



**Commission of
Correction**

**Final Report of the
New York State Commission of Correction:**

In the Matter of the Death of

**LeBarnes McClure,
an incarcerated individual of the
Anna M. Kross Center**

December 21, 2021

**To: Commissioner Vincent Schiraldi
NYC Department of Correction
75-20 Astoria Blvd., Suite 100
East Elmhurst, NY 11370**

Allen Riley
Chairman

Thomas J. Loughren
Commissioner

Yolanda Canty
Commissioner

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 LeBarnes McClure who died on November 23, 2019, as result of circumstances which occurred while an incarcerated individual in the custody of the New York City Department of Correction, the Commission has determined that the following final report be issued.

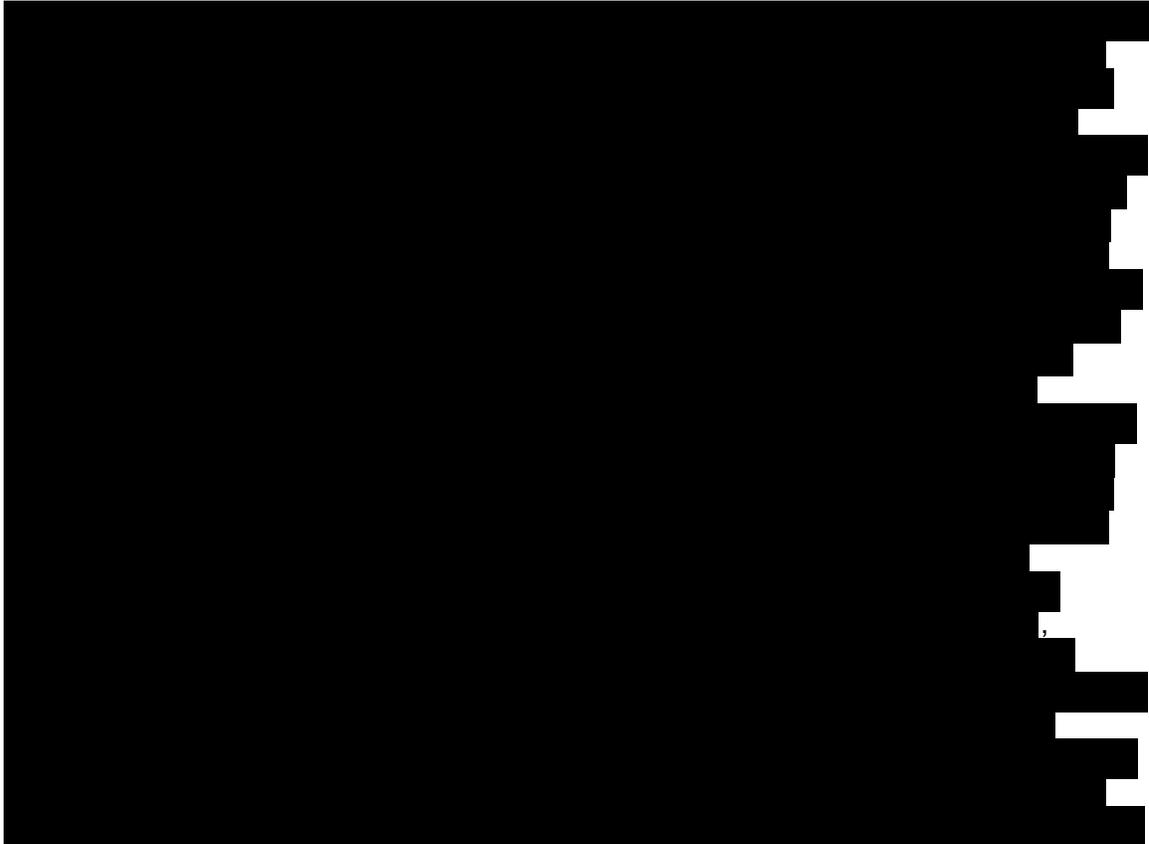
FINDINGS:

