NEW YORK STATE | Commission of Correction

Final Report of the New York State Commission of Correction:

In the Matter of the Death of

Kevin Gilooly, an incarcerated individual of the Onondaga County Justice Center

March 22, 2023

To: Sheriff Tobias Shelley
Onondaga County Justice Center
407 S. State Street
Syracuse, New York 13202

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 Kevin Gilooly who died on January 9, 2021 , as a result of circumstances which occurred while an incarcerated individual in the custody of the Onondaga County Sheriff at the Onondaga County Justice Center, the Commission has determined that the following final report be issued.

FINDINGS:

1. Kevin Gilooly was a 65-year-old male who died on 1/9/21 due to Atherosclerotic and hypertensive cardiovascular disease while in the custody of the Onondaga County Sheriff at the Onondaga County Justice Center. The Medical Review Board has found that multiple NaphCare providers were not licensed to practice in New York State (NYS) during Gilooly's incarceration and at the time of Gilooly's death.

2. Gilooly was born in New York. Gilooly did not finish high school and was not employed. There was no further information available to the Commission regarding Gilooly's demographic or social history.

3. [redacted].

4. [redacted].

5. [redacted]. Gilooly was arrested by the Onondaga County Sheriff's Office on 12/23/20 for a felony bench warrant related to a violation of an order of protection that occurred in Syracuse, NY. Bail was denied and Gilooly was remanded to the Onondaga County Justice Center (JC).

6. On 12/23/20 at 6:04 p.m., Gilooly was admitted to the Onondaga County JC by Deputy J.R. for the charges of Criminal Contempt 1st Degree and Harassment 2nd Degree. Deputy B.W. performed a strip search on Gilooly to check for any contraband and no contraband was detected. Gilooly did not cooperate with the intake process, and he

refused to answer questions during the intake interview. Gilooly scored a one on the Suicide Prevention Screening Guidelines [redacted] Gilooly was placed on high observation that required 15-minute security rounds.

7. [redacted]

8. Gilooly was escorted from intake to [redacted], 5C cell # 23, where he was continued on high observation.

9. [redacted].

10. [redacted].

11. [redacted]. Statcare is a remote provider consult service located at NaphCare Headquarters in Alabama.

12. [redacted]. A review of staff credentials completed during the Medical Review Board's investigation found that

there was no documentation available through the NYS Office of the Professions to verify that NP [redacted]. was licensed to practice in NYS during the time of Gilooly's incarceration. NP [redacted]. was not licensed to practice in NYS until 11/19/2021.

13. [redacted].

14. [redacted]. A review of staff credentials completed during the Medical Review Board's investigation found that there was no documentation available through NYS Office of the Professions to verify that NP [redacted]. was licensed to practice in NYS during the time of Gilooly's incarceration. NP [redacted]. was not licensed to practice in NYS until 7/20/2022.

15. [redacted]. A review of Gilooly's medical chart by Commission staff revealed that there was no documentation that the systolic blood pressure reading of [redacted] was addressed by Statcare. The Medical Review Board finds that Statcare did not acknowledge or respond to the medical staff with further orders for a systolic blood pressure of 162.

16. [redacted]".

17. [redacted]

18. [redacted]

[redacted]

19. [redacted]

20. [redacted].

21. [redacted]

22. [redacted].

23. [redacted].

24. [redacted]. A review of staff credentials completed during the Medical Review Board's investigation found that there was no documentation available through NYS Office of the Professions to verify that NP [redacted]. was licensed to practice in NYS during the time of Gilooly's incarceration. NP [redacted]. was not licensed to practice in NYS until 1/3/2022.

25. [redacted]. A review of staff credentials completed during the Medical Review Board's investigation found that there was no documentation available through NYS Office of the Professions to verify that Medical Dr. [redacted]. was licensed to practice in NYS. The Medical Review Board finds that the Onondaga County Justice Center's medical department was using multiple systems to document medical information back and forth between NaphCare and Statcare. This has the potential for the Justice Center's medical department not to receive adequate feedback regarding the direction of care for the incarcerated individuals' medical needs as evident by NP [redacted]. and Dr. [redacted] both prescribing [redacted] on the same date of 12/26/20.

26. [redacted]

27. [redacted].

28. [redacted].

29. [redacted]

30. [redacted].

31. [redacted]

32. [redacted].

33. [redacted].

34. [redacted].

35. [redacted].

36. [redacted]

37. [redacted].

38. [redacted].

39. [redacted].

40. [redacted].

41. [redacted]. The Medical Review Board finds that Statcare did not acknowledge or respond to the medical staff with further orders for a systolic blood pressure of 180. The Medical Review Board also finds that there was a lack of adequate hypertension management and a lack of attempts to try and complete Gilooly's intake health assessment.

42. [redacted]

43. [redacted].

44. [redacted]

45. [redacted]

46. [redacted].

47. [redacted]

48. [redacted]

49. [redacted]

[redacted].

50. [redacted].

51. [redacted].

52. [redacted].

