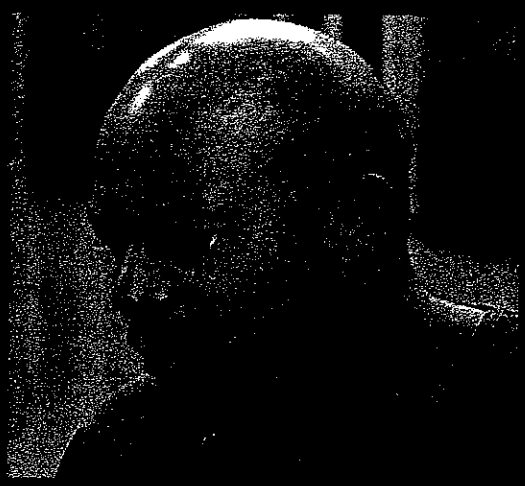
New York State Office of Mental Health

New York State Commission of Correction

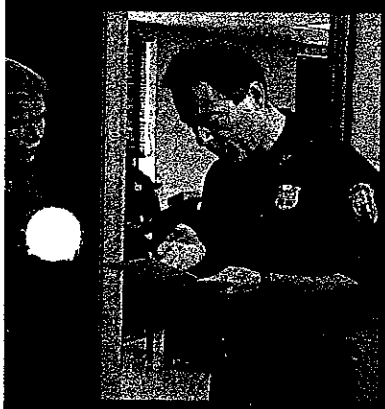
Ulster County Department of Mental Health

This training is intended to be implemented as one component of an overall program which should also, at a minimum, include the development of relevant policies and procedures addressing internal corrections or law enforcement operations, as well as coordination with mental health and/or medical services.

Suicide Prevention Crisis Intervention in County Jails and Police Lockups



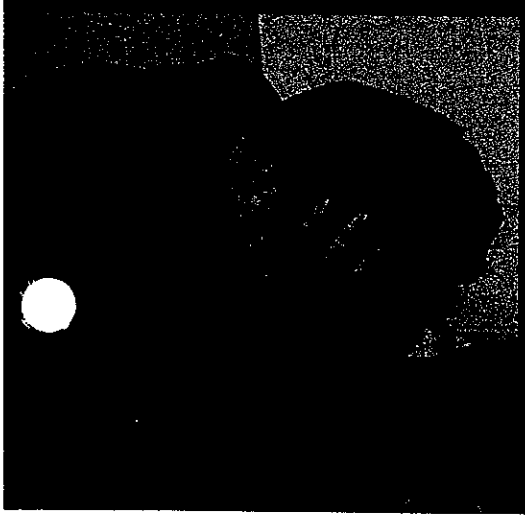
REFRESHER PROGRAM TRAINER'S MANUAL

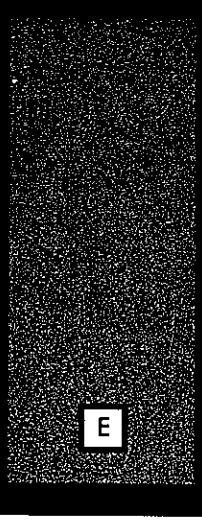


New York State
ffice of Mental Health

New York State
mmission of Correction

Ulster County
partment of Mental Health





Suicide Prevention and Crisis Intervention in County Jails and Police Lockups

REFRESHER PROGRAM TRAINER'S MANUAL

JANUARY 2003

New York State Office of Mental Health

New York State Commission of Correction

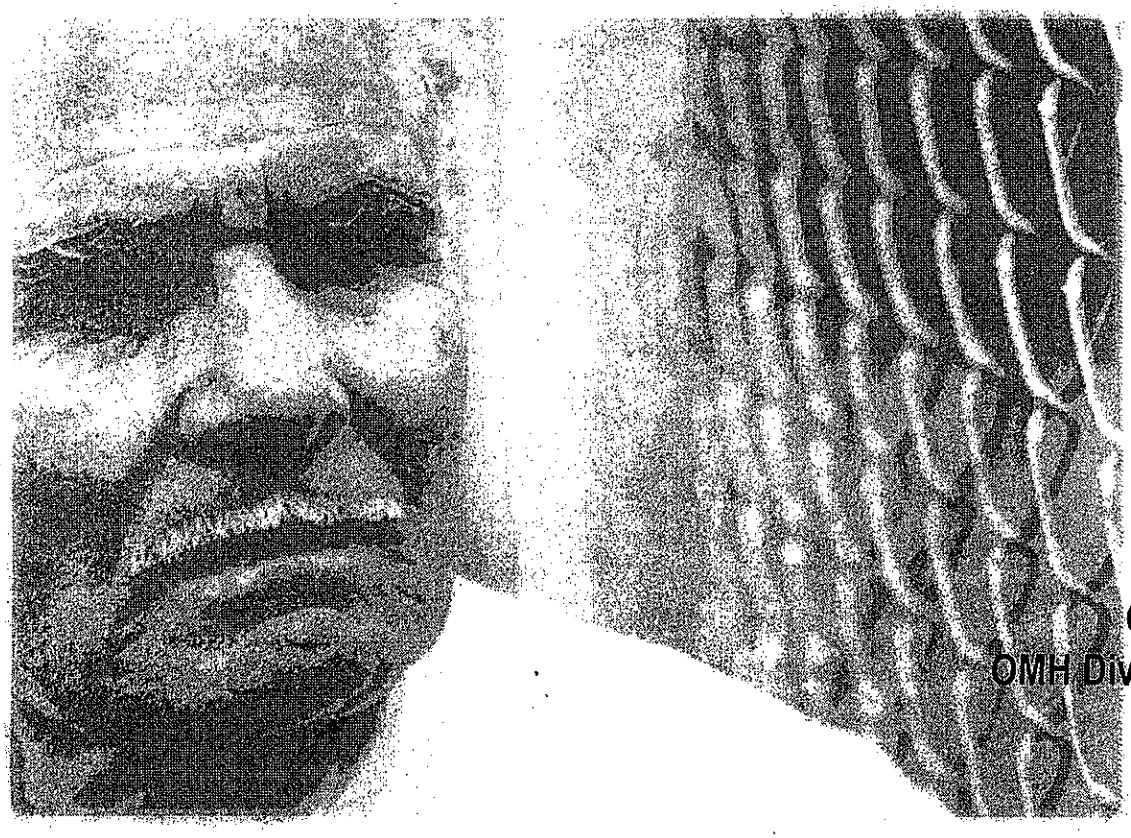
Ulster County Department of Mental Health

Revised 2003

This training is intended to be implemented as one component of an overall program which should also, at a minimum, include the development of relevant policies and procedures addressing internal corrections or law enforcement operations, as well as coordination with mental health and/or medical services.