1. LeBarnes McClure was a 55-year-old, African American male who died on 11/23/2019, while in the custody of the New York City Department of Correction (NYC DOC) the Anna M. Kross Center (AMKC) due to hypertensive and atherosclerotic cardiovascular disease. The Medical Review Board has found that medical providers from Correctional Health Services failed to adequately recognize and manage McClure's acute medical distress when he presented to emergency sick call on 11/22/2019. Medical providers failed to recognize McClure's presenting signs and symptoms, in a patient with multiple known risk factors, as possible acute coronary syndrome and delayed in obtaining emergency transport of McClure to a hospital. McClure's access to medical care was also delayed due to inadequate availability of DOC officers to escort McClure to sick call necessitating an officer to abandon an assigned post and provide an urgent escort him. Additionally, the Medical Review Board identified lapses in McClure's chronic care management including failures to obtain a CPAP, follow up on missed lab appointments, and medication management. The Medical Review Board opines that had McClure received timely and competent medical care, McClure's death may have been preventable.
2. McClure was arrested on 9/10/19, by the New York City Police Department on charges of Criminal Sale of a Controlled Substance, Criminal Possession of a Controlled Substance, Conspiracy to Perform a Class A Felony, and Criminal Possession of a Controlled Substance with Intent to Sell. McClure was arraigned in Kings County Supreme Court and bail was set at \$25,000 cash. McClure was remanded to the custody of the New York City Department of Correction.
3. McClure was physically in NYC DOC's custody at 11:17 a.m. An Arraignment and Classification Screening Form was completed with McClure. Some portions of this form were not completed to include whether McClure had any medical needs, any medical triage completed, whether a phone call was provided to McClure, whether McClure was previously incarcerated, the determined custody level and the signatures of the receiving facility supervisor and the court supervisor. The Medical Review Board finds that the facility failed to thoroughly complete the admission classification form including the determination for possible medical needs of an incarcerated individual with multiple chronic illnesses who utilized medical equipment in the community. McClure stated that McClure's condition was "fine" and the officer documented that McClure appeared "ok". McClure had no signs of withdrawal or trauma. McClure provided an address and the emergency contact was documented as McClure's mother who resided at the same address. McClure denied needing any enhanced security housing and there was no indication for a suicide watch. McClure denied any gang affiliation. McClure scored a zero on the Suicide Preventions Screening Guidelines. The screening officer did

indicate that a non-emergency referral to medical and mental health was generated.

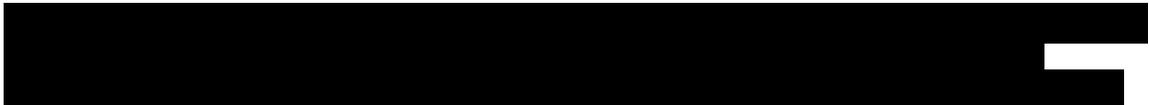
4. As per the Inmate Movement History form, McClure was received at the Brooklyn House Detention Center from court at 5:58 p.m., where McClure was placed in an intake area. On 9/11/19, McClure was moved to housing "4B" at 6:29 a.m. McClure remained there as per the Inmate Movement History until 9/13/19.

5.



The Medical Review Board finds that Dr. [REDACTED] failed to prescribe sublingual nitroglycerine to a patient who had it prescribed in the community, who had suffered a recent myocardial infarction and who presented with several risk factors for a cardiac event.

6.



During an interview with Commission staff, Dr. [REDACTED] stated that patients who are admitted with a history of sleep apnea are asked if they know their CPAP settings. If they do, only then are they provided with a device. If they do not know their settings, they would have to be sent for a sleep study which could take several days. The Medical Review Board finds that Correctional Health Services' system of obtaining CPAP for patients is inadequate with unnecessary institutional barriers. McClure a patient who was morbidly obese and had several comorbidities including known sleep apnea had a medical necessity for CPAP.

