NEW YORK STATE | Commission of Correction

Final Report of the New York State Commission of Correction:

In the Matter of the Death of

Jason Heisler, an incarcerated individual of the Chenango County Jail

March 27, 2024

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

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 Jason Heisler, who died on February 2, 2023 , 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.

FINDINGS:

1. Jason Heisler was a 50-year-old male who died on 2/2/23 from an acute myocardial infarction with coronary vessel rupture 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 Heisler during his incarceration. The Board opines that had Heisler been properly assessed, been properly referred to the jail physician, and timely transferred to a hospital for immediate intervention, his death may have been prevented.

2. Heisler was born in Norwich, NY. Heisler was divorced and had one child. Heisler had a High School Diploma and was unemployed. Heisler served in the Marines from 1994 to 1998 but was dishonorably discharged. There was no further demographic or social history available to the Commission for Heisler.

3. Heisler had no significant medical history and was not prescribed any medications.

4. [redacted]

5. [redacted]

6. On 1/30/23 at 3:30 p.m., Heisler was admitted to the Chenango County Jail by Corrections Officer (CO) C. after being charged with Sex Offender Failure to Report Change of Address. Heisler scored a “five” on the Suicide Prevention Screening Guidelines for being very worried about his dogs, having a family member that attempted or committed suicide, having a history of alcohol and marijuana use, having a previous suicide attempt, and displaying unusual behavior or talking in a strange manner. Heisler reported that the last time he used Marijuana and drank beer was two months prior to his incarceration. CO C. documented that Heisler reported being diagnosed with [redacted] and CO C. notified the on-duty Supervisor. Heisler was placed on 7-to-10-minute supervision rounds by security staff for reporting that he was diagnosed with [redacted]. CO C. referred Heisler to be seen by medical and mental health for an evaluation.

7. [redacted] A review of Heisler's medical chart by Commission staff revealed that RN [redacted] did not notify the facility physician that Heisler had a pulse rate of 108 nor re-evaluate his vital signs to see if there was any improvement. The Medical Review Board finds that RN [redacted] should have notified the facility physician that Heisler had a pulse of 108 in order to obtain further instructions regarding Heisler's medical care. Additionally, the Medical Review Board opines that since Heisler was presenting with an elevated pulse after reporting a regular alcohol drinking history, placement on the Clinical Institute Withdrawal Assessment (CIWA) should have been considered.

8. [redacted]

9. A review of the Housing Unit C logbook by Commission staff revealed that Heisler did not come out of Housing Unit C from 1/31/23 through 2/1/23. A review of Heisler's medical records by Commission staff revealed that Heisler was not seen by medical or mental health from 1/31/23 through 2/1/23.

10. On 2/2/23 at 8:05 a.m., documentation in the unit logbook indicated that CO J.C. started his duty on Housing Unit C with a formal head count of 31 incarcerated individuals (II) with four IIs on 7-to-10-minute supervision rounds.

11. On 2/2/23 at 9:13 a.m., CO J.C. documented in the Housing Unit C logbook that Heisler had movement out of the unit. CO J.C. did not document where Heisler went when he was off of the unit. During an interview with Commission staff, CO J.C. reported that Heisler had left the unit to appear in Court.

12. On 2/2/23 at 12:22 p.m., CO J.C. documented in the Housing Unit C logbook that Heisler returned to the unit.

13. [redacted]

14. On 2/2/23 at 2:11 p.m., CO J.C. documented in the Housing Unit C logbook that Heisler had movement out of the unit. During an interview with Commission staff CO J.C.

reported that he took Heisler to [redacted] and then he returned to the unit to escort another II to mental health. When CO J.C. returned to the [redacted] area, he heard Heisler talking to [redacted]. CO J.C. indicated that Heisler was talking very fast and that he appeared to be very agitated and stressed out. CO J.C. reported that he had not heard Heisler talk in that manner on the unit.

15. [redacted]

16. On 2/2/23 at 2:43 p.m., CO J.C. documented that Heisler returned to the unit. During an interview with Commission staff, CO J.C. reported that Heisler appeared to be calmer when he returned to the unit [redacted].