Suicide Risk Assessment Training

for Criminal Justice Mental Health Providers



2009

NYS State Commission of Correction,
OMH Central New York Psychiatric Center ,
OMH Diversion, Re-entry, & Community Educ. Unit,
OMH Suicide Prevention Initiative

State Operations Manual

Appendix V – Interpretive Guidelines – Responsibilities of Medicare Participating Hospitals in Emergency Cases

(Rev. 60, 07-16-10)

Transmittals for Appendix V

Part I- Investigative Procedures

I. General Information

II. Principal Focus of Investigation

III. Task 1 - Entrance Conference

IV. Task 2 - Case Selection Methodology

V. Task 3- Record Review

VI. Task 4- Interviews

VII. Task 5-Exit Conference

VIII. Task 6- Professional Medical Review

IX. Task 7- Assessment of Compliance and Completion of the Deficiency Report

X. Additional Survey Report Documentation

Part II - Interpretive Guidelines - Responsibilities of Medicare Participating Hospitals in Emergency Cases

§489.20 Basic Section 1866 Commitments Relevant to Section 1867 Responsibilities

§489.20(l)

§489.20(m)

§489.20(q)

§489.20(r)

§489.24(j) Availability of On-Call physicians

§489.24 Special Responsibilities of Medicare Hospitals in Emergency Cases

§489.24(a) *Applicability of Provisions of this Section*

§489.24(c) Use of Dedicated Emergency Department for Nonemergency Services

§489.24(d) Necessary Stabilizing Treatment for Emergency Medical Conditions

§489.24(e) Restricting Transfer Until the Individual Is Stabilized

§489.24(f) Recipient Hospital Responsibilities

come to the hospital to examine the individual if requested to do so by the treating physician. If, however, it is medically indicated, the treating physician may send an individual needing the specialized services of the on-call physician to the physician's office if it is a provider-based part of the hospital (i.e., department of the hospital sharing the same CMS certification number as the hospital) It must be clear that this transport is not done for the convenience of the specialist but that there is a genuine medical reason to move the individual, that all individuals with the same medical condition, regardless of their ability to pay, are similarly moved to the specialist's office, and that the appropriate medical personnel accompany the individual to the office.

If it is permitted under the hospital's policies, an on-call physician has the option of sending a representative, i.e., directing a licensed non-physician practitioner as his or her representative to appear at the hospital and provide further assessment or stabilizing treatment to an individual. This determination should be based on the individual's medical need and the capabilities of the hospital and the applicable State scope of practice laws, hospital by-laws and rules and regulations. There are some circumstances in which the non-physician practitioner can provide the specialty treatment more expeditiously than the physician on-call. It is important to note, however, that the designated on-call physician is ultimately responsible for providing the necessary services to the individual in the DED, regardless of who makes the in-person appearance. Furthermore, in the event that the treating physician disagrees with the on-call physician's decision to send a representative and requests the actual appearance of the on-call physician, then the on-call physician is required under EMTALA to appear in person. Both the hospital and the on-call physician who fails or refuses to appear in a reasonable period of time may be subject to sanctions for violation of the EMTALA statutory requirements.

There is no EMTALA prohibition against the treating physician consulting on a case with another physician, who may or may not be on the hospital's on-call list, by telephone, video conferencing, transmission of test results, or any other means of communication. CMS is aware that it is increasingly common for hospitals to use telecommunications to exchange imaging studies, laboratory results, EKGs, real-time audio and video images of patients and/or other clinical information with a consulting physician not on the hospital's premises. Such practices may contribute to improved patient safety and efficiency of care. In some cases it may be understood by the hospitals and physicians who establish such remote consulting arrangements that the physician consultant is not available for an in-person assessment of the individual at the treating physician's hospital. However, if a physician:

- is on a hospital's on-call list;
- has been requested by the treating physician to appear at the hospital; and
- fails or refuses to appear within a reasonable period of time;

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
A406 (Cont.)	to determine whether or not an emergency medical condition exists.	"Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances, and/or symptoms of substance abuse) such that the absence of immediate medical attention could reasonably be expected to result in: o Placing the health of the individual (or, with respect to a pregnant woman, the health of a woman or her unborn child) in serious jeopardy; o Serious impairment to any bodily functions; o Serious dysfunction of any bodily organ or part; or o With respect to a pregnant woman who is having contractions: -- That there is inadequate time to effect a safe transfer to another hospital before delivery, or -- That the transfer may pose a threat to the health or safety of the woman or the unborn child. Psychiatric hospitals that provide emergency services are obligated under these regulations to respond within the limits of their capabilities. Some intoxicated individuals may meet the definition of "emergency medical condition" because the absence of medical treatment may place their health in serious jeopardy, result in serious impairment of bodily functions, or serious dysfunction of a bodily organ. Further, it is not unusual for intoxicated individuals to have unrecognized trauma. Likewise, an individual expressing suicidal or homicidal thoughts or gestures, if determined dangerous to self or others, would be considered to have an emergency medical condition.
A406 (Cont.)	The examinations must be conducted by individuals determined qualified by hospital bylaws or rules and regulations and who meet the requirements of §482.55 concerning emergency services personnel and direction.	This delegation should be set forth in a document approved by the governing body of the hospital. If the rules and regulations of the hospital are approved by the board of trustees or other governing body, those personnel qualified to perform these examinations may be set forth in the rules and regulations, instead of placing this information in the hospital by-laws. It is not acceptable for the hospital to allow informal personnel appointments that could frequently change.

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
A407 (Cont.)	for **FURTHER MEDICAL EXAMINATION AND TREATMENT** as required to stabilize the medical condition; or	If a physician is not physically present at the time of transfer, then qualified personnel (as determined by hospital bylaws or other board-approved documents) in consultation with a physician can determine if a patient is stable for transfer. The failure of a receiving facility to provide the care it maintained it could provide to the patient when the transfer was arranged, should not be construed to mean the patient's condition worsened as a result of the transfer. A patient is considered stable for discharge (vs. for transfer from one facility to a second facility) when, within reasonable clinical confidence, it is determined that the patient has reached the point where his/her continued care, including diagnostic work-up and/or treatment, could be reasonable performed as an outpatient or later as an inpatient, provided the patient is given a plan for appropriate follow-up care with the discharge instructions. For purposes of transferring a patient from one facility to a second facility, for psychiatric conditions, the patient is considered to be stable when he/she is protected and prevented from injuring himself/herself or others. For purposes of discharging a patient (other than for the purpose of transfer from one facility to a second facility), for psychiatric conditions, the patient is considered to be stable when he/she is no longer considered to be a threat to him/herself or to others. "Stable for transfer" or "Stable for discharge" does not require the final resolution of the emergency medical condition. Hospitals may not circumvent the requirements in §489.24 by admitting individuals with emergency medical conditions to other departments of the hospital and then discharging them prior to stabilization. These requirements apply to all areas of the hospital.
	(ii)For transfer of the individual to another medical facility in accordance with paragraph (d) of this section.	"Transfer" as defined in paragraph (b) of this section, means the movement (including the discharge) of an individual outside a hospital's facilities at the direction of any person employed by (or affiliated or associated, directly or indirectly, with) the hospital, but does not include such a movement of an individual who has been declared dead or leaves the facility without the permission of any such person. If discharge would result in the reasonable medical probability of material deterioration of the patient, the emergency medical condition should not be considered to have been stabilized. When a hospital has exhausted all of its capabilities in attempting to remove the emergency medical condition, it must effect an appropriate transfer of the individual. (See Tag A409)

Return to:

Page 1 of 2

New York State
Commission of Correction
80 Wolf Road, Albany, NY 12205

SCOC M187 6/05
(518) 485-2466 24 Hr On Call
(518) 485-2467 Fax machine

Report of Inmate Death to State Commission of Correction

Instructions: Call the on-call number to advise the Commission of the death within 6 hours of death.
Follow this up by sending a completed **Section I by facsimile within 6 hours of death.**
Section II must be completed and sent within 10 days of death (with a **copy of Part 1**).
Enter clinical summary on page 2, enter "DNA" if not applicable. Answer all questions, explain unavailable information.

