STATE OF NEW YORK **COURT OF CLAIMS**

ESTATE OF LONNIE LAMONT HAMILTON, and LONNIE LEE HAMILTON, Individually and as Administrator of Estate,

Claimant, **DECISION**

-v-

THE STATE OF NEW YORK, **Claim No. 129318**

Defendant.

BEFORE: **HON. FRANCIS T. COLLINS**
Judge of the Court of Claims

APPEARANCES: **For Claimant:**
Richard L. Giampa, Esq., P.C.
By: Zachary Giampa, Esq.

For Defendant:
Honorable Letitia James, Attorney General
By: Thomas P. Carafa, Esq.
Assistant Attorney General

Lonnie Lamont Hamilton (Lonnie) hung himself in a prison cell at Marcy Correctional Facility on March 18, 2016. He was 22 years old. Partial summary judgment on claimant Lonnie Lee Hamilton's cause of action for loss of sepulcher was granted by Decision and Order dated February 19, 2021 and the issue of damages on that cause of action was tried, together with the claimant's remaining causes of action for conscious pain and suffering and wrongful death, from October 18, 2021 through October 21, 2021.

The trial evidence discloses that Lonnie was received into the custody of the Department of Corrections and Community Supervision (DOCCS) on January 2, 2015 at the age of 21. It was his first term in DOCCS' custody after being sentenced to an indeterminate prison term of two to six years for two counts of third-degree robbery. He had been identified by the Office of Mental Health (OMH) as an OMH "Level 2" which, according to Acting Commissioner Anthony J. Annucci, "describes an individual who needs or may need psychiatric treatment for a major mental disorder and requires housing in a facility with full time OMH staff" (Exhibit 1, p. 41). On the form entitled Reception/Suicide Prevention Screening Guidelines dated January 2, 2015 it is noted that Lonnie previously attempted suicide by hanging and felt he had " 'nothing' " to look forward to (*id.* at 424, quoting Lonnie). On a DOCCS Mental Health Referral form dated February 25, 2015 an OMH staff member noted that "Inmate told me he wanted to kill himself" (*id.* at 425). Indeed, Lonnie's medical records are replete with references to his suicidal and self-destructive behavior. Intake forms note scars of self-mutilation on Lonnie's forearms (*id.* at 330) and prior instances of self-harm and threats of suicide (*id.* at pp. 95, 101, 341, 346; *see also* Exhibit 3).

Lonnie was transferred to Marcy Correctional Facility in February 2016 where he was confined to the Special Housing Unit (SHU) to serve a 45-day disciplinary penalty of isolation. During such periods of disciplinary confinement inmates are isolated in a cell with one hour of daily outdoor recreation permitted. Julie Calato, a Habilitation Specialist for the New York State Office of Mental Health, testified that she provides "direct care services" to incarcerated

individuals (Tr. 4, p. 6).[1] Ms. Calato testified she has a Bachelor of Science Degree in Human Services, which she described at trial as a broad-based degree that encompasses the disciplines of psychology, social work, and sociology. As part of her duties Ms. Calato provides inmate suicide-risk assessments and interacts with inmates in the Marcy SHU on a daily basis.

Reviewing her notes, Ms. Calato testified that she met with Lonnie on February 8, 2016 after having received a call from correction staff that he was threatening self-harm. Ms. Calato interviewed Lonnie, determined that he was a suicide risk, and arranged to have him transferred to a mental health facility at Fishkill Correctional Facility. While in treatment at Fishkill, Lonnie told his counselors repeatedly of his depression and worries about going back to Marcy Correctional Facility. For example, Lonnie is quoted as saying the following:

> " 'It's not any good for me at that facility, one day its inmates, other days officers. I'm tired of doing [the] same shit everyday. I got nobody on outside, I see no future ahead for me. When I look in the mirror I see nothing. When I go back to Marcy I'm gonna finish it off" (Exhibit 3, pp. 77-78, quoting Lonnie).

Lonnie was transferred back to Marcy Correctional Facility and Ms. Calato interviewed him upon his return on February 22, 2016. This time Ms. Calato identified no suicidal thoughts or intent to commit self-harm. Ms. Calato met with Lonnie on February 26, 2016, March 2, 2016 and March 7, 2016 at which time she described Lonnie as calm and cooperative. On March 15, 2016 Lonnie was again threatening suicide and Ms. Calato responded to the SHU, performed an assessment, and placed Lonnie on a one-on-one suicide watch. She met with Lonnie the next day, March 16, 2016, this time with Nurse Practitioner Karen Tourtelot, and it was determined that Lonnie would be removed from suicide watch. Although Lonnie appeared happy, he was

---

[1] Numbers in parentheses preceded by "Tr." refer to the page number of the particular trial transcript.

dressed in only a paper smock and was shivering from the cold. Ms. Calato testified that Lonnie was removed from suicide watch, not because he was cold, but because his demeanor had changed– "he had a humor about him"– that he apparently did not have before (*id.* at 67). He was looking forward to his scheduled psychiatric testing the following Monday and discussed certain medication changes with Nurse Tourtelot. Ms. Calato testified that the decision to remove Lonnie from suicide watch was made jointly by herself and Nurse Tourtelot (Tr. 4, pp. 33-34). According to the SHU logbook, the assessment lasted eight minutes (Exhibit 1, p. 142).