17. During an interview with Commission staff, CO J.C. reported that just prior to the end of the shift at 4:00 p.m., Heisler was at his cell door banging on the door. CO J.C. went over to Heisler and Heisler reported that he was having stomach pain. CO J.C. indicated that Heisler reported, “It’s the worse stomach pain I have ever had”. CO J.C. reported that he told Heisler that he was going to call for the nurse and he had Heisler sit down on his bed. CO J.C. reported that Heisler was breathing normal, he had a grimace on his face, and that Heisler was profusely sweating. CO J.C. reported that he immediately called medical and spoke to RN [redacted] and explained that she needed to come and check on Heisler because he was complaining that his stomach was hurting, he was in a lot of pain, and he was sweating. CO J.C. reported that he passed all of the information that he had from Heisler that day, starting at the [redacted] up to RN [redacted] being called to check on Heisler for his complaints of stomach pain, to the oncoming officer CO S.B. A review of the Housing Unit C logbook by Commission staff found that CO J.C. did not document in the logbook that medical had been called for Heisler for having a significant event. This is a violation of 9 NYCRR §7003.3(j)(6)(i)-(iii) which states*: All written records pertaining to facility housing supervision required pursuant to this section shall be recorded in ink in a bound ledger of consecutively numbered pages which shall be maintained in each housing area. Such records shall include, but not be limited to, the following information: any significant events and activities occurring during supervision, including*: *the date and time of such event or problem; the names of all incarcerated individuals and/or staff involved; facility staff response to such event or problem, including a summary of what occurred; a description of the condition of any incarcerated individuals involved.*

18. During an interview with Commission staff, CO S.B. reported that when he took over the housing unit on 2/2/23, CO J.C. reported to him that he had notified medical that Heisler was not feeling well. A review of the Housing Unit C logbook by Commission staff found that CO S.B. did not document in the logbook that medical arrived on the unit to see

Heisler. This is also a violation of 9 NYCRR §7003.3(j)(6)(i)-(iii).

19. [redacted] A review of Heisler's medical record by Commission staff found that RN [redacted] did not document assessing an apical pulse on Heisler for tachycardia, palpating Heisler's abdomen to identify the region or the type of stomach pain that Heisler was experiencing, or address Heisler's hyperventilating.

20. During an interview with Commission staff, [redacted] RN [redacted] reported that the facility does not have oxygen. [redacted]

21. The Medical Review Board has found that there were multiple deficiencies in the medical assessments and treatment of Heisler prior to his terminal event. A review of Heisler's medical records by Commission staff found that RN [redacted] did not document her complete assessment as reported to the Commission staff in Heisler's medical chart and dismissed his signs and symptoms as being solely epigastric related without considering the possibility of acute coronary syndrome. RN [redacted] left Heisler who was still hyperventilating and discussed her assessment findings with a psychiatric nurse practitioner, PNP [redacted], who happened to be at the jail for mental health patients instead of calling the facility physician. The Medical Review Board finds that RN [redacted] did not

notify the facility physician, the responsible authority for the jail's medical care, that Heisler was hyperventilating, tachycardic with a pulse of 102, diaphoretic, and had complaints of stomach pain. The Board opines that had Heisler been properly assessed and timely transferred to a hospital for acute epigastric pain, a complaint that often masks underlying acute coronary syndrome, Heisler's death may have been prevented. The Medical Review Board also found from review that Heisler had extensive cardiac necrosis along with a thrombus which indicated that Heisler was experiencing a myocardial infarction for three to four days prior to his terminal event.

22. During an interview with Commission staff, PNP [redacted] reported that her job duties at the Chenango County Jail are psychiatric assessment and prescribing along with being in charge of the Medication Assisted Treatment (MAT) program. PNP [redacted] reported having a duel certification as a Family Nurse Practitioner (FNP) but that she was not hired in the FNP capacity for the jail. [redacted]

23. Information given to Commission staff by Chenango County Jail's administrative staff found that PNP [redacted] is contracted by the Chenango County Jail to serve as a Psychiatric Nurse Practitioner. Although PNP [redacted] is also qualified as a Family Nurse Practitioner , she is not contracted with the Chenango County Jail for routine medical management of patients at the jail. The Medical Review Board opines that PNP [redacted] should have deferred treatment decisions in this matter to the jail physician.

24. On 2/2/23 at 6:49 p.m., CO S.B. documented in the Housing Unit C logbook that RN [redacted] was on the unit for medication pass. [redacted] The Medical Review Board opines that there was a failure by RN [redacted] to properly follow up on

Heisler who should have at minimum had a full set of vitals taken.