Commission Use Only — Control # 10 M 158 — RI# JJ – 5701

Section I- REPORTING FACILITY, INMATE INFORMATION, CIRCUMSTANCES OF DEATH

1. Name of Reporting Facility: Yates County Jail — 1a Code: 05 01	17. Name of Inmate: Aaron J. Shehu
2. Name of Chief Administrative Officer: Lt. Clay D. Rugar	18. Date of Birth: 7/29/1993 — 19. Height: 5 ' 10" — 20. Weight: 196
3. Name of Hospital: ~~Soldiers & Sailors Memorial~~	21. Race: Blck — 22. Sex: m — 23. Inmate #: 29079 — NYSID #:
4. Name of Reporting Official: ~~Lt. Clay D. Rugar~~	24. Date of Death: 11/27/10 — 24a. Time of Death: 1:15 AM
5. Telephone: 315 536 5175	25. Assigned Housing Unit: E Blockcell 18 — 25 a. Housing Unit type: GH
6. Name of Ambulance/Rescue Squad: ~~Penn Yan~~ Volunteer Amb. Corps	26. Location of Terminal Incident: 227 Main St Penn Yan Ny 14837
7. Date and Time Admitted: 5/18/10 12:20 am	27. Supervision Immediately Prior to Incident: General (x) Active ( ) Constant ( )
8. Date of Arrest: 5/17/10 — 9. Arrest Charge(s): Grand Larc/ Crim Misch	28. History of substance abuse: (check all that apply) Drugs ( ) Alcohol ( ) None (xx) Unknown ( )
10. Date Convicted: N/A — 11. Conviction Charge(s): N/A	29. What type of treatment was inmate under? see page 2 — Medical ( ) Psychiatric (x) None ( )
12. Sentence: N/A — 13. Date of Sentence: N/A	30. Date of last Contact: Medical — Psychiatric [redacted]
14. Intake screening done? Yes (x) score 5 No ( )	31. Officer Supervising Death Location: C.O. Marcuss Mallett
15. Date of Last Admission: ~~5/18/10~~	
16. Witnesses — Staff/Inmate/Other? a ~~Todd Blauvelt~~ ~~Inmate~~ b c	32. Date of this report: 11/27/10

33a. Reported Immediate Cause of Death: Unkown at this time

33 b. Due To or As a Result Of: Suicide by hanging

34 Facility Administrator's Report of Circumstances of Death

Inmate Found hanging in his cell at00:07. Inmate was taken down and CPR and the AED were deployed. Ambulace arrived at 00:12 and took over life saving measures. Inmate pronounced dead at 1:15 at Hospital.

35. Autopsy Performed? (MANDATORY) Yes ( ) Date ______ Time ______ No ( ) Ordered

36. Autopsy: Location

Name of Medical Examiner or Coroner: Douglas Marchionda, Jr.

Create: Suicide See attached memo

YATES COUNTY PROBATION DEPARTMENT

415 Liberty Street
Suite 126
Penn Yan, New York 14527
(315) 536-5155
fax 536-5508

Sharon A. H. Dawes
Probation Director

May 19, 2010

Hon. John Symonds
Town of Milo Court
137 Main Street
Penn Yan, NY 14527

Re: AARON J. SHEHU
DOB: 07/29/1993

Dear Justice Symonds:

This letter is to inform you that I met with the above-named individual on May 19, 2010 for a pre-trial release interview. I was able to verify all the information that he provided and spoke with his (adoptive) mother, Nancy Shehu.

According to the point scale, Aaron J. Shehu does qualify for the pre-trial release program. However, despite his technical qualification for pre-trial release, his mother expressed great concern that if he were to be released from jail he would try to abscond. His mother stated that he has similar pending charges in Tompkins County Court and has tried to run away twice in the last two weeks. Mrs. Shehu also stated that Aaron has mental issues and he was recently discharged from the "psych ward" due to suicide threats.

Although Aaron Shehu does qualify for pre-trial release according to the point scale, further discussion with his mother reveals that he would not be an ideal candidate for release due to his flight risk and mental state.

Please let me know your decision with Mr. Shehu.

Should you have any questions please feel free to contact me at any time.

Tanya M. Hubbard
Probation Assistant

Cc: Alison Connor, Ed Brockman

Form 330 ADM (CC) (4/01)

State of New York
COMMISSION OF CORRECTION
Office of Mental Health

SUICIDE PREVENTION SCREENING GUIDELINES

DETAINEE'S NAME	SEX	DATE OF BIRTH	MOST SERIOUS CHARGE(S)	DATE	TIME
SHEHU, AARON	M	7/29/93	GRAND LARCENY	6/13/10	8:25

NAME OF FACILITY	NAME OF SCREENING OFFICER	*Detainee showed serious psychiatric problems during prior incarceration*
YCSO - JAIL	C. C. BATES	YES ____ NO ____

Check appropriate column for each question

	Column A YES	Column B NO	General Comments/Observations All "YES" Responses Require Note to Document
OBSERVATIONS OF ARRESTING/TRANSPORTING OFFICER			
1. Arresting or transporting officer believes that detainee may be a suicide risk. **If YES, notify supervisor.**			
PERSONAL DATA			
2. Detainee lacks support of family or friends in the community.	✓ No Family Friends		
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).		✓	
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 job).		✓	
5. Detainee's family member or significant other (spouse, parent, close friend, lover) has attempted or committed suicide.	✓		GRANDFATHER 2 YRS AGO
6. Detainee has history of drug or alcohol abuse. (Note drug and when last used.)		✓	
7. Detainee has history of counseling or mental health evaluation/treatment. (Note current psychotropic medications and name of most recent treatment agency.)	✓		DR DURLON MONTH AGO ±
8. Detainee expresses extreme embarrassment, shame, or feelings of humiliation as result of charge/incarceration (consider detainee's position in community and shocking nature of crime). **If YES, notify supervisor.**		✓	
9. Detainee is thinking about killing himself. **If YES, notify supervisor.**		✓	
10a. Detainee has previous suicide attempt. (Explore method and check for scars.)	✓		MONTH AGO
b. Attempt occurred within last month. **If YES, notify supervisor.**	✓		
11. Detainee is expressing feelings of hopelessness (nothing to look forward to). **If YES, notify supervisor.**	✓		NOTHING TO LOOK FORWARD TO
12. This is detainee's first incarceration in lockup/jail.	✓		
BEHAVIOR/APPEARANCE			
13. Detainee shows signs of depression (e.g., crying, emotional flatness).	✓		CALM
14. Detainee appears overly anxious, panicked, afraid or angry.		✓	
15. Detainee is acting and/or talking in a strange manner (e.g., cannot focus attention; hearing or seeing things which are not there).		✓	
16a. Detainee is apparently under the influence of alcohol or drugs.		✓	
b. If YES, is detainee incoherent, or showing signs of withdrawal or mental illness? **If YES to both a & b, notify supervisor.**		✓	

TOTAL Column A 8

Officer's Comments / Impressions

CALM BUT DOESNT WISH TO HARM HIMSELF

ACTION

If total checks in Column A are 8 or more, or any shaded box is checked, or if you feel it is necessary, notify supervisor and institute constant watch.