7.



[REDACTED]

The Medical Review Board finds that Dr. [REDACTED] failed to order an appropriate diet or a dietary consultation for a morbidly obese patient with diabetes, high blood pressure, hyperlipidemia and history of myocardial infarction.

8.

[REDACTED]

9.

[REDACTED]

10.

[REDACTED]

At 7:26 p.m., McClure was moved to AMKC and housed in the "4 Top" housing where McClure remained until the day of the terminal event.

11.

[REDACTED]

The Medical Review Board finds that there was a pattern of no documentation indicating adequate glucose monitoring for a patient with diabetes.

12.

[REDACTED]

13.

[REDACTED]

[REDACTED]

14. [REDACTED]

15. [REDACTED]

16. [REDACTED]

17. [REDACTED]

18. [REDACTED]

19. [REDACTED]

20. [REDACTED]. The Medical Review Board finds that there was a pattern of failure to refer a patient who had a

glucose fingerstick outside of normal parameters to a medical provider.

21. [REDACTED]

22. [REDACTED]

23. [REDACTED]. The Medical Review Board finds that there was a pattern of failure to recognize and provide intervention for medication non-compliance by a patient with multiple potentially life-threatening comorbidities

24. [REDACTED]

25. [REDACTED]

26. [REDACTED]. The Medical Review Board finds there was a failure to follow up on a missed laboratory appointment for a patient with multiple potentially life-threatening comorbidities which caused a two-month delay to obtain the ordered testing.

27. [REDACTED]

28. On 11/22/19 at 3:30 p.m., CO R.C. began the 3:00 p.m.–11:00 p.m. shift. The security check was unremarkable and institutional lock out was at 4:00 p.m. At 4:10 p.m., Capt. L.C. completed a tour with nothing to report. During an interview with Commission staff, Capt. L.C. reported observing McClure and McClure did not appear to be in distress. The only notation specific to McClure was after the 9:30 p.m. supervisory tour by CO R.C. In the logbook, it states “LE 1 out to clinic. Inmate McClure”. During an interview with Commission staff, CO R.C. stated that McClure came to the officer with complaints about a problem with a tooth. CO R.C. stated that the process was that an escort would come and take individuals to medical. There were no escorts available. CO R.C. reported “I took him (McClure) myself”. CO R.C. stated that McClure was able to walk without difficulty to the medical office. Per the A Post logbook, McClure went to the clinic at 9:30 p.m. and returned at 10:30 p.m. [REDACTED]

[REDACTED]

[REDACTED]. A review of recorded video showed that McClure left the unit at 9:10 p.m. and returned at 9:58 p.m. During an interview with Commission staff, Capt. L.C. recalled seeing McClure on the “4 Top landing” and that McClure appeared to be doing better. CO R.C. did not recall who brought McClure back to the dorm.

