`

Commission of Correction

Final Report of the New York State Commission of Correction:

In the Matter of the Death of

Dillin Button, an incarcerated individual of the Chenango County Jail

January 25, 2023

To: Sheriff Ernest Cutting
Chenango County Sheriff's Office
279 County Road 46
Norwich, New York 13815

Allen Riley
Chairman

Thomas J. Loughren
Commissioner

Yolanda Canty
Commissioner

80 South Swan Street, 12th Floor, Albany, New York 12210 | 518-485-2346 – phone | 518-485-2467 – fax | www.scoc.ny.gov

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 Dillin Button who died on March 17, 2021 , as a result of circumstances which occurred while an incarcerated individual in the custody of the Chenango County Sheriff at the Chenango County Jail, the Commission has determined that the following final report be issued.

<u>FINDINGS</u>:

1. Dillin Button was a 22-year-old male who died on 3/17/21 due to complications of bacterial endocarditis while in the custody of the Chenango County Sheriff at the Chenango County Jail. The Medical Review Board has found that there were multiple deficiencies in the medical assessments and treatment of Button during his incarceration. The Medical Review Board has opined that had Button been properly diagnosed and timely referred to a hospital for treatment, his death may have been preventable.

2. Button was born in Binghamton, NY. Button was survived by his child and parents. Button did not finish high school and was not employed. There was no further demographic or social history available to the Commission related to Button.

3.

4. .

5. . In the instant offense on 11/29/20, in the City of Norwich, NY, Button was arrested by the Norwich City Police Department and charged with Criminal Possession Controlled Substance 7th Degree. On March 6, 2021, Button returned to Norwich City Court on a Warrant, and he was arraigned on the charges of Criminal Possession Controlled

Substance 7th Degree, Motor Vehicle License Violation, and Unsafe Movement of a Stopped Motor Vehicle. On 3/11/21, a bench warrant was issued for Button. On 3/15/21, Button returned on the bench warrant and was remanded to the Chenango County Sheriff's Office at the Chenango County Jail. Button's charges were abated by his death.

6. On 3/15/21 at 11:00 a.m., Button was admitted to the Chenango County Jail by Officer M.C. for a charge of Criminal Possession of Controlled Substance 7th Degree. [redacted] . Officer M.C. initiated 7–10-minute supervision rounds on Button as a precautionary measure [redacted] A pat searched was done on Button to check for any contraband however no contraband was found. During an interview with Commission staff, Officer M.C. reported that Button was complaining of being cold. When Officer M.C. was asked if Button seemed to be intoxicated or under the influence during the intake process, Officer M.C. reported, "Yes, he was either sick or intoxicated". Officer M.C. reported that Button was understanding the questions that were asked however Officer M.C. indicated that he could tell that due to Button's response Button was on something. Button did report to Officer M.C. that he would go through withdrawal..

7. Registered Nurse (RN) [redacted] reported to booking [redacted]

8. [redacted]. The Medical Review Board opines that Button should have had his temperature retaken with an oral thermometer for a true reading of his body's temperature. The extent of necrotizing bacteria found Button's lung tissue at autopsy indicate that he had active infection at the time of his admission and would have had an elevated temperature. Additionally, the Medical Review Board finds that RN [redacted] failed to obtain a respiratory rate and an oxygen saturation level on Button who reported having shortness of breath and a cough. [redacted]

[REDACTED].

9. [REDACTED]. Commission staff reviewed the video recording of Button leaving the booking cell to go to the stool where RN [REDACTED] was going to assess him. Commission staff observed Button staggering as he walked out of the booking cell to the stool. The video recording showed Button sitting on the stool and leaning forward with his head hung downward with occasional movements to an upright seated position throughout most of RN [REDACTED]s assessment. The video recording showed RN [REDACTED] performing an assessment on Button as Button was leaned forward with his head resting on the booking desk. [REDACTED] The Medical Review Board finds that a complete medical assessment was not appropriately performed on Button while he sat on a stool and leaning forward with his head resting on the booking desk. The extent of vegetation found on Button's cardiac valves at autopsy indicate that a diastolic murmur would have audible if heart sounds were properly assessed. The Medical Review Board opines that Button should have been sent out to the hospital for an evaluation at that time rather than being put on the list to see the Doctor later that evening. During an interview with Commission staff, RN [REDACTED] was asked, "Do you do withdrawal assessments like the Clinical Opiate Withdrawal Scale (COWS)?" RN [REDACTED] reported that they do "on certain individuals" but it was not standard practice. The Medical Review Board also has found that the facility did not have an adequate withdrawal protocol in place. The Medical Review Board opines that withdrawal protocols should be initiated in the facility and used for each individual that is admitted with a drug or alcohol dependency.