Supervisor Notified: YES ✓ NO ____

Constant Supervision Instituted: YES ✓ NO ____

Detainee Referred to Medical / Mental Health:	EMERGENCY	NON-EMERGENCY
YES ____ NO ____ If YES:	medical ____	medical ____
	mental health ____	mental health ____

Signature and Badge Number of Screening Officer: [signature] 3402

Medical / Mental Health Personnel Actions: (To be completed by medical / MH staff)

Over

Jail Supplement Report

Ph. 315-536-5175
RONALD G. SPIKE
Sheriff

1 ☐ CONTINUATION OF INCIDENT REPORT ☐ INFORMATION REPORT

2. INMATE NAME(IF APPLICABLE)	DATE	PAGE #
SHEHU, AARON	6/12/2010	1

3	CR #	OTHER #
☑ LOCAL ☐ BOARDER		

4. INCIDENT DATE/TIME	5. JAIL LOCATION OF INCIDENT
6/12/2010 10:00PM	BOOKING

6. OTHER INMATES INVOLVED	7. INJURIES	8. PROPERTY DAMAGE	9. PHYSICAL FORCE USED
☐ YES ☑ NO	☐ YES ☑ NO	☐ YES ☑ NO	☐ YES ☑ NO

10. REPORTING OFFICER ON INCIDENT REPORT	11. OFFICERS INVOLVED	12. ON DUTY SUPERVISOR
	Sgt. Neil Freeland, C.O. B. Freeland	Sgt. Neil Freeland

13. NARRATIVE:

On the above date and time Inmate Aaron Shehu told dorm officer B. Freeland that he was not doing well and needed to see Monica as soon as possible. C.O. B. Freeland called me Sgt. Neil Freeland in booking to inform me of his problem so I had him sent up to booking to talk with him at which time he informed me everyone in his family hated him and he had chewed a pencil to a jagged edge to cut thru his wrists. I asked him what talking to Monica would do and he said she could increase his meds so he could use them to kill himself "save them up and take all at once". I had Shehu's property in the dorm packed up and placed Inmate Shehu on constant watch in M-39.

14. REPORTING OFFICER	15. DATE/TIME SUBMITTED	16. REVIEWING SUPERVISOR SIGNATURE
Sgt Neil Freeland	6/12/10 @ 10:20 PM	Sgt. Neil Freeland

IN IT: White Original - Hearing Officer Yellow Copy - Sheriff/Undersheriff Pink Copy - C/Lieut. Goldenrod Copy - Inmate File Make Copy for post

INFORMATION: White Original - Shift Supervisor Yellow Copy - Sheriff/Undersheriff Pink Copy - C/Lieut. Goldenrod Copy - Downposts

Y.C.S.O. (8/93)

I7/10-2

Jail Supplement Report

CORRECTIONS OFFICE OF SHERIFF YATES COUNTY

Penn Yan, NY 14527
Ph. 315-536-5175

RONALD G. SPIKE
Sheriff

1. ☐ CONTINUATION OF INCIDENT REPORT ☒ INFORMATION REPORT

2. INMATE NAME (IF APPLICABLE)	DATE	PAGE #
SHEHU, AARON 10-161	07/05/2010	1 of 1
3. ☒ LOCAL ☐ BOARDER	CR# 10-171	OTHER #
4. INCIDENT DATE/TIME 07/05/2010 1240 pm	**5. JAIL LOCATION OF INCIDENT** G Block Cell 25	

6. OTHER INMATES INVOLVED	7. INJURIES	8. PROPERTY DAMAGE	9. PHYSICAL FORCE USED
☒ YES ☐ NO	☐ YES ☒ NO	☐ YES ☒ NO	☐ YES ☒ NO

10. REPORTING OFFICER ON INCIDENT REPORT	11. OFFICERS INVOLVED	12. ON DUTY SUPERVISOR
CO Hasting	CO's Hasting, Dougherty, Whitford	O.I.C. Whitford

13. NARRATIVE:

WHILE PLACING INMATE SHEHU IN M39, HE STATED, "YOU CAN TAKE EVERYTHING IF YOU WANT TO, BUT I'm STILL GOING TO KILL MYSELF AND YOU CAN'T STOP ME." AFTER PLACING HIM IN HIS CELL, INMATE SHEHU WAS ATTEMPTING TO BITE HIS WRIST. I CALLED FOR ASSISTANCE AND CO's DOUGHERTY, WHITFORD AND LERCH RESPONDED. INMATE WAS TOLD IF HE CONTINUED, HE WOULD BE PLACED IN RESTRAINTS. HE THEN BECAME QUIET AND STOPPED THE AFORE MENTIONED BEHAVIOR. THIS OFFICER SAT WATCH WITH HIM UNTIL HE WAS TRANSPORTED BY OFFICERS SCOTT AND LERCH FOR EVALUATION, AT APPROXIMATELY 1055 AM END OF REPORT

14. REPORTING OFFICER SIGNATURE	15. DATE/TIME SUBMITTED	16. REVIEWING SUPERVISOR SIGNATURE
3033	07/06/2010 115 AM	O.I.C.

INCIDENT: White Original - Hearing Officer Yellow Copy - Sheriff/Undersheriff Pink Copy - C/Lieut. Goldenrod Copy - Inmate File Make copy for posts

INFORMATION: White Original - Shift Supervisor Yellow Copy - Sheriff/Undersheriff Pink Copy - C/Lieut. Goldenrod Copy - Downposts

Y.C.S.O. (8/93)

I 7/10-2

Jail Supplement Report

CORRECTIONS OFFICE OF SHERIFF YATES COUNTY

Penn Yan, NY 14527
Ph. 315-536-5175

RONALD G. SPIKE
Sheriff

1. ☐ CONTINUATION OF INCIDENT REPORT ☒ INFORMATION REPORT

2. INMATE NAME (IF APPLICABLE)	DATE	PAGE #
Nacon Sheku	7/16/10	1
3. ☒ LOCAL ☐ BOARDER	CR# 10-171	OTHER #
4. INCIDENT DATE/TIME 7/5/10 11:35pm	5. JAIL LOCATION OF INCIDENT 2-Block 6-25	
6. OTHER INMATES INVOLVED ☐ YES ☒ NO	7. INJURIES ☐ YES ☒ NO	8. PROPERTY DAMAGE ☐ YES ☒ NO
		9. PHYSICAL FORCE USED ☐ YES ☒ NO

10. REPORTING OFFICER ON INCIDENT REPORT	11. OFFICERS INVOLVED	12. ON DUTY SUPERVISOR
Glen Hasting	Hasting, Dougherty, Whitford	O.I.C. P. Whitford

13. NARRATIVE:

On the above date and time C.O. Glen Hasting reported to me he was concerned about Inmate Nacon Sheku. I talked to Inmate Sheku in the LCR. Inmate Sheku said his life was over and he would kill himself and no one would stop him this time. I did a suicide screening on him he scored a nine and refused to answer the questions. I placed him on constant watch. I tried calling Sgt. Dillon, Sgt. Lidley and Lt. Rugar, Lt. Rugar told me to call E.R. and see if they would see him. I did and they said to bring him in.