29. A review of the housing area video shows McClure moving and appearing restless as evidenced by McClure standing, sitting, and leaning on the windowpane. McClure attempted to lay down but does not remain in that position for long. McClure can be seen spitting into tissues and walking to the garbage can spitting. At 10:19 p.m., McClure was given an inhaler by another incarcerated individual who instructed McClure on how to use it. McClure can be seen taking two puffs of the inhaler.
30. At 11:05 p.m., CO R.C. documented that the officer remained on shift in the housing area logbook. At 11:35 p.m., CO R.C. documented in the logbook that McClure was escorted to the clinic. During an interview with Commission staff, CO R.C. stated that at approximately 10:40 p.m., McClure informed CO R.C. that McClure did not feel well, felt like McClure’s “throat was closing” and “could not breath”. CO R.C. reported informing the A post officer to call the clinic for an escort. CO R.C. reported that no escorts came and stated “I took him (McClure) myself. I could tell he was not feeling well” an act that the Medical Review Board finds, despite any potential policy violation for abandoning a security post, notably commendable by the officer. During an interview with CO I.G., who was in the A Post in the clinic, CO I.G. stated that the process that is supposed to be followed if an escort is not available is for the officer to contact a supervisor. There was no evidence that a supervisor was contacted. The Medical Review Board finds that the facility failed to follow protocols to assure a timely transport of an incarcerated individual for a medical evaluation. CO R.C. said that CO R.C. reported to the clinic officers that McClure was having trouble swallowing and was having chest pain. During an interview with Commission staff, officers assigned to the clinic did not recall if McClure reported chest pain. CO R.C. stated that the clinic officers gave McClure a chair and McClure thanked the officer for helping. CO R.C. stated that this was the last time the officer saw McClure. The Medical Review Board finds that there was a failure of the clinic officers to document that McClure arrived in the Clinic A Post log and was complaining of a potentially life-threatening symptom and failed to document the response by security staff.
31. Per a review of the video from the clinic area, McClure entered the clinic at 11:40 p.m. and approached the officers’ desk. McClure remained standing as officers spoke. At 11:42 p.m., McClure was given a chair to sit on in the hallway. At 11:44 p.m., RN [REDACTED] can be seen speaking to McClure and then walk away. McClure stands and sits restlessly the hallway. At 11:49 p.m., McClure speaks to an officer and then walks down the hall and enters an examination room with a physician. Between 11:49 p.m. and midnight on 11/23/19, RN [REDACTED] and Dr. [REDACTED] go in and out of the exam room. Dr. [REDACTED] leaves the room at 12:23 a.m.
32. At 12:29 a.m., McClure left the exam room and walked slowly to the officers’ desk. McClure spoke to an officer and then returned to the hallway outside the exam room.

McClure can be seen speaking to someone over a half wall then reentered the examination room. At 12:30 a.m., McClure can be seen exiting the exam room holding the chest area. McClure leans forward then goes back into the room. At 12:31 a.m., McClure exits the exam room and goes to the half wall and speaks to someone on the other side. At 12:32 a.m., a man and an officer enter the exam room. At 12:33 a.m., McClure exits the exam room with the appearance that McClure is in distress. McClure goes back into the exam room and the nurse reenters at 12:33 a.m. RN [REDACTED] leaves the room at 12:34 a.m. and appears to be talking to someone with hand gestures as the nurse leaves. During an interview with Commission staff, RN [REDACTED] stated that the protocol for triage was to take vital signs and refer the patient to the physician. RN [REDACTED] stated that it was not unusual that a patient be left alone in the treatment room. [REDACTED] CO C.B. stated during an interview with Commission staff that if the health staff feels uncomfortable during triage, then the officer should stand at the door to supervise the incarcerated individual.

33.

[REDACTED]

Dr. [REDACTED] was unavailable for an interview with Commission staff during the investigation. The Medical Review Board finds that Dr. [REDACTED] failed to recognize signs and symptoms of a potentially life-threatening condition in patient with a history of diabetes, hypertension, hyperlipidemia and myocardial infarction and failed to provide an adequate assessment and life-saving interventions such as an EKG and oxygen therapy. The Medical Review Board also finds that Dr. [REDACTED] provided Ipratropium-albuterol 0.5-2.5mg inhalation solution via nebulizer to a patient with no history of acute chronic obstructive pulmonary disease and clear lung sounds.

34.

[REDACTED]

[REDACTED]. During an interview with Commission staff, Dr. [REDACTED] reported the incident consistent with the documentation. The Medical Review Board finds that Dr. [REDACTED] failed to provide a transport via EMS as directed by the Urgicare physician and failed to document as to why it was not completed.

35.