On the morning of Lonnie's death, March 18, 2016, Ms. Calato saw Lonnie cell-side at 10:47 a.m. (*id.* at 148). Although Ms. Calato testified at trial that Lonnie told her " 'he wasn't behaving that morning' " (Tr. 4, p. 40, quoting Lonnie), she testified that Lonnie did not appear "agitated", "angry" or "irrational" (*id.* at 40-41). Ms. Calato testified that she performed a suicide risk assessment during the course of this cell-side visit, and could identify no risk factors. She also testified, however, that as she was leaving the SHU Lonnie could be heard banging on his cell door "yelling" for his lunch (*id.* at 43). The cell-side visit concluded at 10:50 a.m. (*id.* at 44; *see also* Exhibit 1, p. 148 [SHU logbook]).

As Ms. Calato was leaving the SHU, lunch was being served. Joseph Mead,[2] who recently retired and had been employed as a correction officer at Marcy since 1997, was on duty in the Marcy SHU on March 18, 2016. He testified that lunch in the SHU was distributed between 10:45 a.m. and 11:00 a.m. The logbook reflects lunch arrived on the unit at 10:45 a.m. and that the occupant of cell number 30, Lonnie Hamilton, had refused his lunch (Exhibit 1, p.

[2] For the sake of clarity the Court will refer to Joseph Mead as Correction Officer Mead since that was his title at the time of the underlying events at issue.

146; Tr. 3, pp. 33-34). Indeed, Correction Officer Xeina, the second floor officer on duty in the SHU that day other than Correction Officer Mead, testified that he assisted Mead in the distribution of trays and that Mead informed him Lonnie had refused his meal. Officers Mead and Xeina both testified at trial that although they did recall Lonnie yelling that morning, they recalled no reaction from Lonnie about not getting his lunch.

Correction Officer Mead testified that he did a security round at 11:00 a.m. at which time he observed Lonnie standing on his bed. Mead did not speak or interact with Lonnie at that time and simply continued his round. He testified that although an incarcerated individual "[p]robably shouldn't be standing on the bed", there was no specific DOCCS' policy prohibiting it (Tr. 3, p. 36).

Correction Officer Mead next saw Lonnie at 11:24 a.m. hanging from a ceiling vent by a strip of bedsheet tied around his neck. Correction Officer Mead testified that Lonnie had one foot on the bed, the toes of the other foot touching the floor, and his right hand was clenched in a fist. Mead testified he called Lonnie's name several times but Lonnie did not respond. Mead called out to Xeina, who arrived at Lonnie's cell, and the two officers discussed what to do next. Correction Officer Mead explained "I didn't want to open the door immediately because I felt that it was a threat with his hand, you can't tell if he is holding a weapon or not" (*id.* at 40; *see also id.* at 89). Correction Officer Mead testified that he considered Lonnie a threat although he did not know and had never interacted with Lonnie prior to March 18, 2016, and had no reason to fear that Lonnie was angry with him. The officers decided to call for a sergeant, who was immediately summoned by Officer Coppola.

After Sergeant Marshall arrived and directed that the cell door be opened, Mead, together with Sergeant Marshall, lifted Lonnie while Officer Xeina used the cut-down tool to cut the bedsheet. They laid Lonnie on the floor and immediately started CPR. Correction Officer Mead performed chest compressions, Sergeant Marshall checked his airway and the AED device was used to deliver two electric shocks. DOCCS' medical personnel arrived at 11:33 a.m. and Kunkel Ambulance Service arrived at 11:53 a.m. to remove Lonnie from the scene by ambulance (Exhibit 1, p. 148 [SHU logbook]). Although ambulance personnel reported "a change in pulse" it was "very hypotensive" and Lonnie was pronounced dead at St. Elizabeth's Hospital at 12:36 p.m. (Exhibit 7, p.3).

On cross-examination Correction Officer Mead testified, for the first time, that in addition to performing the 11:00 a.m. security round (when he saw Lonnie standing on his bed), he performed a count round before discovering Lonnie hanging at 11:24 a.m. According to the SHU logbook, the count round was performed at 11:17 a.m. However, Correction Officer Mead testified that he had no recollection of performing this round. Although Mead initially testified the count round could have been performed before 11:00 a.m and merely recorded at 11:17 a.m., he conceded that the console officer (also referred to at trial as the "bubble officer") is immediately informed upon completion of the count round, and it is therefore reasonable to accept the times entered in the log as the time the count round was performed. Correction Officer Mead could not recall what Lonnie was doing at the time he performed the 11:17 a.m. count round.

Mead testified that although Lonnie may have been yelling during lunchtime, he does not recall Lonnie wanting his lunch. Mead denied any recollection of asking Lonnie in response to

his screams for lunch "save your breath, aren't you suppose to be killing yourself?" or otherwise having any conversations with Lonnie (Tr.3, p.75). Confronted with the statements of other incarcerated individuals to the contrary, Mead continued his denials. When asked at trial whether he was informed that Lonnie had been recently removed from suicide watch, Correction Officer Mead stated "Someone told me that[;] I don't remember who, yes" (*id.* at 110). He also testified at an examination before trial that he was informed on the morning of March 18, 2016 that Lonnie had been removed from suicide watch within the last two days (Exhibit 19, p. 76).

Sergeant Alfred Xeina, promoted to sergeant two years ago, was a correction officer in the SHU together with Correction Officer Mead on the day of Lonnie's death. Both he and Correction Officer Mead testified that incarcerated individuals are entitled to a one-hour period of recreation which may not be denied, if requested. To convey their desire for recreation and other personal-care items, incarcerated individuals in the SHU complete "go-around slips" which are collected by a correction officer and used to create a master list from which the inmates are accorded the items they requested and an opportunity to go outside for recreation (Tr. 3, p. 118). Although the master list reflects that four inmates requested recreation on March 18, 2016 (Exhibit 1, p. 189), including Lonnie, both Mead and Xenia testified they did not recall any of the SHU inmates being released for recreation that morning. Both Mead and Xeina testified they could recall no reaction from Lonnie after he was not let out for recreation, and neither heard Lonnie threaten suicide that day. Both Mead and Xeina admittedly heard Lonnie yelling but testified they could not recall what he was saying. Significantly, although Mead and Xeina testified Lonnie declined both recreation and lunch, Officer Xenia's statement given on the day

of Lonnie's death clearly reflects that his belief was, in this regard, based entirely on what he was told by Correction Officer Mead (*see* Exhibit 1, p. 215).