Inmate Sheku stated he would not talk to the nurse in the morning because she doesn't take him serious. He also stated he had to be evaluated by two doctors before the 15th of July and he wasn't going back to a mental hospital No matter what.

Inmate Sheku was transported to Soldiers and Sailors Hospital at around 12:55AM by C.O.'s Leech and Scott.

End of Report.

14. REPORTING OFFICER SIGNATURE	15. DATE/TIME SUBMITTED	16. REVIEWING SUPERVISOR SIGNATURE
Pamela B. Dougherty	7/16/10 1:23 AM	SGT. [illegible]

INCIDENT: White Original - Hearing Officer Yellow Copy - Sheriff/Undersheriff Pink Copy - C/Lieut. Goldenrod Copy - Inmate File Make copy for posts

INFORMATION: White Original - Shift Supervisor Yellow Copy - Sheriff/Undersheriff Pink Copy - C/Lieut. Goldenrod Copy - Downposts

Y.C.S.O. (8/93)

my funeral plans

place	people	date
freedom village	harley Luje Lewis Cunningham ~~[illegible]~~ ~~[illegible]~~ missy-pastor mark & wife. robin & nick ~~Art~~- cory, catlina & terry [illegible]	1993- 7-2-10

Found in Shehu's cell on 7/5/10 "My Funeral plans

I7/10-2

Jail Incident Report

CORRECTIONS OFFICE OF SHERIFF YATES COUNTY N.Y.

Penn Yan, NY 14527
Ph. 315-536-5175

RONALD G. SPIKE
Sheriff

INMATE NAME	I.D. #	DATE	CR #
SHEHU, AARON	10-161	07/05/2010	10-171

SEX	RACE	AGE	HOUSING LOCATION	AC or DC	CR # (if crime)
M		16	G 25		

COMMITMENT OFFENSE	LOCAL or BOARDED	IF BOARDED, WHAT CO. OR AGENCY
Grand Lar. 4th	LOCAL	

INMATE'S ACTIONS: PHYSICAL RESISTANCE ☐ OTHER INMATE CONTACT ☐ VERBAL ABUSE ☐

OTHER INMATES INVOLVED - NAMES: SANFORD (G26) AND REXFORD (G27)

INJURIES TO:	PROPERTY DAMAGE TO:
NONE	NONE

INCIDENT DATE	TIME	INCIDENT LOCATION	OFFICERS INVOLVED
07/05/2010	11 35 PM	G BLOCK	CO HASTING, DOUGHERTY, WHITFORD

RULES VIOLATED

PHYSICAL FORCE USED BY C.O. ☐ YES ☒ NO

NARRATIVE:

WHILE DOING MY 11:30 PM ROUND, THIS OFFICER WAS ALERTED BY INMATES SANFORD (G26) AND REXFORD (G27) THAT INMATE SHEHU WAS MAKING CHOKING SOUNDS, I OBSERVED INMATE SHEHU IN HIS BUNK WITH HIS HEAD COVERED, I ASKED HIM IF HE WAS ALRIGHT AND HE RESPONSED YES, IN WHAT THIS OFFICER FELT WAS AN ANGRY TONE.

I PROCEEDED TO BOOKING AND REPORTED THE ABOVE TO O.I.C. WHITFORD. SHE INSTRUCTED OFFICER DOUGHERTY AND MYSELF TO ENTER G BLOCK AND VERIFY INMATE'S CONDITION. SHEHU APPEARED ANGRY. CONTACTED O.I.C. WHITFORD. AFTER SUICIDE SCREENING, O.I.C. WHITFORD ORDERED INMATE SHEHU PLACED ON 5TH SIGHT CONSTANT WATCH IN CELL M39. CO DOUGHERTY AND MYSELF ESCORTED SHEHU TO M39 AND PLACED HIM ON WATCH. END OF REPORT

PAST HISTORY:

WAS PLACED ON WATCH UPON INITIALLY ARRIVING AT THIS FACILITY.

LOCK IN -	LOCK IN HOURS	HEARING REQUESTED	OTHER PRE-HEARING DISCIPLINE
☐ YES ☒ NO	—	☐ YES ☒ NO	

OFFICERS ACTION:

REMARKS:

REPORTING OFFICER	DATE/TIME SUBMITTED	ON DUTY SUPERVISOR
	07/06/2010 1:15 PM	O.I.C. WHITFORD

OFFICER RELEASING INMATE FROM LOCK-IN	DATE/TIME	SUPERVISING OFFICER

WHITE ORIGINAL: HEARING OFFICER YELLOW COPY: SHERIFF PINK COPY: JAIL ADMIN. GOLDENROD COPY: INMATE FILE MAKE COPY FOR POSTS

Y.C.S.O. (4/93)

Form 330 ADM (CC) (4/01)

State of New York
COMMISSION OF CORRECTION
Office of Mental Health

SUICIDE PREVENTION SCREENING GUIDELINES

DETAINEE'S NAME	SEX	DATE OF BIRTH	MOST SERIOUS CHARGE(S)	DATE	TIME
Shehu, Aaron T	M	7/29/93	Grand Larceny 4th	7/5/10	11:52 PM

NAME OF FACILITY	NAME OF SCREENING OFFICER	*Detainee showed serious psychiatric problems during prior incarceration*
Yates Co. Jail	Pamela Whitford	YES ____ NO ____

Check appropriate column for each question

	Column A YES	Column B NO	General Comments/Observations All "YES" Responses Require Note to Document
OBSERVATIONS OF ARRESTING/TRANSPORTING OFFICER			
1. Arresting or transporting officer believes that detainee may be a suicide risk. **If YES, notify supervisor.**		X	
PERSONAL DATA	No Family Friends		
2. Detainee lacks support of family or friends in the community.	X		their cama once
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).	X		Family Hates me
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 job).	X		
5. Detainee's family member or significant other (spouse, parent, close friend, lover) has attempted or committed suicide:			RTA
6. Detainee has history of drug or alcohol abuse. (Note drug and when last used.)			RTA
7. Detainee has history of counseling or mental health evaluation/treatment. (Note current psychotropic medications and name of most recent treatment agency.)	X		
8. Detainee expresses extreme embarrassment, shame, or feelings of humiliation as result of charge/incarceration (consider detainee's position in community and shocking nature of crime). **If YES, notify supervisor.**			RTA
9. Detainee is thinking about killing himself. **If YES, notify supervisor.**	X		I will kill myself No matter what
10a. Detainee has previous suicide attempt. (Explore method and check for scars.)	X		
b. Attempt occurred within last month. **If YES, notify supervisor.**			
11. Detainee is expressing feelings of hopelessness (nothing to look forward to). **If YES, notify supervisor.**	X		Nothing to look forward
12. This is detainee's first incarceration in lockup/jail.		X	
BEHAVIOR/APPEARANCE			
13. Detainee shows signs of depression (e.g., crying, emotional flatness).	X		depressed
14. Detainee appears overly anxious, panicked, afraid or angry.	X		angry
15. Detainee is acting and/or talking in a strange manner (e.g., cannot focus attention; hearing or seeing things which are not there).		X	
16a. Detainee is apparently under the influence of alcohol or drugs.		X	
b. If YES, is detainee incoherent, or showing signs of withdrawal or mental illness? **If YES to both a & b, notify supervisor.**			

