NEW YORK STATE | Commission of Correction

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

## In the Matter of the Death of

## Robert Durso (13A4294), an incarcerated individual of the Green Haven Correctional Facility

## March 27, 2024

**To: Honorable Daniel F. Martuscello, III**
**Commissioner**
**NYS Department of Corrections**
**And Community Supervision**
**The Harriman State Campus**
**1220 Washington Avenue**
**Albany, New York 12226**

**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 Robert Durso, who died on November 16, 2021, while an incarcerated individual in the custody of the NYS Department of Corrections and Community Supervision at the Green Haven Correctional Facility, the Commission has determined that the following final report be issued.

FINDINGS:

1. Robert Durso was a 52-year-old male who died on 11/16/21 due to Acute Intoxication by the combined effects of Fentanyl, Heroin, and synthetic cannabinoid (MDMB-4en-PINACA) while in the custody of the New York State Department of Corrections and Community Supervision (NYSDOCCS) at the Green Haven Correctional Facility (CF). Investigators recovered a contraband blue balloon containing four orange sublingual strips from Durso's front pocket after his death and 12 packets of sugar with the same strips inside his cell. The Medical Review Board identified issues with the emergency response to Durso's terminal event that were also identified by NYS DOCCS during their investigation and mortality review.

2. [redacted] In the instant offense, on 3/16/12, Durso attempted to burglarize a private dwelling. Durso was convicted of Attempted Burglary 2nd Degree. Durso was sentenced in September 2013 to 12 years to life in state prison.

3. [redacted]

4. Durso was received at the Downstate CF on 9/27/13. Durso was transferred to Five Points CF until 2017. Durso was then transferred to Auburn CF.

5. On 8/10/21, Durso transferred to Green Haven CF.

6. [redacted]

7. On 11/16/21 at approximately 5:45 a.m., Corrections Officer (CO) I.B. was conducting the master count, arrived at cell J-01-032 and observed Durso sitting on his bunk. Durso had his back and shoulders against the wall and was slumped forward, unresponsive. CO I.B. notified CO M.H. to activate a medical response. Sergeant R.S. responded to the cell. CO B.F., CO R., CO M.H., and CO I.B. then entered the cell. A review of the incident revealed that there was a documented six-minute delay in opening the cell door

of an unresponsive incarcerated individual (II) At 5:52 a.m., CO M.H. administered Narcan without the desired effect. [redacted] A review of the incident revealed that there was a documented 13-minute delay in the initiation of CPR. Per NYS DOCCS Directive 2124 Automatic External Defibrillator: DOCCS requires correctional security staff and healthcare personnel who encounter healthcare emergencies on the job to immediately provide necessary first aid in any event of cardiac or respiratory arrest, to immediately initiate CPR and to use an AED if indicated.

8. [redacted] According to the Office of Special Investigation report, the AED pads became displaced in the transport. Per NYS DOCCS Directive 4059 Response to Healthcare Emergencies: CPR should continue on location until such time EMS paramedics etcetera arrived in the facility. EMS was called at 6:00 a.m. A review of the medical chart revealed that there was a 15-minute delay in the activation of 911 for an II in cardiac arrest. Per NYS DOCCS Directive 2124: each use of an AED must be accompanied by simultaneous activation EMS by calling 911 or similar arrangements to ensure timely provision of advanced life support and transfer to an emergency medical facility. [redacted] This was found to be in violation of NYS DOCCS Directive 2124 Automated External Defibrillator. There was no indication of any oxygen or any oral airway being used during the cardiac arrest response.

9. [redacted] At 6:33 a.m., EMStar EMS arrived. The Medical Review Board questions the efficacy of administering excessive doses (six in this instance) of intranasal Narcan to a subject in cardiac arrest when the lack of adequate circulation hinders the ability of the medication to bind to the opioid receptors.

10. [redacted] The information related to the terminal event was noted on the Emergency Response form but there was no documentation of the cardiac arrest in the medical chart. According to Health Services Policy 4.01 Inmate Health Records Encounter, notes are to be written on ambulatory health record progress note form 3105.

11. Per the NYS DOCCS Unusual Incident Report, an investigator recovered a contraband blue balloon containing four orange sublingual strips from Durso's front pants pocket. Additionally, in Durso's cell, 12 packets of sugar with the same strips were located.

12. A Mortality Review by NYS DOCCS was completed at the facility. Based on the findings of their review, a Corrective Action Recommended included a review and training of security staff and medical staff related to the following findings:

    - There was a documented six-minute delay in opening the cell door of an unresponsive incarcerated individual (II)

- There was a documented 13-minute delay in the initiation of CPR There was evidence in the chart that Durso was moved during resuscitation. and the AED pads became displaced in the transport.

- There was evidence in the chart of a 15-minute delay in the activation of 911 for an II in cardiac arrest.

- There's no evidence of oxygen or any oral airway was used during the arrest.

- The Emergency Response Form was missing the following information: time 911 called, allergies, recorder, and security staff in attendance.

- According to the facility mortality quality investigation, an IV was attempted unsuccessful at 6:25 a.m. But there is no documentation of this in the chart.

- There was evidence on the Narcan Usage Report dated 11/16/21 that two doses of Glucagon were administered intramuscularly. There was only one injection of Glucagon documented on the Emergency Response Form. There was no dosage documented.

ACTIONS REQUIRED:

TO THE DEPUTY COMMISSIONER OF HEALTH SERVICES FOR DOCCS:

The Board requests that the Deputy Commissioner conduct a review of first responder Narcan use on subjects in known cardiac arrest to prevent the use of interventions that have minimal effect.

*In a response dated 1/26/24 DOCCS Deputy Commissioner for Health Services indicated they would take the Board's findings under advisement and review.*

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 27 h day of March 2024.

Allen Riley
Chairman
Commission of Correction

AR:DC:vc
2021-M-0155
March 27, 2024

cc: Dr. Carol Moores, Deputy Commissioner Chief Medical Officer
James Donahue, Associate Commissioner of Mental Health
Superintendent Mark Miller, Green Haven CF