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Commission of Correction

Final Report of the New York State Commission of Correction:

In the Matter of the Death of

Ronald Pierce, an incarcerated individual of the Oneida County Jail

June 28, 2023

To: Sheriff Robert M. Maciol
Oneida County Sheriff's Office
6065 Judd Road
Oriskany, New York 13424

Allen Riley
Chairman

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 Ronald Pierce who died on August 9, 2021, as a result of circumstances which occurred while an incarcerated individual in the custody of the Oneida County Sheriff at the Oneida County Jail, the Commission has determined that the following final report be issued.

FINDINGS:

1. Ronald Pierce was a 56-year-old male who died on 8/9/2021 from an accidental Fentanyl overdose while in the custody of the Oneida County Sheriff at the Oneida County Jail (CJ). The Medical Review Board opines that the Oneida CJ staff failed to administer Narcan to an unresponsive individual in a timely manner despite the known history of drug use. The Medical Review Board opines that the security staff failed to preform adequate supervisory tours evidenced by the presence of postmortem changes when Pierce was found.

2. [redacted]. In the instant offense, Pierce was arrested on 8/5/21 by the Utica Police Department (PD) for a violation of parole and charges of Petit Larceny, False Personation, and Resisting Arrest. Pierce was to appear in Utica City Court 8/11/21.

3. [redacted].

4. On 8/6/21 at 12:10 a.m., Pierce was transported to the Oneida CJ by Utica Police. Pierce was booked into the jail at 12:23 a.m. [redacted]

[redacted].

5. [redacted].

6. [redacted]

7. On 8/6/21 at 5:56 p.m., per the Shift Log Entry Summary, Pierce complained of having difficulty breathing and medical was advised. Pierce was sent from the housing unit to medical at 5:57 p.m. and returned to the housing unit at 6:16 p.m. A review of the medical record revealed that there was no medical documentation noted for this encounter. This is a violation of 9 NYCRR §7010.2(j) which states: *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.*

8. [redacted].

9. [redacted].

10. On 8/7/21 at 8:56 a.m., per the Shift Log Entry Summary, Pierce requested a breathing treatment. There was no indication in the logbook that Pierce was taken to medical. [redacted] A review of the medical record revealed that there was no medical documentation of the nurse addressing the request for a breathing treatment or any other treatment provided other than the administration of medication. This is a violation of 9 NYCRR §7010.2(j).

11. [redacted].

12. On 8/7/21 at 10:50 a.m., per the Shift Log Entry Summary, Pierce was sent to medical and returned at 10:53 a.m. A review of the medical record revealed that there was no medical documentation noted for this encounter. This is a violation of 9 NYCRR §7010.2(j).

13. On 8/7/21 at 4:27 p.m., per the Shift Log Entry Summary, Pierce was moved to housing unit POD 4, P4-49, under general supervision with added tours.

14. .

15. . A review of the medical record revealed that there was no medical documentation noted for this encounter. This is a violation of 9 NYCRR §7010.2(j).

16. .

17. On 8/8/21 at 11:39 p.m., Corrections Officer (CO) A.P. escorted RN to Pierce's cell . CO A.P. noted that Pierce was sleeping on the floor and was difficult to arouse. Pierce did awaken and was appropriate once awake. CO A.P. noted that it appeared that Pierce had vomited in the toilet area several times during the night. CO A.P. and RN . were present when Pierce vomited again. Pierce was apologetic and offered to clean up his vomit. During an interview with Commission staff, CO A.P. stated that Pierce did not request medical assistance and was alert and appropriate with his responses. . This was a significant increase in Pierce's COWS score. RN did not document this encounter, did not document that Pierce vomited in the RN's presence, or document any assessment of the findings. This is a violation of 9 NYCRR §7010.2(j). RN . is no longer employed at the Oneida CJ.

18. On 8/8/21 from 11:39 p.m. through 8/9/21 at 7:55 a.m., supervisory tours were completed by CO M.B., CO J.L., CO H.S. CO D.J. and CO A.P. All of these tours did not note anything of significance with regard to Pierce.

19. On 8/9/21 at approximately 7:55 a.m., CO D.J. was completing a supervisory tour and noted that Pierce's cell was dark and that it was difficult to see inside. After finishing the supervisory tour, CO D.J. returned to housing unit station. At the same time, CO A.P. was handing out breakfast trays and upon arrival to Pierce's cell, CO A.P. indicated that he called out Pierce's last name a few times without a response. CO A.P. entered the cell and called CO D.J. for assistance. Pierce was noted to be under the table in a slouched position and unresponsive. CO D.J. was unable to palpate a pulse and noted that Pierce was cool to the touch. CO D.J. called a medical emergency at 7:57 a.m. CO D.J. immediately began performing CPR. CO T.M. responded and began providing rescue breaths. At 7:58 a.m., medical responded.

[redacted]. At 8:01 a.m., EMS was activated. [redacted] At 8:17 a.m., EMS arrived [redacted]. At approximately 8:22 a.m., EMS departed the facility with Pierce. The Medical Review Board opines that Narcan should have been administered to Pierce immediately when he was found unresponsive.

20. [redacted]

ACTIONS REQUIRED:

TO THE ONEIDA COUNTY JAIL PHYSICIAN:

1. The jail physician shall conduct a quality assurance review to determine why the medical staff failed to document multiple medical encounters with Pierce in accordance with the requirements of 9 NYCRR §7010.2(j).

2. The jail physician shall conduct a quality assurance review to determine why the medical staff did not perform and document vital signs when COWS assessments were completed.

3. The jail physician shall conduct a quality assurance review to assure that Narcan is administered immediately upon discovery of an unresponsive individual due to unknown causes.

A report of the findings and any corrective actions taken shall be forwarded to the Board upon completion.

In a response dated 4/26/23 to the Commission's preliminary report, the Oneida County Sheriff indicated that new policies and procedures have been implemented including the issuing of Narcan to uniformed staff, having Narcan stations throughout the facility and having Narcan available in the medical bags carried by nurses.

TO THE CHAIR OF THE ONEIDA 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[1].

[1] As of January 1, 2023, a new medical provider, Wellpath Inc., began providing services for the Oneida CJ

WITNESS, HONORABLE ALLEN RILEY, Chairman, 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 28th day of June, 2023.

Allen Riley
Chairman
Commission of Correction

AR:MB:jdb
2021-M-0102
June 2023