TOTAL Column A 9

Officer's Comments/Impressions He is very angry says this is the end of life. It is black home. He will die No matter what. We can't stopped him he promises.

ACTION

If total checks in Column A are 8 or more, or any shaded box is checked, or if you feel it is necessary, notify supervisor and institute constant watch.

Supervisor Notified: YES X NO ____

Constant Supervision Instituted: YES X NO ____

Detainee Referred to Medical/Mental Health: YES X NO ____

If YES:	EMERGENCY	NON-EMERGENCY
medical	____	____
mental health	____	____

Signature and Badge Number of Screening Officer: Pamela B. Whitford 3M21

Medical/Mental Health Personnel Actions: (To be completed by medical/MH staff)

Over

I9-10-4

Jail Incident Report

CORRECTIONS OFFICE OF SHERIFF YATES COUNTY N.Y.

Penn Yan, NY 14527
Ph. 315-536-5175

RONALD G. SPIKE
Sheriff

INMATE NAME	I.D. #	DATE	CR #
~~Ethan Bailey~~ Aaron Shehu		9/5/10	10-161

SEX	RACE	AGE	HOUSING LOCATION	AC or DC	CR # (if crime)
M	Wh	18	A Dorm	AC	

COMMITMENT OFFENSE	LOCAL or BOARDED	IF BOARDED, WHAT CO. OR AGENCY
Grand Larceny 4 2 counts	Local	

INMATE'S ACTIONS: PHYSICAL RESISTANCE ☐ OTHER INMATE CONTACT ☒ VERBAL ABUSE ☐

OTHER INMATES INVOLVED - NAMES: Aaron Shehu and Thomas Rexford

INJURIES TO: none

PROPERTY DAMAGE TO: none

INCIDENT DATE	TIME	INCIDENT LOCATION	OFFICERS INVOLVED
9/5/10	10:20 Pm	A Dorm	CO's D. Rider, W. Backer

RULES VIOLATED: 110.02; 110.04; 130.01; 130.04; 140.02; 140.17

PHYSICAL FORCE USED BY C.O. ☐ YES ☒ NO

NARRATIVE:

At approximatly 10:20 Pm, Correction Officer (CO) Glen Hastings came to me, CO Dorothy Rider, to state that Inmate Ethan Bailey told him he was afraid that either Inmate Aaron Shehu or Inmate Thomas Rexford were going to stab him with a shank they had made. I went to the dorm and asked the Inmates on A side if any of them had any weapons and if so to give them to me. Inmate Shehu went to the trash can and pulled a blue pen out. He handed it to me and I asked if this was a weapon. He tried to take the bottom off, when he couldn't do that he pulled and

PAST HISTORY: Has tried to hurt himself before

LOCK IN -	LOCK IN HOURS	HEARING REQUESTED	OTHER PRE-HEARING DISCIPLINE
☐ YES ☒ NO		☒ YES ☐ NO	

OFFICERS ACTION:

Went to see Inmate
Took weapon
Turned it over to Sgt.

RKS:

needs to see special Doctors

REPORTING OFFICER	DATE/TIME SUBMITTED	ON DUTY SUPERVISOR
CO Dorothy Rider	9/5/10 12:20 Am	Sgt. R. Gardner

OFFICER RELEASING INMATE FROM LOCK-IN	DATE/TIME	SUPERVISING OFFICER

WHITE ORIGINAL: HEARING OFFICER YELLOW COPY: SHERIFF PINK COPY: JAIL ADMIN. GOLDENROD COPY:

Penn Yan, NY 14527
Ph. 315-536-5175

RONALD G. SPIKE
Sheriff

Jail Supplement Report

(I 9/10-4)

1. ☒ CONTINUATION OF INCIDENT REPORT ☐ INFORMATION REPORT

2. INMATE NAME (IF APPLICABLE)	DATE	PAGE #
~~Ethan Bailey~~ Aaron Shehu	9/5/10	
3. ☒ LOCAL ☐ BOARDER	CR# ~~10-161~~	OTHER # 10-161
4. INCIDENT DATE/TIME: 9/5/10 10:20 Pm	5. JAIL LOCATION OF INCIDENT: A Dorm	
6. OTHER INMATES INVOLVED: ☒ YES ☐ NO	7. INJURIES: ☐ YES ☒ NO	8. PROPERTY DAMAGE: ☐ YES ☒ NO / 9. PHYSICAL FORCE USED: ☐ YES ☒ NO

10. REPORTING OFFICER ON INCIDENT REPORT	11. OFFICERS INVOLVED	12. ON DUTY SUPERVISOR
CO Dorothy Rider	CO's D. Rider; W. Bacher	

13. NARRATIVE:

then used his teeth to take the ball point off to reviel a piece of wire sticking out. All the other Inmates had nothing. I brought everything to Booking where CO William Bacher was and took the piece of metal out to find it was the side piece of a pair of glasses. CO Bacher and myself went to the dorm where Inmate Shehu stated he'd found it under his bed while cleaning a couple of days ago. We questioned Inmate Shehu who stated he wanted to keep it for when he get out on Sept. 17, 10. He was going to use it to cut his arms up. When Sgt. Freeland came in at 11Pm, he took over and moved Inmates Shehu and Rexford to I Block.

14. REPORTING OFFICER SIGNATURE	15. DATE/TIME SUBMITTED	16. REVIEWING SUPERVISOR SIGNATURE
CO Rider Dorothy Rider	9/6/10 12:20 Am	

INCIDENT: White Original - Hearing Officer Yellow Copy - Sheriff/Undersheriff Pink Copy - C/Lieut. Goldenrod Copy - Inmate File Make copy for posts

INFORMATION: White Original - Shift Supervisor Yellow Copy - Sheriff/Undersheriff Pink Copy - C/Lieut. Goldenrod Copy - Downposts

YCSO (8/02)

I - 11/10 - 14

Jail Incident Report

CORRECTIONS OFFICE OF SHERIFF YATES COUNTY N.Y.

