`

Commission of Correction

Final Report of the New York State Commission of Correction:

In the Matter of the Death of

Steven Murray, an incarcerated individual of the Clinton County Jail

June 28, 2023

To: Sheriff David N. Favro
Clinton County Sheriff's Office
25 McCarthy Drive
Plattsburgh, New York 12901

Allen Riley
Chairman

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 Steven Murray who died on September 10, 2021, as a result of circumstances which occurred while an incarcerated individual in the custody of the Clinton County Sheriff at the Clinton County Jail, the Commission has determined that the following final report be issued.

FINDINGS:

1. Steven David Murray was a 62-year-old male who died on 9/10/21 while in the custody of the Clinton County Sheriff at the Clinton County Jail (CJ) from congestive heart failure due to hypertensive and atherosclerotic cardiovascular disease. Contributing factors in Murray's death were co-morbidities that included: Cirrhosis, Renal Cell Carcinoma and Chronic Obstructive Pulmonary Disease (COPD). The Medical Review Board has found that there were failures by medical staff to properly assess and provide intervention for Murray's complex medical conditions with complaints of worsening symptoms prior to his terminal event.

2. Murray was born in Potsdam, NY. Murray dropped out of school with an 8th grade education. Murray was single and had one child. Murray's parents were deceased and he had three sisters. Murray was unemployed and lived with his girlfriend prior to his incarceration.

3. . In the instant offense, Murray was being held at the Clinton CJ as a federal detainee awaiting trial. .

4.

.

5. .

6. .

7. .

8.

9. On 8/16/21 at 11:45 a.m., Murray was admitted to Clinton CJ by Correction Officer (CO) A.D. On the initial risk assessment, Murray answered "YES" that he had medical problems that included heart problems and cancer and that he was on numerous medications. CO A.D. noted that Murray's appearance was normal and that Murray did not appear to be under the influence of drugs or alcohol. Murray answered "YES" that . Murray answered "YES" that he had been previously arrested 100 times . Murray indicated that he had been previously incarcerated at Clinton CJ. CO A.D. referred Murray to medical RN . due to Murray's medication use.

10. At 12:07 p.m., CO A.D. performed a suicide risk assessment while admitting Murray to the jail. Murray scored a 2 out of 8 for answering "YES" to lacking close friends and family and [redacted]. Murray was housed in general population in D-Pod, cell 9.

11. [redacted] This is a violation of 9 NYCRR §7010.2(b)(1) which states: *"Each prisoner shall be examined by a physician licensed to practice in the State of New York or by medical personnel legally authorized to perform such examination at the time of admission or as soon thereafter as possible, but no later than 14 days after admission".* Additionally, the Board finds that there was a lack of accounting for Murray's [redacted] history and any follow-up said condition necessitated.

12. [redacted]. 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.

[redacted]
The Medical Review Board finds that there was a failure by the RN to perform an adequate assessment, failed to notify a medical provider of Murray's condition, and diagnosed and then ordered increased fluids for dehydration without a referral to the medical provider.

13. [redacted]

14.

15. . The Medical Review Board opines that the nursing staff should have made attempts to obtain Murray discharge records from CVPH to assure proper continuity of care.

16. .

17. On 9/10/21 at 5:15 a.m., Murray was heard coughing loudly in his cell by CO T.R. CO T.R. called into Murray's cell via the intercom to ask if Murray was alright. Murray informed CO T.R. that he was having trouble breathing. Murray claimed that he had already used his keep on person inhaler, and that it was not helping. Murray said that he had another inhaler on the medication cart. CO T.R. called Sergeant (Sgt.) C.T. to make him aware of Murray's condition. Sgt C.T. and CO J.M. met in medical to retrieve Murray's other inhaler from the medication cart. Sgt C.T. instructed CO J.M. to bring the inhaler to Murray. CO J.M. brought the inhaler to Murray and Murray took two puffs and reported that the medication did not help with his difficulty breathing. Murray told CO J.M. and CO T.R. that his breathing had never been that bad and that he needed oxygen or to go to the hospital. Sgt C.T. called the unit a few minutes later to check on Murray and was informed by the CO T.R. that Murray was not getting any better. Sgt. C.T. advised CO M.W. to bring a wheelchair to D pod. Sgt. C.T. went to Murray's cell to speak with him. Murray was sitting up on his bed in cell 9 and told Sgt. C.T. that he was having a hard time breathing. While speaking with Sgt C.T., Murray's speech became more quiet and harder to understand. Murray denied taking any drugs or medications when Sgt. C.T. asked him. Sgt. C.T. used a pulse oximeter on Murray which yielded a reading of a pulse of 42 and an oxygen saturation of 80%. Murray closed his eyes and began to lean to the left. Sgt. C.T. did a sternal rub on Murray with no response. Sgt. C.T., CO M.L., and CO J.M. moved Murray to the floor. Sgt. C.T. radioed jail control to call EMS. Per the Clinton County Jail Supervisor's report, EMS was called at 5:25 a.m. Sgt C.T. instructed CO M.W. to get the AED. Sgt C.T. administered two doses of nasal narcan to Murray in each nostril with no response. Murray began to foam at the mouth. Sgt C.T. had CO M.L. retrieve the first aid kit and assemble the breathing mask. Sgt C.T. and CO J.M. started CPR on Murray. Sgt C.T. gave breaths and CO J.M. did compressions. The AED was applied to Murray however no shocks were advised. Sgt. C.T. gave two more doses of nasal narcan to Murray with no response. Sgt. C.T. reported that the AED gave the no shock prompt six times before EMS arrived.