Correction Officer Xeina testified that he was in the console area when he was called over by Correction Officer Mead who informed him "there might be a hanging" (Tr. 3, p. 123). He arrived at Lonnie's cell in seconds and found Mead in front of the cell. Correction Officer Xeina testified that he and Officer Mead did not immediately open the cell door because "[h]e had his fist clenched. Both his feet were touching. And we didn't know, at the time, if it was a real, you know, suicide or if it was manipulation" (Tr.3, pp. 132-133). Correction Officer Xeina testified that Sergeant Marshall arrived within two minutes of being called.

Unlike Correction Officer Mead, Officer Xeina testified unequivocally that the master count in the Marcy SHU is performed once at 11:15 a.m. (Tr. 3, p. 134), thereby confirming the accuracy of the 11:17 a.m. logbook entry.[3] While Mead admittedly saw Lonnie standing on his bed during the security round at 11:00 a.m., neither he nor Xeina recalled performing the master count at 11:15 a.m. Notably, Officer Xeina testified at an examination before trial that although he recalled seeing Lonnie awake in his cell that day, he could not recall whether or not he saw him standing on his bed, stating "I may have. I don't know... I don't remember" (Exhibit 20, p. 231).

Dayvon Williams was formerly incarcerated under DOCCS' custody and was confined to cell 26 in C-Wing of the Marcy SHU when Lonnie hung himself. Although he was unable to see Lonnie's cell– it was on the other side of a concrete wall–, he heard Lonnie screaming that he

---

[3] There were six late entries recorded in the SHU logbook after Lonnie was removed from the scene by ambulance (Tr.3, p. 169-170; Exhibit 1, p. 158).

wanted to kill himself on March 15, 2016, and he heard him again on March 18, 2016 screaming that he wanted recreation and would kill himself if he did not get it. According to Mr. Williams:

> "Lonnie sat there and told the officer, 'I don't get recreation, I'm going to kill myself.' And they told him, 'save your breath if you're going to kill yourself, you're going to die anyway.' "(Tr. 2 at p. 20 [quoting Lonnie and a correction officer]).

Mr. Williams described Lonnie as "loud" and yelling and kicking his cell door, first for being denied recreation and then for failing to receive lunch (*id.* at 21). He testified that at lunchtime Lonnie "was saying 'officer, I didn't get my food, you're playing with my food ... I need my food. [If] I don't get my food, I'm going to kill myself' " (*id.* at 26, quoting Lonnie). Mr. Williams described Lonnie's tone as upset and angry and he identified Correction Officer Mead as stating in response to Lonnie's demands " 'save your breath, you're going to die anyway' " (*id.* at 27, quoting Mead; *see also id.* at 33). According to the witness, Lonnie continued yelling for 20-30 minutes before he said " 'I can't do it no more, they playing with me, they want me to kill myself' " (*id.* at 27-28, quoting Lonnie). Mr. Williams testified that he tried to calm Lonnie, and that after he went quiet he called out "Yo Country" (Lonnie's nickname), but there was no response (*id.* at 28). The next thing Mr. Williams recalls is hearing an officer shout to Lonnie " 'Why you got to do that...come on, get down from there' " (*id.* at 29, quoting officer). According to Mr. Williams' testimony, approximately seven to eight minutes passed from the time he last heard Lonnie to when he heard his cell door open.

On cross-examination Mr. Williams testified that he and Lonnie became friends in January 2021 when he was transferred to Marcy Correctional Facility. Mr. Williams readily admitted he was unable to see Lonnie through the wall that divides the C-Wing but testified

nevertheless that he heard Lonnie threaten suicide "numerous times" by screaming it repeatedly after he did not get recreation on March 18, 2016 (*id.* at 51). Lonnie started screaming again around lunchtime about not getting his lunch and, according to Mr. Williams' testimony, he remained screaming for between 15 and 30 minutes, even as a correction officer on the tier was still serving lunch. Ultimately, Mr. Williams was released from DOCCS' custody on March 25, 2016 and he thereafter contacted claimant regarding Lonnie's death.

Claimant called Francis Rosato-Maurino to testify as an expert on his behalf at trial. Ms. Maurino retired from the New York City Department of Corrections as Deputy Warden of Programs. She has a Doctor of Jurisprudence degree as well as two Masters Degrees in Special Education and Public Administration. Prior to being promoted to Deputy Warden she worked her way up through the ranks, first as a correction officer and then as a Captain and Shift Commander where she bore ultimate responsibility for every incident occurring on her shift. Ms. Maurino has received training on inmate suicide prevention which she described as "part-and-parcel of what a correction officer has to do" (Tr. 2, p. 79). She has experience supervising solitary confinement units and has previously qualified as an expert witness in the Court of Claims.