Penn Yan, NY 14527
Ph. 315-536-5175

RONALD G. SPIKE
Sheriff

INMATE NAME	I.D. #	DATE	CR #
SHEHU, AARON	10-161	11/18/10	N/A

SEX	RACE	AGE	HOUSING LOCATION	AC or DC	CR # (if crime)
m	B	17	E-Block	BC	N/A

COMMITMENT OFFENSE	LOCAL or BOARDED	IF BOARDED, WHAT CO. OR AGENCY
GRAND LARCENY	LOCAL	N/A

INMATE'S ACTIONS: PHYSICAL RESISTANCE ☐ OTHER INMATE CONTACT ☐ VERBAL ABUSE ☐

OTHER INMATES INVOLVED - NAMES: N/A

INJURIES TO:	PROPERTY DAMAGE TO:
N/A	N/A

INCIDENT DATE	TIME	INCIDENT LOCATION	OFFICERS INVOLVED
11/18/10	850 pm	E-Block	O'Mallon, Bates

RULES VIOLATED: N/A

PHYSICAL FORCE USED BY C.O. ☐ YES ☒ NO

NARRATIVE:

ON ABOVE DATE AND TIME-FRAME, I C.O. O'MALLON AND C.O. BATES RESPONDED TO E-BLOCK. UPON ENTERING BLOCK, INMATE SHEHU WAS COMPLAINING ABOUT CHEST PAIN. I NOTIFIED SGT. GRIDLEY; HE REPORTED TO BLOCK. E.M.S. RESPONDED AT APPROXIMATELY 858pm, AND EXITED BLOCK WITH INMATE SHEHU 904pm.

PAST HISTORY:

LOCK IN -	LOCK IN HOURS	HEARING REQUESTED	OTHER PRE-HEARING DISCIPLINE
☐ YES ☑ NO	N/A	☐ YES ☑ NO	N/A

OFFICERS ACTION:

HEARD INMATES COMPLAINT, NOTIFIED SGT. GRIDLEY.

REMARKS:

MICHAEL O'MALLON JR.

REPORTING OFFICER	DATE/TIME SUBMITTED	ON DUTY SUPERVISOR
	11/18/10 926pm	Sgt Chad Gridley 3104

OFFICER RELEASING INMATE FROM LOCK-IN	DATE/TIME	SUPERVISING OFFICER

WHITE ORIGINAL: HEARING OFFICER YELLOW COPY: SHERIFF PINK COPY: JAIL ADMIN. GOLDENROD COPY: INMATE FILE MAKE COPY FOR POSTS

Y.C.S.O. (4/93)

Jail Supplement Report

Ph. 315-536-5175
RONALD G. SPIKE
Sheriff

1. ☐ CONTINUATION OF INCIDENT REPORT ☑ INFORMATION REPORT

2. INMATE NAME(IF APPLICABLE)	DATE	PAGE #
Shehu, Aaron 10-161	11/18/2010	1
3. ☑ LOCAL ☐ BOARDER	CR # NA	OTHER # NA
4. INCIDENT DATE/TIME 11/18/10 8:50pm	5. JAIL LOCATION OF INCIDENT E-Block	
6. OTHER INMATES INVOLVED ☐ YES ☑ NO	7. INJURIES ☐ YES ☑ NO	8. PROPERTY DAMAGE ☐ YES ☑ NO
9. PHYSICAL FORCE USED ☐ YES ☑ NO		

10. REPORTING OFFICER ON INCIDENT REPORT	11. OFFICERS INVOLVED	12. ON DUTY SUPERVISOR
C.O. O'Mallon	C.O.'s O'Mallon and Bates	Sgt Chad Gridley

13. NARRATIVE:

On The above date and time Corrections Officer (C.O.) Mike O'Mallon radioed for myself, Sgt Chad Gridley to respond to E-Block. When I arrived Inmate Aaron Shehu was sitting at the table holding his chest. After asking how he was feeling and what his problems were I call dispatch for an ambulance. The ambulance crew arrived at 8:58pm and was on the way to the hospital at aprox 9:10pm. C.O. Smith rode in the ambulance and C.O. Bates followed behind in transport vehicle. Wrote report.

Sgt Chad Gridley

Sgt Chad Gridley

Reporting Officer	15. DATE/TIME SUBMITTED	16. REVIEWING SUPERVISOR SIGNATURE
Sgt Chad Gridley 3no4	11/18/10 9:30pm	Sgt Chad Gridley 3no4

INCIDENT: White Original - Hearing Officer Yellow Copy - Sheriff/Undersheriff Pink Copy - C/Lieut. Goldenrod Copy - Inmate File Make Copy for post

INFORMATION: White Original - Shift Supervisor Yellow Copy - Sheriff/Undersheriff Pink Copy - C/Lieut. Goldenrod Copy - Downposts

Y.C.S.O. (8/93)

Jail Supplement Report

CORRECTIONS OFFICE OF SHERIFF YATES COUNTY

Penn Yan, NY 14527
Ph. 315-536-5175

RONALD G. SPIKE
Sheriff

1. ☐ CONTINUATION OF INCIDENT REPORT ☒ INFORMATION REPORT

2. INMATE NAME (IF APPLICABLE)	DATE	PAGE #
Aaron Shehu	11/25/10	
3. ☒ LOCAL ☐ BOARDER	CR#	OTHER #
4. INCIDENT DATE/TIME: 10:30 Pm 11/25/10	5. JAIL LOCATION OF INCIDENT: E Block	
6. OTHER INMATES INVOLVED: ☐ YES ☒ NO	7. INJURIES: ☐ YES ☒ NO	8. PROPERTY DAMAGE: ☐ YES ☒ NO / 9. PHYSICAL FORCE USED: ☐ YES ☒ NO

10. REPORTING OFFICER ON INCIDENT REPORT	11. OFFICERS INVOLVED	12. ON DUTY SUPERVISOR
	CO Dorothy Rider	CO Tom Simonsen

13. NARRATIVE:

While passing meds, Inmate Aaron Shehu took his Seraquil, Spit it into his cup and acted as if he'd taken it. I, Correction Officer D. Rider heard the pill hit the inside of the glass and asked to see the cup after Inmate Shehu thought he'd gotten away with it. I took the cup with the pill in it, showed C.O. Tom Simonsen and wrote report.

14. REPORTING OFFICER SIGNATURE	15. DATE/TIME SUBMITTED	16. REVIEWING SUPERVISOR SIGNATURE
Dorothy Rider	11/25/10 10:53 Pm	Thomas E Simonsen

INCIDENT: White Original - Hearing Officer Yellow Copy - Sheriff/Undersheriff Pink Copy - C/Lieut. Goldenrod Copy - Inmate File Make copy for posts

INFORMATION: White Original - Shift Supervisor Yellow Copy - Sheriff/Undersheriff Pink Copy - C/Lieut. Goldenrod Copy - Downposts

Y.C.S.O. (8/93)

To: dad

I'm sorry I can't take this like any more. I'm sorry

I love you and mom so much.

T: mom

I'm sorry

I can't take

this life I'm

living any more

I loveg You and

dad so

much

To Wheeler

I'm Sorry I am sitting in jail and I can't take this anymore. You were right When you heard I've tried to kill myself. and you said that is which people don't care and it is the easy way out but I don't care anymore.