53. [redacted]. The Medical Review Board finds that RN [redacted]. failed to perform a full medical assessment on Gilooly and finds the review by PA [redacted]. to be inadequate by accepting and co-signing an incomplete medical assessment on Gilooly who had a past medical history of HTN, Asthma, and seizures. The Medical Review Board finds that although the health assessment was within 14 days since Gilooly's admission, given Gilooly's history and presentation showing acute hypertension, attempts should have been made to complete his intake assessment sooner rather than later into the 14-day time frame.

54. [redacted].

[redacted]

55. [redacted].

56. [redacted].

57. On 1/8/21 at 9:02 a.m., CO J.H. documented in the 5C unit logbook that Gilooly was no longer on medical keeplock.

58. On 1/8/21 at 10:58 a.m., CO J.H. documented in the 5C unit logbook that Gilooly was out for recreation.

59. [redacted]

60. [redacted].

61. [redacted].

62. [redacted].

63. [redacted].

64. On 1/9/21, documentation in the [redacted] housing unit 5C logbook indicated that unit rounds were done by Deputies W.B. and C.D. with a flashlight on 1/9/21 at 10:06 p.m., 10:14 p.m., and 10:32 p.m. After a review of video recordings of the rounds performed on 1/9/21 between 10:06 p.m. to 10:32 p.m. by the Commission staff, the Medical Review Board finds that the officers did indeed shine a flashlight into Gilooly's cell during each round, but the officers did not slow down their walking pace to check to check to see if Gilooly was breathing.

65. On 1/9/21 at 10:40 p.m., CO W.B. was conducting a 15-minute round on unit 5C. As CO W.B. approached cell # 8 that housed Gilooly, CO W.B. observed Gilooly who appeared to be sleeping half-way off his mattress, and he was not wearing his shirt as he usually

did. CO W.B. started to bang on the cell door to try to get Gilooly's attention but Gilooly did not respond. CO W.B. opened Gilooly's cell door and went inside the cell and tapped Gilooly on the shoulder but Gilooly did not respond. CO W.B. attempted to turn Gilooly on his side and observed Gilooly to be in physical distress and he was unresponsive. CO W.B. immediately called for a medical emergency. RN [redacted]. was working in the medical unit across from unit 5C when he heard the medical emergency being called. RN [redacted] along with four other nurses responded to 5C immediately and they were directed to cell #8. [redacted]

ACTIONS REQUIRED:

TO THE OFFICE OF ONONDAGA COUNTY SHERIFF:

The Sheriff shall conduct an inquiry into the conduct of the correction officers who were responsible for Gilooly's supervision in view of the fact that obvious post-mortem changes indicate that his death occurred at least two hours prior to discovery. Administrative action should be taken if found to be in violation of facility policy and procedures.

TO THE ONONDAGA COUNTY JAIL PHYSICIAN AND MEDICAL DIRECTOR FOR NAPHCARE:

1. The Medical Director shall conduct a comprehensive quality assurance review regarding the following:

   a. Why on 12/25/20 at 1:51 a.m., Statcare did not acknowledge or respond to the medical staff with further orders for a systolic blood pressure of 162.
   b. Why on 12/26/20 both NP [redacted] and MD [redacted]. prescribed [redacted] daily to Gilooly.
   c. Why on 12/28/20 at 7:00 p.m., [redacted] was documented being administered on the Drug Administration Sheet by LPN [redacted]. and LPN [redacted].
   d. Why on 12/30/20 at 2:06 a.m., Statcare did not acknowledge or respond to the medical staff with further orders for a systolic blood pressure of [redacted]
   e. Why attempts were not made to complete Gilooly's medical intake assessment sooner rather than later into the 14-day time frame due to his uncontrolled [redacted]
   f. Why on 1/4/21 at 4:22 p.m., RN [redacted]. was negligent by not performing a full medical assessment on Gilooly for his initial physical assessment.
   g. Why on 1/5/21, PA [redacted]. was negligent by co-signing the incomplete initial physical assessment that was done on Gilooly by RN [redacted]. on 1/4/21.

2. The Medical Director shall review the credentials of all employees to assure that any providers who are assessing patients and writing orders are properly licensed to practice in New Yok State.

A response dated 2/23/23 to the Commission's preliminary report was provided by the law firm of Costello, Cooney & Fearon PLLC. who indicated that they represent Proactive, the contracted health services provider that worked in partnership with NaphCare. There was no response received from the directed recipients; the Onondaga County Jail Physician or the Medical Director for NaphCare.

TO THE CHAIR OF THE ONONDAGA COUNTY LEGISLATURE:

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.

TO THE NYS DEPARTMENT OF EDUCATION, OFFICE OF PROFESSIONAL DISCIPLINE:

That Office of Professional Discipline note the Commission's findings in this case and conduct an investigation into the NaphCare (Proactive) company and the multiple instances of unlicensed medical professions who were documented providing services to Gilooly.

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 22nd day of March, 2023.

Thomas J. Loughren
Commissioner & Chair
Medical Review Board

TJL:BB:jdb
2021-M-0006
March 2023