10. On 3/15/21 at 3:14 p.m., Button was escorted from intake to housing unit C cell #13 with the continuation of 7-10-minute supervision checks.

11. [REDACTED]

[REDACTED].

In a response dated 11/8/22 to the Commissions preliminary report, the Chenango County Sheriff Office explains that the medication delivered to Button at 5:00 p.m. was the medication ordered by the jail physician after the 6:32 p.m. medical exam and was only documented in the 5:00 p.m. time entry on the medication administration record but not actually given at that time. The Commission will acknowledge that this was not an instance of medication administration without an order, however the Medical Review Board continues to endorse the report findings as the documentation in this matter was inaccurate, deficient, not properly reflective of the actual patient care given, and subject to repeat error if not corrected.

12. On 3/15/21 at 6:32 p.m., documentation in the unit logbook indicated that Button was taken off the unit and escorted to medical to be seen by the doctor.

13. [REDACTED]. A review of the medical assessment by Commission staff, revealed that an updated set of vital signs was not obtained by RN [REDACTED] or Dr. [REDACTED] at the medical encounter. An updated set of vitals may have indicated further information regarding Button's medical condition at the time of the assessment. Further review also revealed that the medical sick call form did not have the time entered for the encounter. The Medical Review Board has found that the medical documentation did not comport with the requirements of 9 NYCRR§7010.2(j) which state:

    Adequate health service and medical records shall be maintained which shall include but shall not necessarily be limited to such data as: date, name(s) of inmate(s) concerned, diagnosis of complaint, medication and/or treatment prescribed. A record shall also be maintained of medication prescribed by the physician and dispensed to a prisoner by a staff person.

14. On 3/15/21 at 6:45 p.m., documentation in the unit logbook indicated that Button returned to the unit.

15. . The Medical Review Board opines that RN should have notified Dr. that Button refused the one-time dose of at 9:00 p.m. and obtained clarification if the Doctor wanted a new order.

16. During an interview with Commission staff, CO C.B. reported that he was training with CO K.M. on 3/16/21 for the overnight shift on C pod that housed Button. CO C.B. reported that Button could be heard moaning from the officer's desk while they were getting the report from the off going officers. CO C.B. reported that he did not recall anything specific being reported about Button. CO C.B. reported that around 2:00 a.m. to 3:00 a.m., he and CO K.M. went to Button's cell and asked Button if he wanted any Tylenol or Ibuprofen. CO C.B. reported that Button refused the medications but requested to see a doctor. CO C.B. reported that Button was told that once the nurse got there in the morning, she would come and check on him because during the night they do not have a nurse. CO C.B. reported that the supervisor, Corporal (Cpl.) K.H., was updated and Cpl. K.H. reported that medical understood that Button had a problem and that Button would have to wait until medical figured out what to do. CO C.B. reported that Button continued to moan and remained consistent throughout the night. During an interview with Commission staff, Cpl. K.H. did not recall receiving any specific notifications regarding Button. The Medical Review Board opines that consultation with an on-call medical provider should have occurred or Button should have been sent to the hospital for evaluation.

17. .

18. A review of the medical documentation by Commission staff revealed a problematic disjunction between the nurses notes, physician's order and the MAR. The Medical Review Board has found that the physician orders were not properly clarified by the nursing staff nor properly transcribed over to the MAR as they were written. The medical documentation also was not in comportment with the requirements of 9 NYCRR §7010.2(j).

19. . During an interview with

Commission staff, RN reported that requested medical records come to a fax machine that is located in the medical office.

20.

21.

. The Medical Review Board opines that Button needed to be sent out to the hospital for an evaluation and that RN is licensed to make assessments and patient care plans which would include referring a patient to a hospital.

22.

[REDACTED].
During an interview with Commission staff, Cpl. K.H. did not recall being updated to Button's condition when he reported for his shift. The Medical Review Board finds that there was deficient medical documentation from the RNs regarding phone conversations, medical updates and new orders which did not comport with the requirements on 9 NYCRR §7010.2(j). Additionally, the use of random posted notes to transmit clinical information and advisories to staff is an unacceptable practice.

23. [REDACTED]

24. On 3/17/21 at 12:04 a.m., documentation in the unit logbook indicated that CO S.F. started his duty on Housing Unit C and did 7–10 minutes supervision rounds.