18. Plattsburg Fire Department EMT ., EMT . and Sgt. arrived at the pod at 5:45

a.m. EMS loaded Murray onto their stretcher and left to pod at 5:49 a.m. [redacted] .

19. In the Plattsburgh Fire Department patient care report, EMS reported that officers were not outside to meet them therefore they did not enter the jail through the sallyport and had to come in through the front lobby. EMS reported that they were greeted by a CO that did not know what was going on. EMS reported that these factors slowed their time getting to Murray. EMS also documented that they were given the wrong information when dispatched to the jail. EMS reported that they were told that a male of an unknown age overdosed, was given narcan and then became conscious and was breathing. The EMS report documented that because they believed their patient was conscious, they did not bring all of the supplies and equipment that they should have brought for an unconscious patient into the jail. Once EMS reached Murray, they were able to load him onto the stretcher and continue CPR as they rolled the stretcher back to the lobby. [redacted] EMS noted in the report that jail staff did not know how to use their stretcher and were performing poor compressions on Murray. During a review of the video of the terminal event, Commission staff observed that EMS had the stretcher raised to the high position and that the COs were continuing to try and give CPR.

20. [redacted]. During interviews with Commission staff, multiple security staff stated that EMS was told that Murray went unresponsive while speaking with Sgt. C.T. inside his cell. Security staff further indicated that EMS staff delayed Murray leaving housing unit, and claimed that they could not render care due to COVID. The Medical Review Board opines that there was an inadequate response by EMS to Murray's cardiac arrest along with an unsupported justification in the patient care report as to why care was not rendered. The Board finds it unacceptable that the Advanced Life Support providers did not bring appropriate equipment to manage an acute medical emergency. Additionally, the Board finds the field termination procedure that occurred was inappropriate as Murray was a witnessed cardiac with immediate CPR given and should have had advanced cardiac life support interventions attempted.

ACTIONS REQUIRED:

TO THE CLINTON COUNTY JAIL PHYSICIAN:

1. The Jail Physician shall review the adequacy of medical assessments performed by the physician and PA on 5/24/21 and 8/16/21 and investigate the reason why Murray's admission assessments were not reviewed by a provider within 14 days in accordance with 9 NYCRR §7010.2(b)(1).

2. The Jail Physician shall investigate the reason why on 8/25/21, Murray's complaints of

dizziness and stroke symptoms were not adequately addressed by RN ███, why a medical provider was not called, why RN ███. diagnosed Murray with dehydration and ordered increased fluids without referring to a provider, and why RN ███. did not document Murray's respirations in accordance with 9 NYCRR §7010.2(j).

3. The Jail Physician shall review as to why there was no documented review or follow up regarding Murray's documented history of renal cancer.

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

<u>TO THE REGIONAL MEDICAL ADVISOR COMMITTEE AND MEDICAL CONTROL DIRECTOR FOR CLINTON COUNTY:</u>

1. The EMS program director shall investigate the reason why on 9/10/21, EMS personnel did not bring the proper equipment into the Clinton County Jail that was needed to care for Murray and the reason why EMS personnel failed to physically assist jail staff in performing CPR on Murray.

2. The EMS program director shall review the appropriateness of the field resuscitation termination given the lack of any advanced cardiac life support intervention attempted on a witnessed cardiac arrest with immediate intervention and CPR being provided.

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

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:JW:jdb
2021-M-0121
June 2023