I'm Sorry

Seen on the other Side

Weaver

To: harley

Im sorry I can't take it
anymore I tried to not let
my depreion win but it
has. I just don't care
anymore

I'm

Sorry

To devin

devin I'm sorry I can't
take it any more I tried
to deal with it and I
can't I sorry I had to
in jail or the hospital

10-F-1186

U.S. Office
5275 Route 14
Lakemont, NY 14857
Phone: (607)243-8126
Fax: (607)243-5521
info@freedomvillageusa.com
www.freedomvillageusa.com

Canadian Office
760 Brant Street, Unit 406
Burlington, ON L7R 4B7
Phone: (905)634-5558
Fax: (905)634-5559
www.freedomvillage.ca

Freedom Village
North America's Premier Home for Troubled Teens

DEC 2 0 2010

December 13, 2010

To Whom It May Concern:

I am writing in regard to your request for information about Aaron Shehu.

Aaron was a student in our residential program from January 27, 2010 until April 10, 2010.

In order to adequately address your request for information, I will begin by describing our program and its objectives.

Our program, Freedom Village, is a private, faith-based program for at-risk youth. We are a voluntary program that seeks to offer parents alternatives to traditional placement options for children who have any number of personal challenges and difficulties.

Our program is designed to provide support and structure to young people as we help them grow as individuals. We are not a clinical psychological institution, and we do not medicate our students. We typically deal with young people who are presenting their families with behavioral difficulties.

Aaron's family applied to our program, seeking help with their son who was having a number of behavioral difficulties. Aaron was granted an intake interview aimed at determining whether or not he was a good candidate for our program.

During this interview process, it was explained that Aaron was presenting his family with serious challenges. Aaron's immature and irrational behavior had become too much for his family to bear. They felt as if they did not get adequate help from the other avenues that they had pursued, and were looking for more help.

Aaron was portrayed as a low-functioning young man whose intelligence scores marked him as being borderline mentally retarded. It was made clear that, among his other behavioral problems, Aaron had been suicidal. His parents felt as though he often acted out for attention and that he was not genuinely suicidal.

Because of his issues, Aaron was not a good candidate for our program. These issues were discussed at length with Aaron's family and with Aaron himself. All parties were in agreement that if we were to give Aaron a shot, it would be very tenuous, and that any threats to hurt himself would be dealt with seriously and likely result in dismissal.

After these conversations and assurances from his family that they understood the challenges we faced and that they would support whatever decisions we had to make, Aaron was allowed the opportunity to enter our program.

Aaron immediately presented serious social challenges and proved to have great difficulty functioning in a dorm setting. He was given a very caring, resilient roommate who was charged with being around Aaron at all times and reporting on his behavior regularly. His roommate did an admirable job in reporting every problem that arose, to the point that Aaron became very frustrated with him.

Aaron was spoken to on several occasions, as he often left notes of a morbid tone, referencing his desire to die or referring to his loneliness.

On one occasion, Aaron was found trying to put something around his neck and threatening to hurt himself. This brought things to a head, and Aaron's father met with Aaron and I to discuss the situation and determine the proper course of action. After counseling with Aaron and speaking with Aaron and his

father, it was determined that Aaron would be given one more chance on the most tenuous grounds.

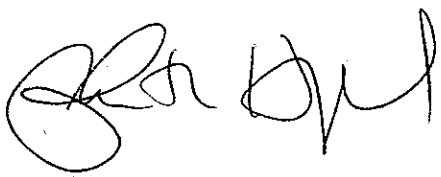
A couple of weeks later, Aaron was again found threatening to hurt himself. At this point, it became clear that Aaron was unwilling/ unable to control his behavior and he was a threat to himself. His parents were immediately contacted and Aaron was dismissed into their custody so that they could consider the best course of action for Aaron going forward.

Ultimately, Aaron was a very low-functioning, impulsive young man who felt very hopeless. Regrettably, we were unable to help Aaron. We made every effort we could to give Aaron the opportunity to succeed within our program, but his issues proved to be more serious than what we are designed to handle. He was returned to the care of his parents who had full knowledge of the issues that we had dealt with each step of the way.

Again, we are not a psychological facility and, as such, can not offer any clinical treatment reports. Instead, I trust this summary of how we counseled with Aaron and dealt with his issues will satisfy your request for information.

If you need further information, please do not hesitate to contact us.

Sincerely,



Jonathan Hempel
Dean of Men

Dr. Fletcher Brothers
Founder / Director

Freedom Village U.S.A.
Student Progress Report
February 2010

STUDENT NAME: Shehu,Aaron

Number of Write-ups for the month: 4
Number of Commendations for the month: 2

OVERALL LEVEL
(Refer to Parent Guide for explanation of levels)

WEEK #	1	2	3	4
LEVEL EARNED	C	A	NL	A

Last month's scripture to be memorized was: Ephesians 6:10-18
Chore assignments may change during the month. Last month, Aaron was responsible for:
cleaning the sinks and mirrors

Scripture	E	E	E	E
Chore	C	C	C	C
Dorm	C	A	A	A
School	A	A	A	A

OVERALL CHARACTER
PC = Excellent E = Good Job C = Satisfactory
A = Needs Improvement NL = Poor

Is Courteous / Polite	A
Gets Along Well with Others	A
Exhibits Self Control	A
Shows Respect for Authority	A
Responds Well to Correction	A
Keeps a Tidy Room	A
Participates in Devotions	A
Participates in Activities	A
Encourages Others	A

DEAN'S COMMENTS:

Aaron has shown some serious difficulties adjusting to the program. Initially, he was a little reserved and quiet, but he has started to really be disrespectful and argumentative. He intentionally hassles his big brother and tries to make him feel bad. He is still new, but these issues need to improve. While we are hopeful he can succeed in our program, he is not off to a great start.

Freedom Village U.S.A.
Student Progress Report
March 2010

STUDENT NAME: Shehu,Aaron

Number of Write-ups for the month: 5
Number of Commendations for the month: 4

OVERALL LEVEL
(Refer to Parent Guide for explanation of levels)

WEEK #	1	2	3	4
LEVEL EARNED	NL	A	NL	A

Last month's scripture to be memorized was: Ephesians 6:10-18
Chore assignments may change during the month. Last month, Aaron was responsible for: cleaning the sinks and mirrors

Scripture	E	E	E	E
Chore	C	C	C	C
Dorm	A	A	A	A
School	A	A	A	A

OVERALL CHARACTER
PC = Excellent E = Good Job C = Satisfactory
A = Needs Improvement NL = Poor

Is Courteous / Polite	A
Gets Along Well with Others	A
Exhibits Self Control	A
Shows Respect for Authority	A
Responds Well to Correction	A
Keeps a Tidy Room	A
Participates in Devotions	A
Participates in Activities	A
Encourages Others	A

DEAN'S COMMENTS:

Aaron has had a difficult month. He continues to have trouble adjusting socially. He has been acting depressed, writing morbid notes that he intends his roommates to find. Aaron has also received discipline for swearing, arguing and being disrespectful. In light of our recent meeting, Aaron needs to make some immediate changes in order to safely continue in the program.