According to Ms. Maurino, Correction Officers Mead, Xeina and Coppola all deviated from the applicable standard of penological care on suicide prevention set forth in Directive 4101 as well as the training customarily provided to correction officers (*see* Exhibits 4 and 5). Ms. Maurino testified that the applicable standard of care requires that when an incarcerated individual exhibits signs he or she may be in imminent threat of self-harm, such as where an individual is screaming and kicking their cell door over a prolonged period of time, a correction

officer is required to notify someone in the mental health unit, notify a supervisor, and arrange for the incarcerated individual's constant observation. Directive 4101 (IV) (C) (1) states the following with regard to OMH Level 2 facilities: "1. If an inmate is identified as being in need of an immediate referral to OMH, call Mental Health; notify your supervisor and the Watch Commander. Do not leave the inmate unattended" (Exhibit 4, p. 7). According to Ms. Maurino, the correction officers failed to comply with these requirements in every respect thereby violating Directive 4101 (IV) (C) (1) (*id.*).

In her expert opinion, officers Mead, Xeina and Coppola deviated from the accepted procedures set forth in Directive 4101 as well as the applicable training (Exhibits 4 and 5), initially, by failing to provide recreation to Lonnie as required. Ms. Maurino opined that it was also a violation of the applicable standard of care not to provide Lonnie lunch that day. Ms. Maurino made clear that DOCCS is not allowed to deny incarcerated individuals food except for medical reasons, not present here. She testified that all of the incarcerated individuals' statements she reviewed indicated Lonnie did not get his lunch and that he made threats of self-harm as a result.[4] In addition to relying on the statements of other incarcerated individuals in this

[4] To the extent the factual support for Ms. Maurino's opinion that officers failed to report Lonnie's threats of self-harm rests on statements or sworn testimony of other incarcerated individuals, the Court finds those statements (*see* Exhibit 1, pp. 242-244; 247-249; 252-254; 257-258; 259-262; Exhibits 17,18) admissible for the purpose of providing notice of the risk of harm. "[A]lthough the contents of the statements in a record are not admissible for the truth of the matters asserted therein under the business records exception to the hearsay rule when the informant was not acting pursuant to a business duty to report, 'the contents of the record [nevertheless] may be used for a non-hearsay purpose' " (*People v Patterson*, 28 NY3d 544, 550-551 [2016], quoting Jerome Prince, Richardson on Evidence § 8-307 at 606 [Farrell 11th ed. 1995]). Contrary to defendant's contention at trial, the statements of other incarcerated individuals contained in the OSI investigation (Exhibit 1 at pp. 242-244; 247-249;252-254; 257-258; 259-262) and their sworn depositions (Exhibits 17 and 18) describing Lonnie's threats of suicide and Mead's response(s) are not hearsay because they were not offered for the truth of the matters asserted therein, i.e., that Lonnie was going to kill himself, but instead were offered to establish that DOCCS had notice of the potential for self-harm (*see e.g. Stowe v Furness*, 150 AD3d 1654 [1st Dept 2017]; citing *Nucci v Proper*, 95 NY2d 597 [2001]).

regard, Ms. Maurino reviewed Ms. Calato's Primary Therapist Progress Note completed on the morning of March 18, 2016, which tends to support claimant's contention that Lonnie did not refuse his lunch as Mead and Xeina posited. Calato's note states: "As this writer was leaving SHU, the patient was banging on his cell door wanting his 'chow.' The officers were delivering the lunches as this writer was leaving" (Exhibit 3, p. 120, quoting Lonnie). Ms. Maurino concluded, based on Lonnie's demands for lunch, that he was intentionally deprived of his meal.

Even absent Lonnie's articulated threats of suicide, Ms. Maurino opined that Correction Officer Mead deviated from the standard of care when he observed Lonnie standing on his bed but did nothing. The standard of care required that he ask Lonnie what he was doing in order to assess whether he could respond rationally. If Lonnie was unable to provide a rational response, further action would clearly be needed, in Ms. Maurino's opinion. Considering all that happened that day, Lonnie's banging and yelling about not getting both recreation and lunch, and the fact that he was admittedly observed by Correction Officer Mead (and, possibly, Officer Xeina) standing on his bed, Ms. Maurino made clear that even if the correction officers did not hear Lonnie's threats of suicide, as they testified, the OMH should have been called based on Lonnie's irrational conduct that day.

Ms. Maurino also opined that it was a violation of the applicable standard of care not to immediately open Lonnie's cell to render assistance when Correction Officer Mead saw him hanging by his neck. According to Ms. Maurino, applicable protocol and Directive 4101 required that assistance be immediately rendered while simultaneously calling for aid. Ms. Maurino testified that the failure to follow this course of action violated that portion of Directive 4101 (VI)(B), which states:

> "Correctional personnel shall never wait for medical staff to arrive before entering a cell and initiating appropriate life-saving measures immediately on-site. Further, staff shall not presume that the victim is dead. Staff must initiate and continue appropriate lifesaving measures on-site until relieved by arriving Medical staff" (Exhibit 4, Directive 4101, p. 14).

Ms. Maurino opined that the applicable protocol and the standard set forth in Directive 4101 required that the cell be immediately opened even if the officers thought Lonnie was faking. According to Ms. Maurino, no true threat was present given there were three officers present in the SHU that day.

Ms. Maurino also testified that in accordance with Directive 4101 (V) (J) (2) only three people may discontinue a suicide watch– an OMH psychiatrist or OMH Unit Chief, or his or her designee (*see* Exhibit 4, Directive 4101, p. 14). Here, Lonnie's suicide watch was discontinued by Ms. Calato, a Habilitation Specialist with only a Bachelor of Science Degree. In Ms. Maurino's opinion, Lonnie should have been on one-on-one suicide watch until Monday when a more in-depth psychiatric evaluation was scheduled.