25. On 2/2/23 at 10:03 p.m., CO S.B. was conducting a 7-to-10-minute check on Heisler on Housing Unit C and observed Heisler laying on his bunk in cell # 5 with his head and arm laying off the side of the bunk. During an interview with Commission staff, CO S.B. reported alerting RN [redacted] and CO H., who were on the housing unit for medication pass, that Heisler was unresponsive. CO S.B. reported that CO H. and RN [redacted] entered cell # 5 and [redacted] Sergeant (Sgt.) J.G. and CO B. arrived at the scene with the Automated External Defibrillator (AED) [redacted]

26. A review of Heisler's medical chart by Commission staff found that RN [redacted] did not document the occurrence of the medical emergency, the assessment of Heisler, performing CPR, or the death of Heisler in Heisler's medical chart. This is a violation of 9 NYCRR §7010.2(j) Health Services 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.*

27. On 2/2/23 at 10:14 p.m., Norwich Fire/EMS arrived at the scene and assumed the care of Heisler. [redacted]

28. A review of Heisler's medical chart by Commission staff finds that Heisler demonstrated signs and symptoms of an impending myocardial infarct hours prior to going into cardiac arrest. Heisler was exhibiting an increased heart rate, he was hyperventilating, he was diaphoretic, he had complaints of stomach pain, he had complaints of gas with belching, he was very agitated, and he was anxious. The Medical Review Board opines that had Heisler received a proper medical assessment by RN [redacted] and the facility physician Dr. [redacted] had been consulted to medical's assessment findings, his death may have been prevented. The Medical Review Board also opines that the cited deficiencies of the nursing assessments and care is indicative of absent supervision of the nursing staff by the jail physician.

ACTIONS REQUIRED:

TO THE OFFICE OF CHENANGO COUNTY SHERIFF:

The Sheriff shall conduct an inquiry into the conduct of the correction officers responsible for Heisler's supervision that failed to document significant events that occurred with Heisler on 2/2/23 in comportment with 9 NYCRR §7003.3(j)(6)(i)-(iii).

TO THE OFFICE OF CHENANGO COUNTY SHERIFF AND CHENANGO COUNTY JAIL PHYSICIAN:

The Sheriff and the Jail Physician shall arrange to have an independent physician peer review regarding Heisler's medical care to answer the following:

1. On 1/30/23 at 8:17 p.m., why RN [redacted] failed to notify the facility physician that Heisler had a pulse of 108 in order to receive further instructions.
2. On 1/30/23 at 8:17 p.m., why RN [redacted] did not consider placing Heisler on the Clinical Institute Withdrawal Assessment (CIWA) due to the elevated pulse and Heisler reported drinking alcohol 1-2 drinks, two times a week.
3. On 2/2/23 at an unindicated time, why PNP [redacted] prescribed Heisler [redacted] daily.
4. On 2/2/23 at 4:15 p.m., why RN [redacted] reported to PNP [redacted] that Heisler was hyperventilating, tachycardic with a pulse of 102, diaphoretic, and had complaints of stomach pain instead of notifying the facility physician.
5. On 2/2/23 at 4:15 p.m., why RN [redacted] left Heisler in his cell unattended while he was hyperventilating with complaints that his lips and fingertips were prickly.
6. Why the facility is not equipped with portable oxygen tanks.
7. On 2/2/23 at 4:15 p.m., why RN [redacted] did not call the facility physician to notify him that Heisler was hyperventilating, tachycardic with a pulse of 102, diaphoretic, and had complaints of stomach pain.
8. On 2/2/23 at approximately 10:03 p.m., why RN [redacted] did not document the assessment of Heisler, performing CPR, or the death of Heisler in Heisler's medical chart in comportment with 9 NYCRR §7010.2(j).

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

In a response dated 2/21/2024 to the Commission's preliminary report, the Chenango County Sheriff's Office and Jail Physician indicated the requested reviews were completed with corrective action including retraining of staff was completed.

TO THE CHAIR OF THE CHENANGO 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 DEPARTMENT OF EDUCATION, OFFICE OF PROFESSIONAL DISCIPLINE:

The Medical Review Board requests that an investigation be conducted into the professional misconduct of Registered Nurse [redacted] for failing to maintain proper records due to not documenting the assessment of Heisler, performing CPR, or the death of Heisler in Heisler's medical chart.

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:BB:vc
2023-M-0012
March 27, 2024