Per a review of the video from the clinic area, at 12:35 a.m., McClure is observed stepping out of the exam room and speaking to someone over the half wall. McClure

was seen near the officer's desk at 12:39 a.m. speaking to the officer. At this time, the physician was standing next to McClure. The physician was observed patting McClure's back and arm. McClure can be seen speaking to the officer and the officer motions toward a plastic chair in front of the desk. McClure goes to the chair and sits briefly. McClure then stands and hangs onto the physician. The nurse approaches and then walks away. McClure then collapses next to the physician. Several staff come to assist, and McClure is placed on a stretcher. The Medical Review Board finds that the facility failed to provide supportive and adequate medical care to McClure as evidenced by video footage of a patient moving around the clinic in obvious distress and collapsing in a hallway.

36. As per the clinic logbook, Emergency Medical Services (EMS) was activated at 12:40 a.m. Per a review of the recorded video, a health staff person can be seen performing compressions at 12:42 a.m. Health staff bring equipment to the area including an oxygen tank and what appears to be a cardiac monitor.

37. McClure was moved to the examination room at 12:43 a.m. Dr. [REDACTED] arrived on the scene from Urgicare at 12:49 a.m. [REDACTED]

[REDACTED]

[REDACTED] During an interview with Commission staff, Dr. [REDACTED] reported the incident consistent with the documentation. EMS arrived at bedside [REDACTED]

[REDACTED]

38.

[REDACTED]

[REDACTED] During an interview with Commission staff, RN [REDACTED] reported that there was no protocols for the reassessment of a patient following a nebulizer treatment unless it was ordered by a physician. [REDACTED]

[REDACTED]

[REDACTED] During an interview with Commission staff, RN [REDACTED] stated that officers would usually let the nurses know if someone was in distress. [REDACTED]

[REDACTED]. The Medical Review Board finds that RN [REDACTED] failed to provide an adequate initial nursing assessment, follow-up assessment following treatment, and left a patient alone that was in distress.

39. A review of the video showed that EMS arrived at 1:00 a.m. The EMS record indicated that they were delayed initially in getting to the patient due to security clearance. The record indicated that this delay was 13 minutes. [REDACTED]

40. [REDACTED]

41. Following the incident, an investigation was conducted by the NYC DOCS Investigative Division. The inventory of McClure's belongings included pharmacy packets of seven unopened Coreg 6/25mg tablets, four unopened aspirin 81mg tablets, four unopened tablets of Januvia 100mg and seven unopened tablets of Singulair 10mg. Also, noted in the crime scene photographs is a beclomethasone dipropionate multidose inhaler with a pharmacy label for another incarcerated individual. This incarcerated individual was interviewed and reported having lost an inhaler in the past. This incarcerated individual was not housed at AMKC at the time of this incident.

ACTIONS REQUIRED:

TO THE COMMISSIONER OF THE NEW YORK CITY DEPARTMENT OF CORRECTION:

1. The Commissioner shall review the policies and procedure related to the completion of the Arraignment and Classification Risk Screening Form and develop a system to assure the completion of the form to adequately screen individuals at intake for the proper intake interventions when needed.
2. The Commissioner shall conduct an investigation as to why there was a failure to provide transport to an incarcerated individual to medical for an evaluation twice in one shift.
3. The Commissioner shall conduct an investigation as to why there was a failure to

document McClure's arrival in the clinic and failure to provide an immediate response by security staff.

4. The Commissioner shall review the policies and procedures regarding the supervision of incarcerated individuals within the medical department.

A report of the findings and corrective actions taken shall be provided to the Medical Review Board upon completion.

In a response to the Commission's preliminary report dated 12/7/21, the NYC DOC Commissioner indicated that the requested reviews and investigations were completed with corrective actions taken. The Commission has found the response acceptable and will noted for future verification and monitoring.

TO THE SENIOR VICE PRESIDENT OF CORRECTIONAL HEALTH SERVICES, NYC HEALTH AND HOSPITALS CORPORATION:

1. The Senior Vice President shall conduct an investigation as to why there was a failure to order nitroglycerine, an appropriate diet, and a dietary consultation for a patient with diabetes, hypertension, history of myocardial infarction and morbid obesity.