Claimant's causes of action for conscious pain and suffering and wrongful death are premised on allegations of both negligent supervision and negligent infliction of emotional distress. Addressing first claimant's cause of action for negligent supervision, like any other negligence cause of action claimant must demonstrate "the existence of a duty that the defendant owed to the [claimant], a breach of that duty, and that the breach of such duty was a proximate cause of his or her injuries" (*Davison v State of New York*, 180 AD3d 995, 996 [2d Dept 2020]; *see also Montanez v New York State Elec. & Gas*, 144 AD3d 1241, 1242-1243 [3d Dept 2016]). "When prison authorities know or should know that a prisoner has suicidal tendencies or that a prisoner might physically harm himself, a duty arises to provide reasonable care to assure that

such harm does not occur" (*Gordon v City of New York*, 70 NY2d 839, 840 [1987]; *see also Sanchez v State of New York*, 99 NY2d 247 [2002]; *Huntley v State of New York*, 62 NY2d 134 [1984]). The State is not an insurer of inmate safety, however, and negligence can not be inferred merely because an incident occurred (*Sanchez v State of New York*, 99 NY2d at 256). In cases where there is a clear institutional failure to supervise inmates or patients, such as where notice of the potential risk of self-harm has been ignored, liability has been imposed without reference to professional standards of medical or psychiatric care (*see Huntley, 62 NY2d 134*; *Martindale v State of New York*, 269 NY 554 [1935]; *Kerker v Hurwitz*, 163 AD2d 859, 860 [4th Dept 1990], *amended on rearg* 166 AD2d 931 [4th Dept 1990]; *Miller v Albany Med. Ctr. Hosp.*, 95 AD2d 977 [3d Dept 1983]). In such cases, the gravaman of the claim is not the negligence in furnishing psychiatric care, but the institution's negligence in fulfilling its separate duty to protect the claimant from self-harm. Breach of this duty therefore constitutes common law negligence rather than medical malpractice (*see generally Bleiler v Bodnar*, 65 NY2d 65 [1985]).

Prison records reflect Lonnie's five prior suicide attempts, three of which occurred in either jail or prison, and Lonnie's history of self-mutilation. Although Mead and Xeina denied hearing Lonnie threaten suicide the day of his passing, they admittedly heard him yelling and screaming in the SHU, a place where both officers testified talking was not allowed. Moreover, Mead testified he learned at the beginning of his March 18th shift that Lonnie had been released from one-on-one suicide watch on March 16, 2016, only two days prior to his death. The trial testimony of Dayvon Williams, which the Court finds credible, together with the examination before trial testimony of Jermal Garrett (Exhibit 17), who was confined next to Lonnie in cell 29, describe Lonnie as a tortured young man who yelled and screamed for hours upon being denied

his right to recreation and lunch. Mr. Garrett described Lonnie as "full-blown angry" and yelling he was going to kill himself after the lunch cart passed his cell without stopping (Exhibit 17, p. 30). Kaleff Krigger, who was an incarcerated individual confined to the same C-Wing as Lonnie but on the other side of the concrete wall, testified at an examination before trial that although he did not know Lonnie and never spoke to him before his death, he heard him screaming, first for recreation and lunch and then, after the lunch cart passed his cell without a correction officer giving him his meal (Exhibit 18, pp. 14-18), that he was going to kill himself (Exhibit 18, p. 19; *see also* Exhibit 1, pp. 242-244; 247-249;252-254; 257-258; 259-262). No reason is apparent why these incarcerated individuals would lie and the similarity in their version of events is persuasive.

Correction Officer Mead's testimony, on the other hand, was problematic. Officer Mead testified at trial that Lonnie was not at his door when recreation was called, and that although he heard Lonnie yelling from his cell, he could not "remember what he was saying" (Tr. 3, p. 27). He denied, however, that he heard Lonnie threaten to harm or kill himself after not receiving recreation. Contrary to his trial testimony, however, Officer Mead stated in a supporting deposition provided to the New York State Police that "[a]t approximately 8:45 a.m. Inmate Hamilton began creating a disturbance because he said he didn't get rec" (Exhibit 1, p. 209). According to the Officer's statement, he even went to Lonnie's cell and explained to him that he had been sleeping when recreation was called. The statement indicates Lonnie continued to create a disturbance "for a good part of the morning" and that "[t]hroughout the morning inmate Hamilton continued to cause a problem" (*id.*). Officer Mead did not testify at trial, as he did in his

prior statements, that he was aware Lonnie was upset about missing recreation or that he spoke to Lonnie and explained to him he had been sleeping at the time recreation was called.

Mead testified at trial that when lunch was being distributed Lonnie did not receive a meal because "[h]e was not on his door", and the officer could recall no reaction from Lonnie when he did not receive his meal (Tr. 3, p. 30). However, in a statement provided to DOCCS' Office of Special Investigations (OSI) Mead stated that when he "got to I/M Hamilton's cell he refused [lunch] and said something to the effect 'I don't want to eat that' " (Exhibit 1, p. 211, Mead's statement to the OSI, quoting Lonnie). Ms. Calato, though, states in her Progress Note, recorded March 18, 2016 at 10:47 a.m.: "As this writer was leaving SHU, the patient was banging on his cell door wanting his 'chow' " (Exhibit 3, p. 120, quoting Lonnie). Officer Mead also testified at trial that he did not know Lonnie and had never interacted with him prior to March 18, 2016, despite the fact that Lonnie had resided in the Marcy SHU for almost a month prior to that date and the SHU had been Officer Mead's regular shift assignment since July 2015.