25. On 3/17/21 at 1:30 a.m., CO S.F. and CO B.K. were conducting a break during the shift tour on C pod. As CO B.K. walked by cell #13 that housed Button, CO B.K. observed that something wasn't right with Button's body position. During an interview with Commission staff, CO B.K. reported that Button was laying on his right side with his left arm over his chest and his legs were hanging off the bunk from his knees down. COs S.F. and B.K. attempted to get Button's attention by knocking on the cell door with a key but got no response from Button. At that time, CO J.M. entered the Pod and was called over to cell #13 by COs S.F. and B.K. CO J.M. called Button's name to try to get his attention with no response from Button. Cpl. K.H. was notified immediately and was told to bring the crash cart to C pod. EMS was notified to respond to the facility. CO J.M. entered the cell and tried to get a response from Button, however Button was not responsive. At 1:31 a.m., Sgt. R.S. and Cpl. K.H. arrived at the scene and checked for a pulse on Button. Button was pulseless and without respirations. Button was transferred from the bunk to the floor. The AED was applied to Button's chest with no shock advised. Cpl. K.H. initiated Cardiopulmonary Resuscitation (CPR) and Sgt. R.S. began rescue breaths. CPR was continued until with staff rotations until 1:49 a.m. when Norwich Fire and Emergency Medical Systems (EMS) arrived and assumed the care of Button. [REDACTED].
[REDACTED]

ACTIONS REQUIRED:

TO THE CHENANGO COUNTY JAIL PHYSICIAN:

The Jail Physician shall conduct a comprehensive quality assurance review regarding the following:

1. On 3/15/21 at 12:45 p.m., why RN ▇▇▇ failed to take Button's temperature with an oral thermometer after the non-touch thermometer had a reading of ▇▇▇.
2. On 3/15/21 at 12:45 p.m., why RN ▇▇▇ failed to obtain a respiratory rate and an oxygen saturation level on Button who reported having shortness of breath and a cough.
3. On 3/15/21 at 12:45 p.m., how RN ▇▇▇ completed and documented a full medical assessment with Button who was sitting on a stool, leaning forward with his head hung downward on the booking desk.
4. On 3/15/21 at 12:45 p.m., why RN ▇▇▇ did not have Button sent to the hospital for an evaluation per 9 NYCRR §7010.1(b) for an immediate evaluation and treatment.
5. On 3/15/21 at 9:00 p.m., why RN ▇▇▇ did not update Dr. ▇▇▇ that Button refused the ▇▇▇ one-time order and inquire if Dr. ▇▇▇ had further orders.
6. Why posted notes were used and left on the medication cart by the RNs to alert staff to an individual's condition when the medical record was not updated to reflect the condition of the individual.
7. Why Button was not sent to the hospital for an evaluation on 3/16/21 between 2:00 a.m. and 3:00 a.m., when he was moaning and requested to see a doctor.

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

In a response dated 11/8/22 to the Commissions preliminary report, the Chenango County Sheriff Office indicated that the requested reviews were completed. The Sheriff Office indicated that adequate assessments were conducted on Button and that proper procedures were followed. The Medical Review Board remains opined in their findings that Button did not have an adequate medical assessment as clinical signs of acute illness would have been present, that there were deficiencies in the medical documentation, and that Button's death could have been prevented had he been timely referred to a hospital for treatment.

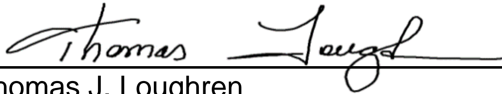
<u>TO THE CHAIR OF THE CHENANGO COUNTY LEGISLATURE:</u>

As the appointing authority for the delivery of jail incarcerated individual health services pursuant to Correction Law section 501, the County Legislature shall review the above findings and conduct an inquiry into the fitness of the currently designated provider.

Additionally, the county shall arrange for a peer review to be conducted of the jail physician with regard to:

1. On 3/15/21, why a set of vital signs were not obtained on Button during his physician visit.
2. On 3/15/21, why the time of the medical encounter on the sick call form by Dr. ▇▇▇ was not documented per requirements of 9 NYCRR §7010.2(j).
3. Why Button's MAR, Sick Call Form, and Medical Assessment Form had inconsistent medication orders which were not verified by the nurse nor properly transcribed.
4. Why the facility does not have a withdrawal protocol in place for all individuals that are admitted with a drug or alcohol dependency.
5. Why Button was not ordered to be sent for an evaluation at a hospital after reported complaints of rib pain, having decreased oxygen saturation levels and receiving records documenting a history of recent treatment for respiratory infection.

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 25th day of January, 2023.



Thomas J. Loughren
Commissioner & Chair
Medical Review Board

TJL:BB:jdb
2021-M-0041
January 2023