In a response dated 11/16/21, [REDACTED]

The Medical Review Board did not find in their review of the provided medical records where McClure was asked about his prior nitroglycerin use to determine that it was only prescribed in the context of an acute prior myocardial infarction.

2. The Senior Vice President shall review and revise the policies and procedures pertaining to the continuation of treatment for a patient with obstructive sleep apnea to assure that the care and treatment is consistent with the care patients receive in the community.

In a response dated 11/16/21, [REDACTED]

. The Medical Review Board finds this unacceptable as CPAP settings are most often ordered by a physician and calibrated by someone trained to perform this function and most patients receiving this therapy do not know or understand these settings. The Medical Review Board remains opined that CHS should revise policy and procedure for appropriate continuation of treatment for obstructive sleep apnea.

3. The Senior Vice President shall conduct an investigation as to why there was a failure to monitor ordered fingerstick glucose levels as ordered and a failure to report any values that are outside of the normal parameters for treatment.
4. The Senior Vice President shall review and revise the policies and procedures regarding the monitoring and reporting of any non-compliance with ordered medication therapy to assure that there is immediate notification to the ordering provider when medications are not picked up or consumed by a patient.

In a response dated 11/16/21, Correctional Health Services indicated that they disagree with the Medical Review Board's finding that immediate notification to the provider should be made when a patient does not pick up a supply of medications or does not consume them. The Board found this response unacceptable as a pattern of disconnect between the reporting of missed doses of medications and notification to the providers in this system has been identified in previous matters reviewed by the Board.

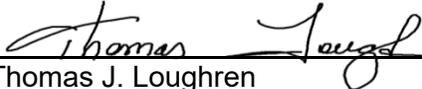
5. The Senior Vice President shall conduct an investigation as to why there was a failure to obtain the ordered laboratory testing for two months following the order.
6. The Senior Vice President shall conduct an investigation into the care provided to McClure by Dr. [REDACTED] related to the assessment, the failure to recognize a potentially life-threatening condition, prescribed treatment and failure to provide a transfer via 911 when recommended by Urgicare physician, and the failure to provide adequate medical and supportive care.
7. The Senior Vice President shall conduct an investigation into the care provided by RN [REDACTED] to McClure related to the inadequate assessment, failure to provide adequate medical and supportive care and the abandonment of a patient in distress.

In a response dated 11/16/21, Correctional Health Services indicated that they disagree with the Medical Review Board's findings and state that in an overnight setting analogous to an outpatient setting it is expected that a nurse leave a patient unattended to obtain supplies or complete a treatment. The Board holds that an adequate assessment of a patient with respiratory distress was not completed by the RN and as a result, the patient was left unattended. Additionally, recorded video reviewed by the Board showed that McClure was observed gasping for air and clenching his chest giving clear indication that he was in distress.

A report of the findings and corrective actions taken shall be provided to the Medical Review Board upon completion.

In a response to the Commission's preliminary report dated 11/16/21, the Senior Vice President for Correctional Health Services indicated that the requested reviews and investigations were completed. The Medical Review Board has found the responses to items 3, 5, & 6 acceptable and 1, 2, 4, & 7 unacceptable and will noted for future verification and monitoring

WITNESS, HONORABLE THOMAS J. LOUGHREN, Commissioner, NYS Commission of Correction, Alfred E. Smith State Office Building, 80 South Swan Street, 12th Floor, in the City of Albany, New York 12210 on this 21st day of December, 2021.



 Thomas J. Loughren
 Commissioner & Chair
 Medical Review Board

TJL:ET:jdb
2019-M-0124
December 2021

cc: Dana Wax, Acting Chief of Staff
Melissa Guillaume, Deputy General Counsel
Patricia Yang, DrPH, Senior Vice President
Correctional Health Services
Ross MacDonald, MD, Chief Medical Officer
Correctional Health Services
Ronald Greenberg, Director, Compliance and Inspections
NYC Department of Correction
Margaret Egan, Executive Director
NYC Board of Correction