In addition to the above inconsistencies, Officer Mead repeatedly testified at trial that he could not recall what Lonnie was saying as he continued to yell throughout the morning. Mead testified quite clearly, however, that the call for morning recreation was made "[r]ight outside the bubble– at the end of the gallery, basically where all – all the galleries come together... [s]o when I make the announcement– whoever makes the announcement– you can hear it throughout the building" (Tr.3, pp. 24-25). He did not explain how the call for recreation, made just outside the bubble, could be heard "throughout the building", and yet neither he nor Correction Officer Xeina could understand what Lonnie was continuously yelling from his cell over the course of the morning of March 18, 2016.

In the instant matter, the Court finds it unnecessary to determine whether Lonnie was intentionally denied recreation or lunch, or to resolve any credibility issues, because the facts otherwise establish a shocking dereliction of duty on the part of the correction officers involved. Lonnie was designated an OMH Level 2 incarcerated individual. He threatened suicide on February 8, 2016, shortly after arriving at Marcy, and again on March 15, 2016. Correction Officer Mead knew on the morning of March 18, 2016, the date Lonnie died, that he had been under suicide watch and had only recently been released. Although he asserts he could not hear what Lonnie was yelling, his testimony and statements make clear that Lonnie began creating a disturbance at approximately 8:45 a.m. which continued throughout the morning. At no time did Officer Mead or Officer Xeina speak to Lonnie to inquire what was the matter or to determine his state of mind given his recent release from one-on-one suicide watch.

The first paragraph of DOCCS Directive 4101 entitled "Inmate Suicide Prevention" states in part the following:

> "OVERVIEW: It is the policy of the Department of Corrections and Community Supervision (DOCCS) to effectively monitor all inmates for the potential for self-harm or suicide attempts ... All staff have responsibility for preventing suicides by effectively monitoring inmates, understanding potential suicide indicators, and knowing the appropriate responses when it is determined that an inmate may be at risk for self-harm or suicidal behavior. It is understood that all suicidal threats, attempts, or indicators are to be taken seriously given the potential risk to the life of an inmate" (Exhibit 4, p. 1).

Here, an OMH Level 2 inmate who had threatened suicide twice since arriving at Marcy in early February 2016 was admittedly yelling, banging on his cell door and creating a disturbance throughout the morning of March 18, 2016. Despite his awareness that Lonnie had been only recently released from suicide watch, Correction Officer Mead did not contact OMH staff and did

not even speak to Lonnie to learn why he was acting out and how his concerns might be addressed. Then with knowledge of both the recent suicide watch and Lonnie's persistent disruptive behavior in the SHU that morning, Officer Mead observed Lonnie standing on his bed during the 11:00 a.m. security round. Even in the absence of overt threats of suicide, such behavior by an OMH Level 2 designee recently released from suicide watch should have served as a crystal clear indication that the potential for self-harm was present (*see Rappaport v Correctional Med. Care, Inc.*, 200 AD3d 1150 [3d Dept 2021]; *Iannelli v County of Nassau*, 156 AD3d 767 [2d Dept 2017]). Correction Officer Mead did not speak or otherwise interact with Lonnie after observing him standing on his bed, but simply continued his round. Twenty-four minutes later Lonnie was found hanging in his cell with one foot on his bed and the toes of his other foot touching the floor.

The Court credits the expert opinion testimony of Ms. Maurino, which was based on her 20 years of experience with the New York City Department of Corrections and her review of the applicable rules and regulations, that correction personnel deviated from the applicable standards of penological care when they failed, knowing Lonnie had only been recently released from one-on-one suicide watch, to call OMH staff for assistance upon hearing him yelling and screaming and observing him standing atop his bed. Directive 4101 (IV) (C) (1) specifically requires that when an inmate is identified as being in need of an immediate referral to OMH, correction staff shall "call Mental Health; notify your supervisor and the Watch Commander. Do not leave the inmate unattended" (Exhibit 4, p. 7). This was not done here despite clear notice of the immediate need for referring Lonnie to OMH. As Ms. Maurino observed, DOCCS' training materials require that Correction Officers "treat all threats as the real thing regardless of how

obvious it may seem that it is a manipulative maneuver. Do not pass judgment. Let the Mental Health experts make the decisions" (Exhibit 5, Suicide Prevention and Intervention training materials, p. 7). Both the Directive and applicable training required that correction personnel defer to the judgment of the OMH. Sadly, that was not done with the tragic result that a young man lost his life.

The Court finds claimant established, by a preponderance of the credible evidence, that the defendant's negligent supervision was a substantial factor in causing Lonnie's death.

To the extent claimant seeks damages on his cause of action for negligent infliction of emotional distress separate and apart from his cause of action for negligent supervision, the Court is unpersuaded. The same injury and conduct which form the basis for the claimant's negligent supervision cause of action forms the basis for the claimant's negligent infliction of emotional distress cause of action as well. Thus, the negligent infliction of emotional distress cause of action must be dismissed as duplicative of the claimant's cause of action for negligent supervision (*Fay v Troy City Sch. Dist.*, 197 AD3d 1423, 1424 [3d Dept 2021]).

The issue of contributory negligence in a suicide case involves the issue of whether the decedent was able to control his or her actions (*see Padula v State of New York*, 48 NY2d 366 [1979]; *Arias v State of New York*, 195 Misc 2d 64 [Ct Cl 2003], *affirmed* 33 AD3d 951 [2d Dept 2006]). As noted by the Court in *Padula*, even though the act of suicide may be the result of a voluntary judgment by the patient, it may "still be the product of impulse or irrational behavior beyond his control. Under such circumstances, a [claimant] should not be held to any greater degree of care for his own safety than that which he is capable of exercising" (*Padula*, 48 NY2d at 373 [internal quotation marks and citations omitted]). Here, defendant failed in its burden of

establishing that Lonnie was able to control his behavior on the date of his death and the Court finds no basis on this record to conclude that he was.[5] Accordingly, the Court finds the State 100% liable for Lonnie's pain, suffering and death as a result of defendant's negligent supervision.[6]

Turning to the issue of damages on claimant's cause of action for conscious pain and suffering, the law is settled that such a claim belongs to the estate of the decedent rather than the distributees (*Heslin v County of Greene*, 14 NY3d 67, 76–77 [2010]; EPTL 11–3.2 [b]). "By contrast, 'a wrongful death action belongs to the decedent's distributees and is designed to compensate the distributees themselves for their pecuniary losses as a result of the wrongful act' " (*Cragg v Allstate Indem. Corp.*,17 NY3d 118, 121 [2011], quoting *Heslin v County of Greene*, 14 NY3d at 76; *see also* EPTL 5–4.3). A claim to recover damages for conscious pain and suffering generally requires proof that the injured party experienced some level of cognitive awareness following the injury (*Cummins v County of Onondaga*, 84 NY2d 322 [1994]; *McDougald v Garber*, 73 NY2d 246, 255 [1989]; *Williams v City of New York*, 71 AD3d 1135, 1137 [2d Dept 2010]; *Johnson v. Jacobowitz*, 65 AD3d 610, 614 [2d Dept 2009], *lv denied* 14 NY3d 710

---

[5] Contributory negligence of the claimant is an affirmative defense to be pleaded and proved by the defendant (CPLR 1412).

[6] To the extent claimant sought to predicate liability on the allegation that the State inappropriately released Lonnie from suicide watch on March 16, 2016 in violation of Directive 4101 (V) (J) (2), he failed to meet his burden of proving that neither Ms. Calato nor Ms. Tourtelot were an appointed designee for the purpose of removing Lonnie from suicide watch (*see* Exhibit 4, p. 14). Claimant also failed to prove medical malpractice by reference to expert medical standards.

With respect to claimant's contention that Mead and Xeina violated the applicable standard of care because they failed to immediately enter the cell while simultaneously calling for help, the Court agrees. Three correction officers were present in the SHU and should have immediately entered the cell and assisted Lonnie, who was in extremis, under circumstances such as these where there was no specific, articulable basis to fear that a trap or assault was likely. Nevertheless, claimant has not demonstrated that the failure to immediately open the cell and go to Lonnie's aid was a substantial contributing factor in causing his death. There was no proof Lonnie was alive when Mead first discovered him hanging or that his life could have been saved had Mead and Xeina entered his cell immediately.

[2010]). " 'However, the factfinder is not required to sort out varying degrees of cognition' " (*Granata v City of White Plains*, 162 AD3d 641, 644 [2d Dept 2018], *lv denied* 32 NY3d 918 [2019] [citation omitted]).

The deposition testimony of Jermal Garrett, who was in the adjacent cell and speaking through the vent with Lonnie minutes before his death, establishes Lonnie's suffering. Garrett testified that about five minutes after their last conversation he heard Lonnie "choking" and "gagging" before the correction officer appeared approximately 15 minutes later (Exhibit 17, pp. 35, 37,57, 71-72).

It has been acknowledged that when the interval between injury and death is relatively short, as it was here, " 'the degree of consciousness, severity of pain, apprehension of impending death, along with duration, are all elements to be considered' " (*Ramos v Shah*, 293 AD2d 459, 460 [2d Dept 2002], quoting *Regan v Long Is. R.R. Co.*, 128 AD2d 511, 512 [2d Dept 1987]). The measure of damages is therefore not to be determined exclusively by the duration of the pain and suffering, but also by the degree and nature of the pain and suffering experienced. While claimant offered no expert proof relating to the severity of Lonnie's pain, the Court as factfinder is entitled "to rely on common sense and common experience to conclude that an amateur, improvised hanging is likely to produce a painful death by asphyxiation" (*Sinkov v Americor, Inc.*, 419 Fed. Appx 86, 92 [2d Cir 2011]). As a result, the Court concludes that Lonnie struggled and suffered in the period between when he placed the noose around his neck and the time he lost consciousness.

When reviewing the amount of damages to be awarded to a claimant for personal injuries, the reasonableness of compensation must be measured against relevant precedent from

comparable cases (*see* CPLR § 5501 [c]). Here, the Court has reviewed comparable cases as well as those involving shorter or longer durations of suffering (*see Vatalaro v County of Suffolk*, 163 AD3d 893 [2d Dept 2018] [award reduced to $400,000 for pain and suffering by decedent who was only minimally conscious for 11 - 20 minutes]; *Oates v New York City Tr. Auth.,* 138 AD3d 470 [1 st Dept 2016], *affd* 28 NY3d 1046 [2016] [award of $300,000 for decedent's 2-5 seconds of pain and suffering after getting hit by bus was affirmed on appeal]; *Creo v State of New York,* Ct Cl, May 14, 2015, Bruening, J., claim No. 121050, UID No. 2015-048-537 [$2.5 million awarded for approximately five to seven minutes of pain and suffering before death by hanging]; *Sinkov v Americor, Inc.*, 419 Fed. Appx 86, *supra* [$300,000 not excessive for pain and suffering before death by hanging]; *Glaser v County of Orange* 54 AD3d 997 [2d Dept 2008] [award reduced to $350,000 for pain and suffering of two to three minutes duration before death from sudden impact]; *Maracallo v Board Of Educ. of City of N.Y.*, 21 AD3d 318 [1st Dept 2005] [award increased to $1.25 million for pain and suffering by accidental drowning victim]). Consideration of the foregoing leads this Court to award claimant as administrator of the estate of Lonnie Hamilton the sum of $1.1 million as reasonable compensation for his son's conscious pain and suffering from the onset of his injury to the time of his death.

With respect to the claimant's wrongful death cause of action, no pecuniary losses were shown. Accordingly, claimant's second cause of action for wrongful death is dismissed.

By Decision and Order dated February 19, 2021, claimant's motion for partial summary judgment on his eighth cause of action for loss of sepulcher was granted, and the issue of damages was tried together with the claimant's remaining causes of action, addressed above. In support of this claim the claimant, Lonnie's father, testified that he did not learn of Lonnie's death until two

months after he died when he contacted Marcy to check on his son and was informed that Lonnie was deceased. With the help of his lawyer, claimant obtained a Court Order for the exhumation of Lonnie's body, which had been buried at Marcy Correctional Facility. Both the claimant and his brother, Alexander Hamilton, witnessed the exhumation and claimant testified that Lonnie's unembalmed remains were buried in a plywood box which appeared about to fall apart at any moment. Mr. Hamilton was able to identify his son's remains but testified that his face was badly decomposed, which is an image he has been unable to erase from his memory. He testified that the photograph received in evidence as Exhibit 15 depicts the way his son appeared when he saw his body in the funeral home. Lonnie was finally laid to rest in September 2016 after a funeral was held with a closed casket in the Bronx. The claimant testified he was "in a dark place" after his son's death (Tr.1, p. 44). He stated that as a result of this incident, he has been unable to sleep, is scared, and is always angry (*id.* at 45).

Although Mr. Hamilton has not sought professional help to address his mental health issues, both he and his brother testified that such help is frowned upon in the African-American culture. He therefore sought the spiritual advice and consolation of his brother Alexander Hamilton, who is an Associate Minister in the Rapture Preparation Church where Lonnie's funeral was held. The claimant testified that he and his son exchanged letters and he sent Lonnie packages while he was in prison, although his communications with Lonnie tapered off around Christmas time in 2015.

On cross-examination it became clear that Lonnie spent a good part of his childhood in Georgia where he was in the custody of his father's sister before being placed in foster care. Claimant testified that Lonnie lived with his mother in Georgia for a brief time, and then with his

Aunt, before returning to New York, and he was unaware of the fact that Lonnie had ever been in foster care. Alexander Hamilton, on the other hand, testified that Lonnie had been in a group home in Georgia. Defendant contends that as a result of the claimant's estranged relationship with his son, damages on his loss of sepulcher claim are diminished.

The right of sepulcher is "geared toward affording the next of kin solace and comfort in the ritual of burying or otherwise properly disposing of the body, it is the *act of depriving the next of kin of the body*, ... that constitutes a violation of the right of sepulcher" (*Shipley v City of New York*, 25 NY3d 645, 654 [2015]). Thus, "[d]amages are limited to the emotional suffering, mental anguish and psychological injuries and physical consequences thereof experienced by the next of kin" as a result of the interference with their right to immediate possession of a decedent's body (*Shipley v City of New York*, 25 NY3d at 653). Reviewing comparable cases (*Estate of Loughlin v State of New York*, 146 AD3d 863 [2d Dept 2017] [$75,000 to each of two siblings whose father died in prison and was buried on prison grounds and later exhumed]; *Shipley v City of New York*, 105 AD3d 936 [2d Dept 2013], *revd on other grounds* 25 NY3d 645 [2015] [$500,000 awarded to each of two claimants was reduced on appeal to $300,000 each where the medical examiner failed to return decedent's brain to the next of kin for burial]; *Jones v City of New York*, 80 AD3d 516 [1st Dept 2011] [award of $800,000 was reduced to $400,000 where the medical examiner improperly released the decedent's body to the wrong funeral home, requiring exhumation and cremation due to the passage of time]; *Emeagwali v Brooklyn Hosp. Ctr.*, 60 AD3d 891 [2d Dept 2009] [award of $1.8 million for mother of stillborn infant reduced on appeal to $250,000 on her loss of sepulcher claim]; *Duffy v City of New York*, 178 AD2d 370 [1st Dept 1991], *lv dismissed* 80 NY2d 924 [1992], *lv denied* 81 NY2d 702 [1993] [reduction of award to

$250,000 affirmed on appeal for withholding news of son's death for 18 months]), the Court finds an award to claimant in the amount of $400,000 reasonable compensation. Although the claimant had obviously been estranged from his son during his childhood, it appears they maintained a relationship upon his return to New York and that the claimant suffered deeply from the heartbreak he experienced witnessing the exhumation of his son's decomposing body.

Based on the foregoing, the Court awards:

(1) the claimant Lonnie Lee Hamilton in his capacity as administrator of the estate of Lonnie Lamont Hamilton the sum of $1.1 million on his first cause of action for negligent supervision for the conscious pain and suffering of the decedent, Lonnie Lamont Hamilton; and

(2) the claimant Lonnie Lee Hamilton in his individual capacity the sum of $400,000 on his eighth cause of action for loss of sepulcher.

Interest on the award for conscious pain and suffering shall accrue at the statutory rate from the date of this Decision, and

Interest on the award for loss of sepulcher shall accrue from February 19, 2021, the date partial summary judgment in claimant's favor on the issue of liability was determined (*see Love v State of New York*, 78 NY2d 540 [1991]).

All remaining causes of action not previously dismissed or withdrawn are hereby dismissed.

Any filing fee paid by claimant shall be recovered pursuant to § 11-a (2) of the Court of Claims Act.

All trial motions not heretofore decided are now deemed denied.

Let judgment be entered accordingly.

Saratoga Springs, New York
April 20, 2022

FRANCIS T. COLLINS
Judge of the Court of Claims